

BRITISH MEDICINE IN WEST AFRICA, 1800-1860

HEALING THE 'AFRICAN BODY' IN THE AGE OF ABOLITION?

BRITISH MEDICINE IN WEST AFRICA, CIRCA 1800-1860

By

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ABSTRACT:

This investigation provides an in-depth examination of British and African interactions in British West Africa within the field of health and medicine, circa 1800-1860. It examines how Britons perceived, created, and understood Africans and their bodies during a period of extensive and significant change. This assists our understanding of one of the historical roots of racialized medicine, provide insight into British perceptions of and interaction with overseas peoples, and illuminates how Britons developed or expanded notions about Africans, their bodies, and their health during a relatively neglected period for relevant scholarship. It also examines African responses to European medicine in a variety of contexts. In order to gain a clearer understanding of the intersection of race and medicine during this period, the study examines how leading theorists of race formulated and constructed the African body, explores how missionaries from the Church Missionary Society and Wesleyan Methodist Missionary Society understood health and medicine, examines the British medical system established in West Africa and particularly the ways in which it handled the care of liberated Africans, and studies the health of European and African personnel in the armed forces stationed in West Africa. The thesis emphasizes the multiplicity both in forms of medical practice and in approach to ‘the African body.’

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Chapter One

Introduction: Objectives; Contexts; Historiography

This study explores the relationship between Britons and West Africans circa 1800-1860, in respect to the topics of health and medicine. It examines British/African interactions to determine how Britons, especially in West Africa, perceived, created, and understood Africans and their bodies during a period of extensive and significant change. This will assist in our understanding of one of the historical roots of racialized medicine, provide insight into British perceptions of and interaction with overseas peoples, and illuminate how Britons developed or expanded notions about Africans, their bodies, and their health during a relatively neglected period for relevant scholarship. The study also examines (as far as British sources permit) the bi-directional nature of medical practice and knowledge in Africa, African therapeutics and reactions to European medicine, and how British medical practitioners managed African health complaints.

From the late eighteenth to the middle of the nineteenth century, British perception of and involvement in Africa changed dramatically. In the late eighteenth century the trans-Atlantic slave trade was still in full operation. Most Britons in West Africa were either directly involved in the slave trade or were, as in the case of the Royal Navy, stationed in West Africa to protect the trade. Africa was largely understood as a place to acquire labour. From the 1780s,

Britons began to view West Africa differently.¹ Increasingly, the slave trade had come under attack. The British mercantile system gave way to industrialists and free market advocates, who disproved of the sugar duties that ensured the profitability of West Indian sugar.² Industrialists pushed for the ending of these duties and for free labour to be established throughout the Empire. They argued that free labour and trade would open new markets, creating wealth both in the colonies and at home. Abolitionists also worked to advance the image of a productive Africa buttressed by free labour. No longer was Africa seen primarily as a place to extract labour but as an ideal location for the establishment of free labour. As the abolitionists campaigned for the ending of the slave trade, new plans were created for the settlement of Blacks, including Black loyalists, in West Africa.³ Granville Sharp, a leading advocate of settlement, devised a plan whereby a utopian society based on the principles of equality would be established in Sierra Leone. The new settlement, called the “Province of Freedom” established a basis for future British involvement in West Africa. The vision of a productive Africa buttressed by free trade was an enduring one. It is the power of this image that explains to a considerable extent why numerous Britons risked their lives in Africa.

¹ Philip Curtin, *The Image of Africa; British Ideas and Action, 1780-1850* (Madison: University of Wisconsin Press, 1964), vi.

² Eric Williams, *Capitalism and Slavery* (Chapel Hill: The University of North Carolina Press, 1944), 135-153; Seymour Drescher, *The Mighty Experiment: Free Labor versus Slavery in British Emancipation* (Oxford: Oxford University Press, 2002), 25-26.

³ Drescher, *The Mighty Experiment*, 91.

The first half of the nineteenth century ushered in a new era of discovery. Increased attention was paid to the study of the ‘black body,’ as theories were developed to explain physical differences between ‘Africans’ and ‘Europeans.’ The enthusiasm surrounding Africa led to the formation of new missionary societies, especially the Anglican Church Missionary Society (CMS), and encouraged the established Wesleyan Methodists Missionary Society (WMMS) to turn its attention to Africa.⁴ Missionaries were sent to heal the African soul which they believed had been debased by slavery.⁵ The abolition of the slave trade in 1807 came with increasing responsibilities in care and support. The Royal Navy was charged with policing the West African coast to prevent the illegal transport of slaves. This led in time to a greatly increased presence. To deal with this added responsibility and also as a way of protecting European lives from the deadly fevers of West Africa, Africans were hired to serve along side European naval personnel. Overall, British plans in West Africa increasingly rested on liberated Africans, those rescued from slavers, who were expected to form the nucleus of civilization and to generate wealth for export. This was the beginning of *The Mighty Experiment* where abolitionist and industrialist would prove that free labour was more productive than slave labour.⁶ In 1833, the “experiment” expanded as slavery was abolished throughout the empire. Despite the long-term

⁴ The Church Missionary Society was originally named The Society for the Missions to Africa and the East. The Society soon referred to itself as the Church Missionary Society. This name became official in 1812.

⁵ *Proceedings of the Church Missionary Society for Africa and the East*, 1803, (London: Church Missionary House), 202-203. Later references will be *Proceedings of CMS*.

⁶ Drescher, *The Mighty Experiment*, passim.

failures of this project,⁷ the image of a productive and profitable Africa continued to inform Britons' understanding of Africa and its place within an expanding British empire.

The first half of the nineteenth century marks the zenith of British fascination in West Africa. With the possible exception of 1890-1940, no period can boast of the range of scientific, geographic, and ethnographic information produced during this half century.⁸ Britons were involved with Africa on numerous levels, from the reading of travel literature to mass involvement with the abolitionist movement.⁹ Africans had a role to play in Britons' understanding of themselves. Peter Fryer has argued that the British working class drew parallels between slavery and their own experiences and by doing so, workers developed sympathy for the enslaved.¹⁰ At the beginning of the nineteenth century, Britons were more interested in and 'knew' more about Africa than any generation until the 1950s.¹¹ The desire to explore, understand, and utilize Africa is best represented by the excitement, cost, and the hopes attached to the ill-fated 1841 Niger Expedition. Devised to spread legitimate (non-slave) trade and Christianity to the interior, the Niger Expedition cost the frugal British

⁷ Drescher, *The Mighty Experiment*, 158-230.

⁸ Curtin, *Image of Africa*, vi.

⁹ Roger Anstey, *The Atlantic Slave Trade and British Abolition, 1760-1810* (London: Humanities Press, 1975); Seymour Drescher, *Capitalism and Antislavery; British Mobilization in Comparative Perspective* (London: MacMillan Press, 1986); Clare Midgley, *Women Against Slavery: The British Campaigns, 1780-1870* (London: Routledge, 1992).

¹⁰ Peter Fryer, *Staying Power: The History of Black People in Britain* (London: Pluto, 1984), 212. Scholars in turn have examined this consciousness: Peter Linebaugh and Marcus Rediker, *The Many Headed Hydra: Sailors, Slaves, Commoners, and the Hidden History of the Revolutionary Atlantic* (Boston: Beacon Press, 2000).

¹¹ Curtin, *Image of Africa*, 9-10.

government an astounding 79,143 pounds.¹² The expectations attached to this expedition, despite previous failures to extend British power inland, demonstrates how detached Britons could be from the realities of Africa. Britons whose opinions and value systems are known to us customarily saw Africa not as it was, but as it could and should be.¹³ This encouraged a positive mindset that downplayed the dangers of the African equatorial climate and other risks and limitations.

Little is known, at present, about how the developing racial theories of the period influenced the conception or practice of medicine in West Africa up to circa 1860. Historians have examined the published racial theories, the range of geographic discoveries, and Britain's lofty goals; however, our understanding of Africa should go deeper than simply how Africans were constructed in the metropole. This thesis aims to examine, as best as the British records allow, the mundane every-day medical activities (understood broadly) which occurred in British West Africa. It adds a new perspective to constructions of Africans made from afar by investigating how Africans were understood by Britons who traveled to Africa. It studies both how Africans were constructed on the ground and how theories of race were put into practice. Only by examining British/African interactions in a variety of contexts - in the Royal Navy, with missionaries, and within British managed health-care for liberated Africans - can an assessment of

¹² Howard Temperley, *White Dreams, Black Africa: The Antislavery Expedition to the River Niger, 1841-42* (New Haven: Yale University Press, 1991), 114-116.

¹³ Curtin, *Image of Africa*, vi.

the intersection between race and medicine be achieved. One result is that it can now be determined whether British medical practitioners and missionaries in African relied on previously established theories about Africans or whether they developed their own understanding of Africans and their bodies.

This research project commenced with the posing of a series of central, initial, questions: How did the perception of the tropics as a unique and deadly disease environment affect British perceptions of the health of African patients? What does the practice of the treatment of African bodies add to the nineteenth-century theories of racialized medicine? The research strategy hypothesized that these and other questions could best be pursued by examining the minutia of the daily medical interactions between British medical officers (and others, on the ground in West Africa) and Africans. Too much of our current understanding of race and medicine in West Africa is based solely upon the published medical theories found in nineteenth-century medical journals and monographs. These sources are important, providing insights into the theories of race and medicine held by British physicians and others. However, they do not tell us how medical officers or representatives of church and state actually dealt with different African groups and peoples who held various claims to health assistance or medical attention. By examining the unpublished casebooks, medical journals, and correspondence from the manuscript collections of the British National Archives, the British Library, Rhodes House Library, and the Wellcome Library, the thesis contributes a practical component to our collective understanding of race and

medicine in early nineteenth century Africa. Existing scholarship does not tell us how the theory and the practice of race and medicine interconnected. This is an important theme.

Contexts and Actors

The thesis examines how a variety of British actors on the scene (naval, missionary, colonial) understood and interacted with a multitude of Africans in respect to the history of health and medicine. It is appropriate to introduce pertinent historical actors, institutions, and ideas while providing background information necessary for comprehension. The British divided Africans into a variety of categories based on language, geography, legal status, assumed ethnic differences, and religious affiliations. The primary categories of Africans as formulated by the British and examined in the thesis are Kroomen, workers from present day eastern Liberia who frequently hired themselves out to the Royal Navy; liberated Africans, those who had been rescued from slavers and ‘repatriated’ to Sierra Leone; native Africans, any African who was neither a liberated African nor a Kroomen; and Blacks, those of African descent domiciled outside of Africa. Since British officials did not perceive all Africans to be alike, or possessing equal claims to assistance, and because they tended to generalize about each ‘group,’ it is important to examine how each prescribed grouping was understood and treated.

British involvement in West Africa began in the 1550s and developed with slavery during the seventeenth century. In 1660, the newly restored House of

Stuart created the Royal African Company to increase profits from Africa.¹⁴ Over the course of the seventeenth and eighteenth centuries, activity in West Africa increased as Britons became heavily involved in the slave trade. Colonialization can be traced to the creation of the Province of Freedom in 1787.¹⁵ Freetown, founded in 1792 by the Sierra Leone Company, became the main focus of British efforts in Africa.¹⁶ In 1808, Sierra Leone became a crown colony. In 1821, the British Gold Coast, which had been administered by the Royal African Company or its successors since 1752, came under crown control.¹⁷ In 1816, the British developed the military port of Bathurst (present-day Banjul) which became the seat of British power in the Gambia. In 1821, the Gambia became a Crown colony.¹⁸ The governors of the Gold Coast, until 1850, and the lieutenant governors of the Gambia, until 1843, were subordinate to the lieutenant governors and later governors of Sierra Leone. Effective control over these territories was

¹⁴ Originally known as the Company of Royal Adventures Trading to Africa. For useful histories of British West Africa see: Robin Law, *The Slave Coast of West Africa, 1550-1750: The Impact of the Atlantic Slave Trade on an African Society* (Oxford: Oxford University Press, 1991), esp., 116-224; George Claude, *The Rise of British West Africa; Comprising the Early History of the Colony of Sierra Leone, the Gambia, Lagos, Gold Coast, etc. With a Brief Account of Climate, the Growth of Education, Commerce and Religion and Comprehensive History of the Bananas and Bance Islands and Sketches of the Constitution* (London: Houlston and Sons, 1903); Basil Davidson, *West Africa Before the Colonial Era: A History to 1850* (London: Longman, 1998); Stephen Braidwood, *Black Poor and White Philanthropists: London's Blacks and the Foundation of the Sierra Leone Settlement 1786-1791* (Liverpool: Liverpool University Press, 1994).

¹⁵ John Peterson, *Province of Freedom: A History of Sierra Leone, 1787-1870* (London: Faber, 1969).

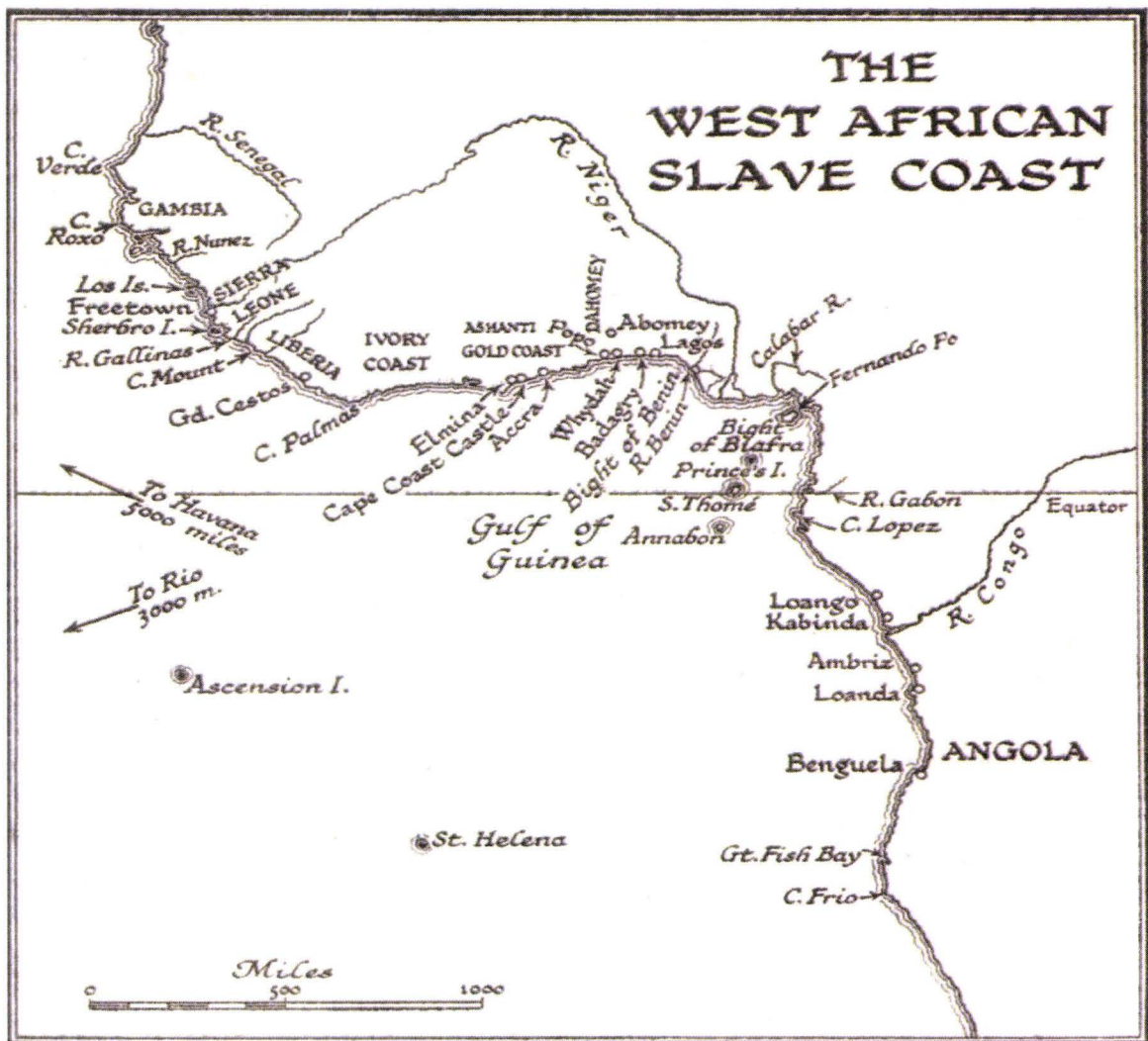
¹⁶ Ellen Gibson Wilson, *The Loyal Blacks* (New York: Capricorn Books, 1976), 158-404; Mary Louise Clifford, *From Slavery to Freetown: Black Loyalists after the American Revolution* (Jefferson: McFarland, 2006).

¹⁷ Kenneth Gordon Davies, *The Royal African Company* (London: Longmans, 1957). For an economic study of the decline of the Royal African Company, see: Ann Carlos and James Brown Kruse, "The Decline of the Royal African Company: Fringe Firms and the Role of the Charter" *The Economic History Review*, ns, 49, no. 2 (May, 1996): 291-313.

¹⁸ Harry Gailey, *A History of the Gambia* (London: Routledge, 1964).

restricted to locations along the coasts and with the exception of Sierra Leone rarely extended into the interior prior to 1860. This thesis, while including relevant material for all three colonies and for the naval base at Ascension, is largely focused upon Sierra Leone, the centre of British power, administration, and concern during the first half of the century.

Map of The West African Slave Coast 1.1¹⁹



¹⁹ Christopher Lloyd, *The Navy and the Slave Trade: The Suppression of the African Slave Trade in the Nineteenth Century* (London: Longmans, Green and Co, 1949), 13.

The West African disease environment proved hostile to unacclimatized European bodies. A high mortality rate was a defining feature of European efforts in West Africa. While reliable statistics are difficult to find, contemporaries did emphasize, however haphazardly, the high European mortality. Early efforts at colonization reveal the high mortality figures. Forty-six percent of Europeans associated with the Province of Freedom and forty-nine percent of Europeans who travelled under the auspices of the Sierra Leone Company died in their first year in West Africa.²⁰ Fifty-four out of eighty-nine missionaries sent to West Africa between 1804 and 1825 died on site, producing a mortality of 606.7 per thousand.²¹ These figures were not out of line with other contemporary accounts.²² This high mortality (and associated morbidity) severely restricted British action and efforts in West Africa. Because of its importance to European advancement, expatriate health in Africa was an ever important issue.

Changes within British churches, most importantly the evangelical revival of the eighteenth century, encouraged Britons to reconsider their role in a world community. This, coupled with a growing concern for the 'plight' of Africa, inspired missionary societies to turn their gaze towards Africa. Two British missionary societies were influential in British West Africa during the half century: the Methodist WMMS; and the Anglican CMS. The WMMS sent its first missionaries to Freetown, Sierra Leone, in 1811. Although formed in 1800

²⁰ Curtin, *Image of Africa*, 483-484.

²¹ Curtin, *Image of Africa*, 483-484.

²² Philip Curtin has compiled a useful appendix of comparative mortality figures, *Image of Africa*, 483-487.

the CMS had difficulty attracting English missionaries for overseas service. Especially in the early years, the CMS relied upon German missionaries recruited from a Lutheran seminary in Basel. The CMS sent its first mission to Africa in 1804. Set on the banks of the Rio Pongas, an area located about a hundred miles north of Sierra Leone, the first mission focused its efforts upon the Susu people.²³ In 1818, after very little was achieved the mission was abandoned. The CMS increasingly focused its attention upon Freetown. After 1807, the CMS and WMMS proselytized to liberated Africans who, because of their dislocation and the harsh treatment they had received, were considered prime targets for conversion.

Slave trade suppression greatly increased the Royal Navy's presence on the West African coast. Although initially staffed by only two ships, by 1847, the height of the Royal Navy's presence, thirty vessels were assigned to suppression.²⁴ The Royal Navy dealt with this increase by hiring Africans, especially Kroomen, to supplement its personnel. Kroomen served under a headman, an experienced sailor who was responsible for 'his' workers. Although supplementary labourers, Kroomen were subjected to the ship's discipline and medical structures. Most medical care within the Royal Navy occurred on board under the direction of the ship's surgeon. However, serious cases could be transferred to hospital, especially to Ascension Island Naval Hospital, the primary

²³ Susu was also commonly spelled Suso or Soosoo by British authorities, traders, and religious figures.

²⁴ Lloyd, *The Navy and the Slave Trade*, 283.

care facility for the West African Station. The comparative health experiences of African and European personnel will be explored below (in chapter five).

A variety of British medical practitioners served in West Africa in the first half of the nineteenth century. Many came in service of the Royal Navy. Dr. Thomas Masterman Winterbottom, and others, worked for the Sierra Leone Company prior to the transfer to crown control. Other practitioners, such as Robert Clarke, served the colonial government. Clarke, who served in Sierra Leone from 1837 to 1854, worked at Kissy Hospital. Located on the eastern outskirts of Freetown, Kissy was the largest and most important British colonial hospital in West Africa. Some such as William Fergusson served as surgeons in the Army before becoming part of the colonial medical department. Other surgeons arrived to support the exploration of the interior of Africa. The hopes attached to the 1841 Niger Expedition coupled with its spectacular failure encouraged many of the practitioners associated with the voyage to publish their medical accounts.²⁵ The fact that British medical practitioners served in different capacities, attending to a mixed and sometimes vast array of Africans, provides the opportunity to study the health of Africans through a variety of individual perspectives and actions.

²⁵ Morris Pritchett, *Some Account of the African Remittent Fever Which Occurred on Board Her Majesty's Steam-Ship Wilberforce in the River Niger and Whilst Engaged on the Western Coast of Africa: Comprising an Inquiry into the Causes of Disease in Tropical Climates* (London: John Churchill, 1843); James Ormiston McWilliam, *Medical History of the Expedition to the Niger During the Years 1841-42, Comprising an account of the Fever which led to its Abrupt Termination* (London: John Churchill, 1863); William Allen and T. R. H. Thompson, *A Narrative of the Niger Expedition sent by her Majesty's Government to the River Niger in 1841*, 2 vols. (London: Richard Bentley, 1848).

In general, medical practitioners hired for colonial work in West Africa were distributed between the colonies of Sierra Leone, the Gambia, and the Gold Coast. British medical practitioners, similar to other officials in Africa, were located almost exclusively in the capitals of each of these colonies. Medical departments were small. Sierra Leone had the largest and could boast of having only three to four British medical practitioners on staff at a time. The medical allotment for the Gambia and the Gold Coast was two surgeons respectively. Each medical department was headed by a colonial surgeon who reported directly to the colony's governor.²⁶ The governors were in turn responsible to the War and Colonial Office.

The War and Colonial Office managed Britain's overseas Crown colonies, under a cabinet member called the Secretary of State for the Colonies. The Colonial Office was established in 1768. In 1782, with the loss of its American possessions, responsibility for the remaining colonies was entrusted to the Home Office until being transferred to the War Office in 1794. In 1801, to reflect the growing importance of the colonies, the War Office was renamed the War and Colonial Office. In 1854, a new and separate Colonial Office was formed to better manage the needs of the colonies.²⁷

²⁶ Thomas Winterbottom had been physician to the Sierra Leone Company; later under crown control, medical personnel held the titles of colonial surgeon, surgeon, or assistant surgeon. By this period, they had received formal training in physic as well as surgery, and were entitled to be termed 'Dr.' For the Royal Navy, the first half of the nineteenth century witnessed the development of university trained M.D.s as ship's surgeons and the replacement of surgeon's mates with assistant surgeons.

²⁷ The following offer detailed histories of the Colonial Office: Henry Lindsay Hall, *The Colonial Office, A History* (London: Longmans, 1937); Sir Charles Joseph Jeffries, *The Colonial*

Colonial medicine allowed the dominant power to re-order the lives of subject people, employing medical discourses that affirmed their own medical, cultural, and racial superiority.²⁸ It was an integrated system whereby medicine is closely associated with the ruling elite. In Africa, colonial practitioners and administrators desired the abolition of ‘traditional’ practices, making western biomedicine the only option. This control was accomplished by ridiculing and suppressing traditional forms and practices.²⁹ Colonial medicine was capable of re-casting non-Europeans as “reservoirs” of disease that must be ordered and controlled.³⁰ Such a construction created both intellectual and physical difference as non-Europeans were separated from Europeans.³¹ Medicine became not only an agent of colonization, but was also customarily employed as the litmus test for progress. Rejection of European medicine served as proof of a lack of civilization, while those who submitted to colonial medicine affirmed their progress.³²

Office (London: Allen & Unwin, 1956). Colonial Office will be employed as a short hand for the various incarnations of this Office.

²⁸ David Arnold, “Medicine and Colonialism,” in *Companion Encyclopedia of the History of Medicine*, ed. W. F. Bynum and Roy Porter, vol. 2 (London: Routledge, 1993), 1406-07; David Arnold, “Introduction: Disease, Medicine and Empire,” in *Imperial Medicine and Indigenous Societies*, ed. David Arnold (Manchester: Manchester University Press, 1998), 8.

²⁹ Arnold, “Introduction: Disease, Medicine and Empire,” 7; Arnold, “Medicine and Colonialism,” 1408.

³⁰ John Farley, “Bilharzia: A Problem of ‘Native Health’, 1900-1950,” in *Imperial Medicine and Indigenous Societies*, ed. David Arnold (Manchester University Press, 1988), 194.

³¹ Philip Curtin, “Medical Knowledge and Urban Planning,” in *The Social Basis of Health and Healing in Africa*, ed. Steven Feierman and John Janzen (Berkeley: University of California Press, 1992), 242-247.

³² This understanding of non-European responses to European medicine was popular in missionary correspondence, see chapter 3, 188-189.

The education of physicians differed widely throughout Scotland and England. In England, medical education was loosely organized. Students were expected to learn from attending lectures and by “walking the wards.”³³ The lectures focused upon theories of disease and new treatment options while the wards provided practical experience. As Charles Newton explains, medical education “was entirely unorganized – it was left to the student to decide on his own curriculum and to find out how it could be followed.”³⁴ Medical education strove to produce “a cultured and highly educated gentleman, with, quite secondarily, an adequate knowledge of medicine.”³⁵ While physicians were learning about bodies and medical science, they were also undergoing another form of education: learning the refinements of the growing profession. Education in England and Scotland was a mix of both the old and the new. The classics were considered an important part of medical training, while by 1800 increased attention was afforded to the emerging medical sciences.³⁶ Medical students were schooled in the miasmatic theory, the belief that bad airs were the cause of disease. Professors had their own opinions on which diseases (if any) were to be regarded as contagious. It is difficult to make generalizations about the exact character of education, for the dedicated and initiated student could profit from the freedom to explore while others could pass through a system that had few checks and little regulation. The Scottish system, a popular option, was highly

³³ Charles Newman, *The Evolution of Medical Education in the Nineteenth Century* (London: Oxford University Press, 1957), 9.

³⁴ Newton, *Medical Education in the Nineteenth Century*, 9.

³⁵ Newton, *Medical Education in the Nineteenth Century*, 9.

³⁶ Newton, *Medical Education in the Nineteenth Century*, 56-57.

structured. Organized around three main areas of study - pathology, physiology, and therapeutics - this system strove to offer students an in-depth understanding of disease and the functions of the human body.³⁷ Students received their education from professors who in addition to their university duties often continued in private practice.³⁸ It is difficult to assess what students gained from their education for they were bombarded with contradictory advice. They were at once instructed to adhere to the knowledge of Galen and other classical writers but also encouraged to embrace the new emerging sciences. Their own professors held contradictory views on exact causes of disease. Medical reform, which began in the first half of the nineteenth century, and helped to standardize medical education, had little impact on practice until the second half of the century.³⁹ Because of the diversity contained within British systems of medical education, it is difficult to construct meaningful generalizations on the medical ideas imbued during training in the minds of those who went on to serve as practitioners in West Africa.

Information is known about seven of the central medical figures examined in the thesis: Robert Knox, Thomas Winterbottom, William Fergusson, Charles White, Sir William Lawrence, James Lind, and James Cowles Prichard. Knox attended Edinburgh University graduating Medical Doctor (M.D.) in 1814. Winterbottom also attended Edinburgh University 1787 to 1788, but undertook

³⁷ Stephen Jacyna, "Theory of Medicine, Science of Life: The Place of Physiology Teaching in Edinburgh Medical Curriculum, 1790-1870," in *The History of Medical Education in Britain*, ed. Vivian Nutton and Roy Porter (Rodopi: Amsterdam, 1995), 142.

³⁸ Jacyna, "Physiology Teaching in Edinburgh Medical Curriculum," 144.

³⁹ Newton, *Medical Education in the Nineteenth Century*, 82-133.

his medical education at Glasgow University. He graduated M.D. in 1792. The Afro-West Indian practitioner William Fergusson, who in 1844 became governor of Sierra Leone, had been licensed by the Royal College of Surgeons, Edinburgh.⁴⁰ Surgeons Charles White and Sir William Lawrence learned their trade through apprenticeship. Lind was educated as both a surgeon and physician. In 1738, after serving as an apprentice in Edinburgh, Lind became a surgeon to the Royal Navy. Lind left the Royal Navy in 1748 and in the same year graduated from Edinburgh University. Prichard also began his training as an apprentice before entering, in 1805, Edinburgh University graduating M.D. three years later. Further details about a practitioner's education will be provided where appropriate.

During the early nineteenth century, medical practice was in flux. Medical practitioners were moving away from the Galenic model of the body although traces of humoralism, the belief that health was achieved by balancing the four humors, remained. Likewise constitutionalism, the idea that a patient's strength, age, and mode of living had a significant influence over health, was beginning to wane. Medical practitioners did, however, still believe that immoral behaviour and intemperance could affect health. Indeed, the effects of spirits on health continued to be studied throughout the century.⁴¹ To ensure healthy behaviour, British medical practitioners constructed manuals on how to 'behave' in the

⁴⁰ Christopher Fyfe, *A History of Sierra Leone* (London: Oxford University Press, 1962, 172.

⁴¹ For example, National Archives, CO 267/173: Dr. Madden's Report on the Gambia and climate of the West Coast.

tropics.⁴² British practitioners in Africa were also influenced by environmentalism, the idea that certain people were suited for particular environments. Adherents divided the world into the tropical and temperate zones. Medical practitioners reasoned that Europeans belonged in temperate climes and that moving to tropical Africa put a tremendous stress upon the European constitution. Emphasis was placed upon the importance of a “seasoning” fever which purportedly helped acclimatize travelers to tropical environments.⁴³ Medical practitioners believed that Europeans, despite their disadvantages, could survive in the tropics by effectively adjusting to the environment and through strict adherence to their directives. The wide range of medical theories discouraged dogmatic approaches to medicine. Although British medical practitioners who served in Africa perceived their medicine to be the height of scientific sophistication, this did not prevent them from learning local cures.

The thesis draws upon the theoretical framework suggested by Frederick Cooper which seeks to transcend the binaries of colonizer/colonized, western/non-western, and domination/resistance. Instead of depicting power as a unilateral force, the emphasis is placed upon mapping the ways in which power flowed in both directions.⁴⁴ Jean and John Comaroff have suggested that scholars need to

⁴² For instance, James Lind, *An Essay on Diseases Incidental to Europeans in Hot Climates: With the Method of Preventing their Fatal Consequences* (London: T. Becket and P. A. de Hondt, 1768); Thomas Masterman Winterbottom, *Medical Directions for the Use of Navigators and Settlers in Hot Climates* (London: Phillips, 1803).

⁴³ Karen Kupperman, “Fear of Hot Climates in the Anglo-American Colonial Experience,” *William and Mary Quarterly*, third series, 41, no. 2 (April 1984): 213-40.

⁴⁴ Frederick Cooper, “Conflicts and Connections: Rethinking Colonial African History,” *The American Historical Review* 99, no. 5 (Dec., 1994): 1517.

take note of the fact that indigenous peoples, in their cases Africans in southern Tswana in the nineteenth century, were active in the process of colonialism, at times rejecting European intrusion while at others co-opting or supporting European endeavours.⁴⁵ The thesis will determine how Africans used Western medicine to their own advantages. Such an approach allows the often obscured actions of Africans to play a more consequential role in the analysis. European medicine was not a single monolithic force pushed on defenseless Africans. Its components were but part of a larger negotiation that directed European and African interactions. Africans could skillfully use medicine, both their own and European, to their own advantage. And 'Western' medicine possessed neither a monopoly, nor a successful track record in West Africa. Also consequential are the questions of the extent to which British actors in West Africa saw binary division between western and African medicine, even if the former was viewed as complex and multi-faceted and the practitioners favourable to elements in the latter. At the same time, elementary binary distinctions were all-pervasive: the British wrote about, studied and cared for 'the African body' (meaning the Black, sub-Saharan human body) and compared this to 'the European body.' This was their language, their mindset, and it has to be captured and explored below. While all binary systems can be probed, not all can be superseded or eliminated from analysis.

⁴⁵ Jean Comaroff and John Comaroff, *Of Revelation and Revolution: Christianity, Colonialism, and Consciousness in Southern Africa*, vol. 2 (Chicago: University of Chicago Press, 1991), 410-411.

Historiography

The following introduction to the relevant historiography is divided into three parts. Firstly, the relevant historiography for the social history of medicine is examined. Secondly, the most important developments in British imperial history as relevant to the first half of the nineteenth century are explored. Thirdly, an overview of how historians have approached the topic of health in British West Africa. The three sections draw connections to overlapping literature, including abolition, imperial careerism, globalization of health, and the practice of tropical medicine.

Social History of Medicine

The history of health and medicine has grown from relative obscurity to an accepted and widely employed means of interpreting history. The history of medicine began largely with physicians and surgeons themselves. These accounts focused, not surprisingly, on medical biography and the whiggish achievements of medical science.⁴⁶ The histories were self referential focusing primarily upon examinations of medical journals and education.⁴⁷ These self-congratulatory interpretations gave way to new perspectives. Physicians began to take a less central role as disease especially, the responses to, and the impact of, epidemics on human history became a primary focus. Historian Henry E. Sigerist was influential in such change. For instance his, *Man and Medicine*, published in

⁴⁶ For instance, Archibald Malloch, *Sir William Osler at Oxford* (London: Chiswick Press, 1921); Morris Fishbein, *Doctors at War* (New York: E. P. Dutton and Company, 1945).

⁴⁷ Bertram Moses Berheim, *The Story of Johns Hopkins: Four Great Doctors and the Medical School they Created* (New York: McGraw-Hill, 1948); Morris Fishbein, *A History of the American Medical Association 1847 to 1947* (Philadelphia: Saunders, 1947).

1932, placed humanity, not doctors, at the forefront of the study of the history of health and medicine.⁴⁸ By emphasizing the importance of patients in understanding medical history, Sigerist created the first real social history of health and medicine.⁴⁹ Sigerist expanded his conception of man and healing in his *Civilization and Disease*, which studied the impact of disease on human civilization.⁵⁰ This work inspired a new generation of scholars, including influential historians Alfred Crosby and William McNeill, who privileged disease over the study of medical practitioners and their achievements. They created sweeping histories; McNeill's *Plagues and Peoples* begins with a chapter on "Man the Hunter" and concludes with an analysis of disease in the twentieth century.⁵¹ For McNeill and Crosby disease had heavily influenced the development of human history directing major historical events including European expansion.⁵²

By creating such an intense focus upon disease, the biological approach engendered a re-evaluation of Western medicine. This approach challenged the early histories; it asserted, implicitly or explicitly, that Western medicine had proven largely inadequate and powerless against disease, and questioned

⁴⁸ Henry E. Sigerist, *Man and Medicine: An Introduction to Medical Knowledge* (New York: W. W. Norton and Company, 1932).

⁴⁹ For a defense of this position see, Gert Brieger, "The Historiography of Medicine," in *Companion Encyclopedia of the History of Medicine*, ed. W. F. Bynum and Roy Porter, vol. 2 (London: Routledge, 1993), 25-27.

⁵⁰ Henry E. Sigerist, *Civilization and Disease* (Ithaca: Cornell University Press, 1943).

⁵¹ William McNeill, *Plagues and People* (Garden City: Anchor Press, 1976).

⁵² Alfred Crosby, *The Columbian Exchange: Biological and Cultural Consequences of 1492* (Westport: Greenwood Publishing Company, 1972), 35-58.

assumptions on the power of biomedicine.⁵³ This undermined the previous paradigm of the ever-improving capability of Western medical science and its practitioners. “European colonialism,” wrote David Arnold “once praised for having freed much of Africa, Asia, and the Pacific from the scourge of disease, is now widely regarded as having” unleashed “a crisis of mortality that it was medically powerless, until relatively recently, to efface.”⁵⁴ By challenging the ‘success’ of medicine on the European periphery, such approaches called into question long held assumptions about the effects of colonization and medicine on non-European peoples.

As the myth of the limitless possibilities of Western medicine unraveled, historians began to evaluate the social impact of disease. Paul Slack and Charles Rosenberg emphasized the social relationship between humans and disease.⁵⁵ Their work encouraged historians to look outside biology, to the ways in which people in the past framed, manipulated, and understood disease. By establishing humans as the central component of health, these historians engendered a new generation of scholars focused on social history. Important to this development was the work of Roy Porter who introduced the patient’s perspective.⁵⁶ By studying historical themes through the eyes of patients, new issues such as pain

⁵³ Arnold, “Medicine and Colonialism,” 1404.

⁵⁴ Arnold, “Medicine and Colonialism,” 1404.

⁵⁵ Paul Slack, *The Impact of Plague in Tudor and Stuart England* (London: Routledge, 1985); Charles Rosenberg, *The Cholera Years: The United States in 1832, 1849, and 1866* (Chicago: University of Chicago Press, 1962).

⁵⁶ Dorothy Porter and Roy Porter, *Patient’s Progress: Doctors and Doctoring in Eighteenth-Century England* (Oxford: Polity Press, 1989); Roy Porter, “The Patient’s View: Doing Medical History from Below” *Theory and Society* 14, no. 2 (1985): 175-198.

management and the importance of the doctor/patient dialectic came to the fore. The ways in which medicine was understood and experienced by people became a central focus of the history of medicine. Porter, Rosenberg, and Slack laid the basis for a revolution in the history of medicine which allowed the social history of medicine to become the chief method for understanding the history of health and medicine.

Social history has profoundly influenced the study of tropical medicine. Historians no longer focus exclusively upon European actions and ‘achievements,’ placing emphasis on indigenous responses to European medicine. Themes of power, coercion, and cross-cultural exchange have come to the fore. The popularity of the social approach is evidenced by Roy MacLeod and Milton Lewis’ edited collection, *Disease, Medicine and Empire* and *Imperial Medicine and Indigenous Societies* edited by David Arnold.⁵⁷ These texts, both published in 1988, offered a turning point in the examination of tropical medicine challenging historians to view this history through the lens of indigenous populations. This has re-ordered understandings of medicine in the tropics allowing valuable insights into indigenous interactions with Western medicine and important questions about Western medicine’s role in colonization to be explored.

The growing internationalism of the history of health and medicine has brought new perspectives to the ways in which Western medicine is understood.

⁵⁷ Arnold, ed. *Imperial Medicine and Indigenous Societies*; Roy MacLeod and Milton Lewis, ed. *Disease, Medicine and Empire* (London: Routledge, 1988).

For instance, Paul Unschuld, a historian of Chinese medicine, has explained how monotheism has had a definitive impact on Western medical traditions.⁵⁸ The idea of a single all powerful god encourages the belief in a single truth.⁵⁹ This idea creates a medical paradigm where illness is linked with and requires a single perfect cure. Such an outlook encouraged practitioners to be less open to alternative theories and created contempt for other traditions where consulting with a variety of practitioners is considered an important component of the healing process.⁶⁰

The social history of medicine has engendered important changes in how historians understand and frame ‘the body.’ Roy Porter demonstrated how the Platonic and Cartesian understandings of humans and their body have led to a separation of mind and body.⁶¹ The mind is conceived of as wholly distinct and central to defining what it means to be human. Contributing to these schools of thought were Christian ideals that stressed the body’s main role was to house the soul. For Christians, ‘the body’ was viewed with suspicion for it was perceived to be a source of sin.⁶² This led to a further intellectual separation of humans from

⁵⁸ Paul Unschuld, “Epistemological Issues and Changing Legitimation: Traditional Chinese Medicine in the Twentieth Century” in *Paths to Asian Medical Knowledge*, ed. Charles Leslie and Allan Young (Berkeley: University of California Press, 1992), 57-58.

⁵⁹ For more on what is unique to Western medicine see, Arthur Kleinman, “What is Specific to Western Medicine?” in *Encyclopedia of the History of Medicine*, ed. W. F. Bynum and Roy Porter, vol. 1 (London: Routledge, 1993), 15-23.

⁶⁰ Anita Jacobson-Widding and David Westerlund, “General Introduction,” in *Culture, Experience and Pluralism, Essays on African Ideas of Illness and Healing*, ed. Anita Jacobson-Widding and David Westerlund (Uppsala: Almqvist and Wiksell, 1989), 11.

⁶¹ Roy Porter, *Bodies Politic: Disease, Death and Doctors in Britain, 1650-1900* (Ithaca, Cornell University Press, 2001), 63.

⁶² Porter, *Bodies Politic*, 63-64; Roy Porter, *Blood and Guts: A Short History of Medicine* (New York: W. W. Norton & Company, 2002).

their physical being. While Porter's emphasis upon 'the flesh' has allowed histories of the body to be written,⁶³ he is careful to depict the body as something more than simple biology. The body is thus understood to be a social and cultural space constructed and framed by society.⁶⁴ More than a simple physical entity, 'the body' acted as a symbol capable of representing a vast array of concepts and peoples. This objectification of Africans and their bodies allowed Africans to be compared with the widely understood 'European body.' This construction, while it facilitated comparisons of African and European physiology, created a tradition where a single image was to represent all Africans. This outlook served well the later racist discourses that insisted on a single vision and truth about Africans and their bodies during the colonial era.

British Imperial Medicine

The approach of historians to colonialism has been transformed over the past six decades. Following the Second World War, scholars moved away from Eurocentric studies that privileged European actions, achievements, and ideals.⁶⁵ Colonial peoples and their achievements were given centre stage. Optimism

⁶³ Porter, *Blood and Guts*; Porter, *Bodies Politic*; M. Feher, ed. *Fragments for a History of the Human Body*, 3 vols. (New York: Zone, 1989); Martin Kemp and Marina Wallace, *Spectacular Bodies: The Art and Science of the Human Body, from Leonardo to Now* (Berkeley: University of California Press, 2000).

⁶⁴ In *Bodies Politic*, Porter illustrated the ways in which society has framed and understood 'the body.' Porter, *Bodies Politic*, *passim*.

⁶⁵ The older tradition, while no longer at the forefront of historical narrative continued to be produced. John Hutch in the preface to his, *The History of Britain in Africa*, published in 1969 wrote: "The object of this work has been to show how British actions have affected African life and the ways in which contact with Africans have influenced society in Britain." John Hutch, *The History of Britain in Africa from the Fifteenth Century to the Present* (London: Deutsch, 1969).

surrounding decolonization coloured much of the work.⁶⁶ The scholarship created heroes out of individuals who acted outside the boundaries of European power. The analysis drew a sharp divide between Europeans and colonized peoples. Europeans were cast as aggressors, colonized people as the victims.⁶⁷ This dichotomy has shaped much of the scholarship in imperial history. Scholars interested in explaining non-European perspectives emphasized the hegemonic forces of European colonialism while highlighting indigenous responses to European encroachment. Detractors complained that in the course of finding an independent colonial history, scholars had skewed reality by over-emphasizing the 'freedom' of action.

By the 1970s, imperial history came to be directed by the political economy approach. An umbrella term, the political economy approach engendered three important forms of analysis: Marxism; the liberal market; and the dependency school.⁶⁸ All three argued that capitalism directed both the actions of colonial peoples and Europeans. For scholars writing from the political economy perspectives, indigenous agency, so long as capitalism remained a dominant force, was largely a myth. Walter Rodney, chief theorist of the dependency school, asserted that Europe underdeveloped Africa; this challenged

⁶⁶ Kenneth Dike, *Trade and Politics in the Niger Delta, 1830-1885* (Oxford: Clarendon Press, 1956); Ade Jacob Ajayi, "The Continuity of African Institutions under Colonialism Rule" in *Emerging Themes of African History*, ed. Terrance Ranger (London: Heinemann, 1969), 189-200; S. O. Biobaku, *The Egba and their Neighbors 1842-72* (Oxford: Clarendon Press, 1957).

⁶⁷ Harvey Amani Whitfield and Bonny Ibhawoh, "Problems, Perspectives, and Paradigms: Colonial Africanist Historiography and the Question of Audience," *Canadian Journal of African Studies* 39, no. 3 (2005): 586.

⁶⁸ Whitfield and Ibhawoh, *Colonial Africanist Historiography*, 587.

the idea of the independence of colonized peoples in a capitalist marketplace.⁶⁹

A. G. Hopkins, a practitioner of the market approach, saw colonized peoples as rational actors in a world market that shaped their societies. Hopkins, a globalizer, placed little emphasis on the ‘peculiarities’ of local history or institutions.⁷⁰ John Gallagher and Ronald Robison’s “Imperialism and Free Trade” which traced how the desire to protect free trade increasingly drew the British into Africa, was influential in conceptualizing the Victorian empire.⁷¹ Gallagher and Robison created a model where the protection of capital directed the expansion of empire. The Marxist school privileged class as the key driver of history and explained resistance in terms of class struggle.⁷² The pendulum had swung from colonial peoples as the protagonists in their history to their being ordered by larger themes of capitalism and class.

The 1980s ushered in the “new” historiography which privileged both social and cultural history. Themes long ignored - women’s history, gender studies, and intellectual history - came to the fore.⁷³ After years of meta-analysis the locality once again gained prominence. Whitfield and Ibhawoh identified “two distinct paradigms” that dominated this new historiography in respect to

⁶⁹ Walter Rodney, *How Europe Underdeveloped Africa* (Washington: Howard University Press, 1972). 93-146.

⁷⁰ Whitfield and Ibhawoh, *Colonial Africanist Historiography*, 588; A. G. Hopkins, *An Economic History of West Africa* (New York: Columbia University Press, 1973).

⁷¹ John Gallagher and Ronald Robinson, “Imperialism and Free Trade,” *The Economic History Review* 6, no. 1 (1953): 1-15.

⁷² Charles Van Onselen, *Chibaro: African Mine Labour in Southern Rhodesia, 1900-1933* (London: Pluto Press, 1976); Arnold Temu and Bonaventure Sawi, *Historians and Africanist History: A Critique: Postcolonial Historiography Examined* (London and Westport: Zed Press, 1981).

⁷³ Whitfield and Ibhawoh, *Colonial Africanist Historiography*, 589.

Africa.⁷⁴ The first emphasized the limits of colonialism and imperial power. In the words of Nancy Hunt:

Colonialism can no longer be viewed as a process of imposition from a single European metropole, but must be seen as tangled layers of political relations and lines of conflicting projections and domestication that converged in specific local misunderstandings, struggles, and representations....⁷⁵

The other argued that colonialism and capitalism played an important role in shaping the lives of colonized peoples. While acknowledging the multiplicity of experience, the second set of scholars maintain that at the heart of non-European/European interaction was an unequal power dynamic which favoured Europeans.⁷⁶ As Whitfield and Ibhawoh stated in 2005, the former school had “gained strikingly more currency.”⁷⁷ This trend continues as scholars emphasize the limits of empire while highlighting indigenous resistance.⁷⁸ The present study draws upon many features of the first model. Western medicine in British West Africa during the first half of the nineteenth century is a case study of the limits of imperial power. Moreover, the colonizer/colonized model clearly oversimplifies relationships obscuring the bi-directional nature of medicine in British West Africa.

⁷⁴ Whitfield and Ibhawoh, *Colonial Africanist Historiography*, 582.

⁷⁵ Nancy Hunt, *Gendered Colonialisms in African History* (Oxford: Blackwell, 1997).

⁷⁶ Mahmood Mamdani, *Citizen and Subject: Contemporary Africa and the Legacy of Late Colonialism* (Princeton: Princeton University Press, 1996); John Lambert, *Betrayed Trust: Africans and the State in Colonial Natal* (Scottsville: University of Natal Press, 1995); Jan Vlasina, *Living with Africa* (Madison: University of Wisconsin Press, 1994).

⁷⁷ Whitfield and Ibhawoh, *Colonial Africanist Historiography*, 583.

⁷⁸ Richard Price, “One Big Thing: Britain, Its Empire, and Their Imperial Culture,” *Journal of British Studies* 45 (2006): 602-627; Alan Lester, *Imperial Networks: Creating Identities in Nineteenth Century South Africa and Britain* (London: Routledge, 2001); Cooper, “Conflicts and Connections,” 1516-1545.

The suppression of the Atlantic slave trade and the abolition of slavery, once thought of as top down movements, are now viewed as having had much wider and more inclusive support. No longer do evangelicals claim center stage,⁷⁹ as other historical actors are central to the analysis. Seymour Drescher, for instance, has examined the role of the British working class in pushing for abolition, while Clare Midgley deftly detailed the contribution of women.⁸⁰ Drescher also emphasizes the importance of intellectual networks in facilitating abolition.⁸¹ Building upon this theme, Lamin Sanneh's has shown the ways in which abolitionists across the Atlantic contributed to the abolition movement.⁸² This is a useful approach, as much can be gained from interrogating the critiques of the slave trade articulated outside the metropole. Missionaries who served in West Africa, for instance, formed a distinct group of activists against the slave trade. Unlike their colleagues in London, missionaries rarely mentioned mortality (except their own), focusing on the horrors of enslavement and the corresponding long-term consequences. Abolition was not simply a metropolitan movement, nor was its critique necessarily representative of the complaints and efforts against slavery formulated and expressed in the periphery. New areas of knowledge and

⁷⁹ Thomas Clarkson, *The History of the Rise, Progress and Accomplishment of the Abolition of the African Slave Trade by the British Parliament* (London: Longman, Hurst, Rees, and Orme, 1808); Sir Reginald Coupland, *The British Anti-Slavery Movement* (London: Frank Cass and Co Ltd, 1933).

⁸⁰ Drescher, *Capitalism and Antislavery*; Midgley, *Women Against Slavery*.

⁸¹ Seymour Drescher, "The Long Goodbye: Dutch Capitalism and Anti-Slavery in Comparative Perspective," *American Historical Review* 99 No. 1 (February 1994): 44-69.

⁸² Lamin Sanneh, *Abolitionists Abroad: American Blacks and the Making of Modern West Africa* (Cambridge: Harvard University Press, 1999).

a deeper understanding will be achieved by investigating abolitionism outside the metropole.

In 1986, Roy Porter asked “What is so colonial about colonial medicine.”⁸³ The question remains central to the study of the history of health and medicine and its relationship to colonialism and empire. Historians have attempted to answer this difficult question over the last twenty years. Colonial medicine both in theory and practice insists on difference. It objectifies the body, separating Europeans from non-European people. By dividing individuals based on race, colonial medicine buttressed racial discourses which assert European superiority and exceptionality. As Philip Curtin has shown, colonial medicine and its discourses of difference led to real and actual divisions as European officials used the perceived disease-ridden condition of colonized peoples to create physical distance between European housing and that of the colonized.⁸⁴ Megan Vaughan has shown how traditional African beliefs became associated with mental illness. The message for colonized people was clear. European customs and culture were the norm and any position outside of these norms was considered deviant and dangerous.⁸⁵ It is colonial medicine’s ability to regulate and order the lives of colonial peoples that makes colonial medicine so powerful and pervasive.

⁸³ Waltraud Ernst, “Beyond East and West. From the History of Colonial Medicine to a Social History of Medicine(s) in South Asia,” *Social History of Medicine* 20, No. 3 (2007): 508; Shula Marks, “What is Colonial about Colonial Medicine? And What has Happened to Imperialism and Health?” *Social History of Medicine* 10 (2002): 205-219.

⁸⁴ Curtin, “Medical Knowledge and Urban Planning,” 235-255.

⁸⁵ Megan Vaughan, *Curing their Ills* (Cambridge: Polity Press, 1991).

Imperial careering and the study of imperial networks offers a new and useful approach to the study of British imperial health and medicine. Increasingly, scholars have traced the ways in which epistemic communities have shaped British knowledge and influenced the governing of the empire. Zoe Laidlaw's, *Colonial Connections* is instructive in this regard. David Lambert and Alan Lester's edited collection, *Colonial Lives Across the British Empire* follows colonial officials as they moved throughout the empire. However, in these important contributions, health and medicine have, to date, been ignored.⁸⁶ Nonetheless, they provide a model in which health and medicine and its relationship with imperial careering can be explored. Indeed, imperial careering offers a method of explaining the relationship between the metropole and periphery while providing insights into the ways in which new knowledge was disseminated throughout the empire.

Historians and Health in British West Africa

Despite academic interest in the study of historical health in Africa, for the first half of the nineteenth century, the field lacks a comprehensive study of the interaction between British medicine and Africans in West Africa. For the most part, historians interested in health, medicine, and Africa during this period have concentrated their efforts in two areas: the health risks and transfer costs of moving Europeans into this threatening disease environment (commonly referred

⁸⁶ David Lambert and Alan Lester, ed. *Colonial Lives Across the British Empire: Imperial Careering in the Long Nineteenth Century* (Cambridge: Cambridge University Press, 2001); Zoe Laidlaw, *Colonial Connections, 1815-45: Patronage, the Information Revolution and Colonial Government* (Manchester: Manchester University Press, 2005).

to as the ‘White Man’s Grave’),⁸⁷ and the health experiences of Africans transplanted to the Americas.⁸⁸ We know next to nothing about the health of Africans who stayed in or returned to Africa. Although studies of the health consequences of the movement of peoples into new environments are of much value, they do not tell the whole story of African and British interaction in the first half of the nineteenth century. Indeed, they ignore the health of most Africans who were exposed to European contact.

The relationships between British health, medicine, and African societies for the period 1800-60 have been largely but not entirely, neglected. Among those who have studied the relationships, the most influential and prolific historian has been Philip Curtin. In his *The Image of Africa*, Curtin established that Europeans constructed Africans in ways that suited European intellectual needs.⁸⁹ Curtin was an expert on mortality and has asserted that increased employment of quinine as a prophylactic sparked, in the 1870s, a mortality revolution for Europeans soldiers serving in West Africa.⁹⁰ This drop in European mortality contributed to the European military dominance over West

⁸⁷ Philip Curtin, “White Man’s Grave, Image and Reality, 1780-1850,” *Journal of British Studies* 1 (1961): 94-110; Philip Curtin, *Death by Migration* (Cambridge: Cambridge University Press, 1989).

⁸⁸ A number of publications focus upon the question of slave mortality while at sea: Raymond Cohn, “Maritime Mortality in the Eighteenth and Nineteenth Centuries: A Survey,” *International Journal of Maritime History* 1 (1989): 159-234; James C Riley, “Mortality on Long-Distance Voyages in the Eighteenth Century,” *Journal of Economic History* 41 (1981): 651-656; Herbert Klein et al., “Maritime Mortality Revisited,” *International Journal of Maritime History* 1 (June 1989): 159-191.

⁸⁹ Curtin, *Image of Africa*, 480.

⁹⁰ Philip Curtin, “‘The End of the ‘White Man’s Grave’? Nineteenth-Century Mortality in West Africa,” *Journal of Interdisciplinary History* 21, no. 1 (1990): 74.

Africans.⁹¹ Curtin remains the authority on transfer costs and in his *Death by Migration* calculated the cost in terms of European lives in managing and expanding the empire.⁹² His work has been sensitive to African health and in “Africans at home and Abroad” he calculated the difference in mortality for Africans who remained ‘at home’ and those transferred to the Americas.⁹³ These quantitative studies provide the best guides to aggregate health in West Africa for the first half of the nineteenth century.

Historians of British Africa once assumed that Western medicine was transported to Africa as a complete and unchanging system.⁹⁴ An attention to social history has undermined this assumption, as historians now highlight the ways in which colonial peoples helped shape the practice of British medicine throughout the empire.⁹⁵ The social history of health and medicine for Africa has benefited from Steven Feierman and John Janzen’s, *The Social Basis of Health and Healing in Africa* published in 1992.⁹⁶ Janzen’s contribution, a study of pre-colonial African therapeutics in West Africa, provides a model for understanding African medical practices. The text links changes in African society to changes in

⁹¹ Philip Curtin, *Disease and Empire: The Health of European Troops in the Conquest of Africa* (Cambridge: Cambridge University Press, 1998).

⁹² Philip Curtin, *Death by Migration*.

⁹³ Philip Curtin, “African Health at Home and Abroad” *Social Science History* 10, no. 4, (1986): 369-98.

⁹⁴ For example, Edmund Burrows, *A History of Medicine in South Africa up to the End of the Nineteenth Century* (Cape town: A. A. Balkema, 1958), 67-68.

⁹⁵ Two of the most important works are: Arnold, ed. *Imperial Medicine and Indigenous Societies*; MacLeod and Lewis, ed. *Disease, Medicine and Empire*.

⁹⁶ Steven Feierman and John Janzen, ed. *The Social Basis of Health and Healing in Africa* (Berkeley: University of California Press, 1992).

therapeutics.⁹⁷ This acknowledgement is important to the study of African medicine because it places social and cultural themes at the centre of practice. These contributions constitute the relevant historiography in the history of health and Africa for the thesis.

Historians have become well attuned to the relationships between medicine and empire.⁹⁸ Daniel Headrick argued that medicine served as an important ‘tool of empire’ in the nineteenth century, while Philip Curtin traced how European medical improvements facilitated the conquest of Africa.⁹⁹ The historiography is deficient in two critical areas. First, as historians have hastened to connect expanding medical science to European dominance over Africans, they have ignored the first half of the nineteenth century where any link between medical knowledge and military, or colonial, success is neither established nor probable. The emphasis upon the later nineteenth century has encouraged a deterministic European-African history where the technologically superior Europeans established both a medical and military dominance over subjugated West Africans.¹⁰⁰ To this extent, some of the assumptions and perspectives within the recent literature on British imperial or tropical medicine contribute little to this study. The thesis is centred upon an earlier period, before proof of the

⁹⁷ John Janzen, “Ideologies and Institutions in Precolonial Western Equatorial African Therapeutics,” in *The Social Basis of Health and Healing in Africa*, ed. Steven Feierman and John Janzen (Berkeley: University of California Press, 1992), 195-211.

⁹⁸ MacLeod and Lewis, ed. *Disease, Medicine and Empire* (Hyderabad: Orient Longman, 2001). Harrison, eds. *Health, Medicine and Empire* (Hyderabad: Orient Longman, 2001).

⁹⁹ Daniel Headrick, *The Tools of Empire: Technology and European Imperialism in the Nineteenth-Century* (New York: Oxford University Press, 1981); Curtin, *Disease and Empire*.

¹⁰⁰ Curtin, *Disease and Empire*, *passim*. Headrick explains how the “conquest” of the West African disease environment led to the subjugation of West African people. Headrick, *Tools of Empire*, 58-79.

germ theory, before Manson, Ross, and the mosquito-vector, when Britons established a tenuous foothold in West Africa and consciously set out to aid Africans in West Africa. It will be demonstrated that during this period, at least some Africans and Britons maintained a bi-directional health dialogue, not least because imperial medicine did not as yet exist as a construct, and those to be subjugated and ‘civilized’ experienced less morbidity and mortality than the newly arrived Europeans. The second deficiency is that although there is an abundance of literature dealing with how the processes of the slave trade and slavery dehumanized the African body, scholars remain silent on the process of humanizing these bodies.¹⁰¹ After examining medical interactions between British officials and Africans for the whole of 1800-1860, it is evident that although medicine can play an important role in dehumanizing a foreign body, it is also capable of confirming humanity.

David Arnold has encouraged historians of medicine and empire to explore how disease and medicine acted as a foci of contact, conflict and, at times, convergence between European medical authorities and indigenous healers and peoples.¹⁰² For Arnold historical disease and medicine constitutes “a relationship of power and authority between ruler and ruled...”¹⁰³ To understand fully

¹⁰¹ Studies that focus upon the health of slaves include: Richard Sheridan, *Doctors and Slaves* (Cambridge: Cambridge University Press, 1985); Todd Savitt, *Medicine and Slavery* (Urbana: University of Illinois Press, 1978); Sharla Fett, *Working Cures: Healing, Health and Power on Southern Slave Plantations* (Chapel Hill: University of North Carolina Press, 2002).

¹⁰² Arnold, “Introduction: Disease, Medicine and Empire,” 1-2; David Arnold “Smallpox and Colonial Medicine in Nineteenth-Century India,” in *Imperial Medicine and Indigenous Societies*, ed. David Arnold (Manchester: Manchester University Press, 1988), 45-62.

¹⁰³ Arnold, “Introduction: Disease, Medicine and Empire,” 2.

colonialism – he and others have asserted convincingly - one must understand the ways in which health and medicine legitimized colonial rule. How do these reflections apply to an earlier period, before wholesale efforts to impose Western medicine upon Sub-Saharan Africa? An investigation of British interest in, knowledge of, and participation in West African health – within the contexts of developing British understandings of medicine and race – is long overdue. Medicine has emerged as an authoritative tool of analysis capable of providing insight into larger themes, especially race and empire.¹⁰⁴ This is why it is important to study African/British medical interactions and their perceptions of health and medicine. Unfortunately, within the published scholarship on medicine, Africa, and the British empire, the first half of the nineteenth century remains, to date, a largely unexplored topic.

The Chapters: Methodology, Sources, and Historiography

This thesis is comprised of four core areas of study: British conceptions of race, missionaries, the Royal Navy, and British health care in Sierra Leone, the Gambia, and the Gold Coast. Each engages with a different set of historiographical and primary materials. The specific methodologies, the sources employed, and the relevant historiography will be outlined here in turn.

Chapter two: “Narratives of Race: British Scholarship on the African” focuses upon the contributors who had the largest impact on British

¹⁰⁴ Mark Harrison, *Climates and Constitution: Health, Race, and Environment and British Imperialism in India, 1600-1850* (Oxford University Press, 1999); Arnold, “Introduction: Disease, Medicine and Empire,” 1-26.

understandings of race and in particular sub-Saharan Africans. The source base is drawn primarily from printed treatises on race and the origins of mankind. The following are all examined in-depth: Johann Friedrich Blumenbach; Georges-Louis Leclerc, Comte de Buffon; James Cowles Prichard; Edward Long; Henry Home, Lord Kames; Baron Georges Leopold Chrétien Frederic Dagobert Cuvier; and Robert Knox. Also studied is the scholarship of medical practitioners who saw, treated, and evaluated the African body first hand. This provides a more complete analysis of racial attitudes and positions than has hitherto been created. It also permits determination of whether those who actually treated Africans had different ideas of race and the African body than those who constructed 'the African' from afar. The treatises range in publication dates from Carl Linnaeus', *Systema Naturae*, published in 1735, to Robert Knox's, *The Races of Men*, first published in 1850.

Racial discussions did not occur in isolation and were frequently enmeshed within discussions concerning the origins of mankind. This debate was defined by the monogenist and polygenist camps. The monogenists argued that all of humanity was created in a single creation as outlined in the book of Genesis, while polygenists argued for separate creations. Central to the question of race was the issue of the mutability of the human constitution. For if the body was believed to be fluid and capable of change, then this adaptability explained how, out of an original pair, the world came to be populated by people with different physical appearances. Those who defended creationism insisted on the

adaptability of the human constitution arguing that physical variations were the result of superficial changes engendered by climate and/or culture. Chapter two develops the British medical implications of this large long-running debate.

Scholars depict the 1840s as the decade where ‘softer’ less defined ideas of race became ‘hardened’ and fixed.¹⁰⁵ They focus primarily upon causation. The thesis takes another approach and by evaluating racial perceptions formulated in the metropole and periphery emphasizes the fluidity that existed in terms of race. By not focusing on causation and instead outlining the fluidity that characterized this period the thesis emphasizes what this ‘unsettledness’ meant for understanding of Africans within the British Atlantic world.

Chapter three examines the degrees to which missionaries from the Anglican Church Missionary Society (CMS) and the Wesleyan Methodist Missionary Society (WMMS) were involved with the health of West Africans. These missionaries provided some of the earliest and most enduring descriptions of Africans. Missionary involvement with Africans occurred in a variety of contexts: in church, in the hospital, and as schoolteachers. Missionary sources provide unique insights into how the British saw (and wanted to see) Africans react to European conversion, contact, and a Western value system. Despite the richness of missionary sources, there are well known deficiencies. Most important is that missionaries wrote for a European audience. The mission was often put in a positive light as missionaries tried to convince those back home to

¹⁰⁵ Curtin, *Image of Africa*, 386-87; Nancy Stepan, *The Idea of Race in Science: Great Britain, 1800-1960* (London: Archon Books, 1982), 4.

support their endeavours.¹⁰⁶ The chief sources employed are the annual proceedings of the CMS and the annual synod minutes of the WMMS. These are buttressed by missionaries' published personnel reflections.

The written histories of the CMS and WMMS missions are nearly as old as the missions themselves. The first initial studies were written by missionaries. These studies emphasized missionaries' personal sacrifice and accomplishments, while offering hopeful predictions about what could be achieved.¹⁰⁷ Published between 1899 and 1916, Eugene Stock's multivolume work, *The History of the Church Missionary Society*, provides a detailed history of the CMS.¹⁰⁸ Stock, a Society administrator, championed missionary achievements and spirit while emphasizing the amount of work still to be done. Characteristic of the early investigations, Stock focused on European efforts, largely ignoring the impact of missions upon indigenous peoples. Historians have abandoned this model and now give full consideration to the effects that missionary/African contact had on Africans and their societies.¹⁰⁹ Scholars now acknowledge that "missionaries

¹⁰⁶ David Lindenfeld, "Indigenous Encounters with Christian Missionaries in China and West Africa, 1800-1920: A Comparative Study," *Journal of World History* 16, no. 3 (Sept., 2005): 328-29; Ryan Dunch, "Beyond Cultural Imperialism: Cultural Theory, Christian Missions, and Global Modernity," *History and Theory* 41 (2002): 310; Robert Bickers and Rosemary Seton, ed. *Missionary Encounters: Sources and Issues* (Richmond: Curzon Press, 1996).

¹⁰⁷ William Fox, *A Brief History of the Wesleyan Missions on the West Coast of Africa including Biographical Sketches of all Missionaries who have Died in the Important Field of Labour: With some Account of the European Settlements and of the Slave Trade* (London: Aylott and Jones, 1851) and William Moister, *Memorials of Missionary Labours in Western Africa, The West Indies, and at the Cape of Good Hope: with Historical and Descriptive Observations, Illustrative of Natural Scenery, The Progress of Civilization, and the General Results of the Missionary Enterprise*, 3rd ed. (London: W. Nichols, 1866). First published in London 1850.

¹⁰⁸ Eugene Stock, *The History of the Church Missionary Society its Environment; Its Men and its Work* (London: Church Missionary Society, 1899-1916).

¹⁰⁹ Lindenfeld, "Encounters with Christian Missionaries," 328.

helped to shape and create not only the ‘modern’ African societies of today but also the ‘traditional’ ones of yesterday” while playing an important role in shaping the development of African churches.¹¹⁰ Missionaries were not somehow outside of African society, but important contributors who influenced the ways in which Africans perceived and understood themselves.

Thirty years ago it was widely assumed that missionaries served as agents of the state.¹¹¹ The recent emphasis upon the multiplicity of colonial experience has undermined this position. Andrew Porter in his *Religion versus Empire* examined missionaries’ role within the imperial mission. Porter, in reference to the first half of the nineteenth century, determined that “it is difficult not to be struck by the comparatively insignificant place occupied by empire in the minds of many evangelicals.”¹¹² Although cognizant of British plans, missionaries charted their own course and seemed only interested in extending colonial power when it was clear that this control would serve the goals of the mission. When colonial expansion threatened their own power or disrupted their plans, missionaries resisted this control and use their influence to affect policy. Missionaries provide a useful lens in which to examine the health of West Africans within a period of initial contact and incipient colonization. The

¹¹⁰ Dmitri van den Bersselaar, “Creating ‘Union Ibo’: Missionaries and the Igbo Language,” *Africa: Journal of the International African Institute* 67, no. 2 (1997): 273.

¹¹¹ A.J. Temu, *British Protestant Missions* (London: Longmans, 1972), 154-155; Walter Williams, *Black Americans and the Evangelization of Africa* (Madison: University of Wisconsin Press, 1982), 104-124; Emmanuel Ayankanmi Ayandele, *The Missionary Impact on Modern Nigeria* (New York: Humanities Press, 1967), 242-243.

¹¹² Andrew Porter, *Religion versus Empire?: British Protestant Missionaries and Overseas Expansion, 1700-1914* (Manchester: Manchester University Press, 2004), 51.

question of the extent to which ‘humanity’ and ‘health’ came together, and in what contexts, is central for this period of abolition of slavery and the slave trade.

There remains to be written a history of British managed state health-care in West Africa for the first half of the nineteenth century. Chapter Four attempts to fill this void by examining how the British managed the health care needs of African patients, centered upon the colony of Sierra Leone. In so far as possible, it traces African responses to the provision of European medicine. The evidence is largely drawn from colonial correspondence housed at the National Archives, Kew, London. All extant records were examined for issues of health (broadly conceived) involving the Colonial Office, its officials, governors, and British medical practitioners. These sources reveal that health was an acknowledged priority for all interested parties. Despite the desire to provide care, medical departments in Africa lacked the manpower and resources necessary to establish an effective health care system. The story therefore is one of lofty goals and expectations with officials on the ground under tremendous strain.

Colonial Office correspondence provides insights into the issues most central to British medical practitioners on the ground. It also affords an opportunity to assess the numerous difficulties, as recorded by physicians and surgeons, of providing medical care to Africans in West Africa. The focus of this analysis is how British medical practitioners in Sierra Leone managed the care of liberated Africans, patients who often arrived in such high numbers and so thoroughly debilitated that they overwhelmed an already understaffed medical

department. The chapter evaluates how British physicians perceived the African body, their medical practitioners, and their therapeutic system. It examines evidence for the bi-directional nature of medicine in Africa, and reveals how at least some Africans influenced, guided, and supervised health-care in British West Africa. This study contributes to the growing field of colonial studies by investigating how British medical practitioners and Africans negotiated care in British West Africa.

Chapter Five “Health and the Armed Forces: African and European health in the West African Squadron,” compares the health of European and African service personnel, focusing upon the well-documented West African Squadron, and includes army documentation so far as extant. The field of nineteenth century British naval medicine remains understudied. This is especially true for the early nineteenth century as the long peace established after 1815 made the period less attractive to naval historians.¹¹³ Our understanding of the eighteenth-century Royal Navy has benefited from the application of social history to naval studies. N.A.M. Rodgers’ illuminating book, *The Wooden World*, studies issues of health while expertly detailing the daily life of a British sailor.¹¹⁴ The nineteenth century can boast of no equal to this work. Christopher Lloyd remains the leading historian of naval health for the nineteenth century. Lloyd has identified and

¹¹³ C. J. Barlett, *Great Britain and Sea Power, 1815-1853* (Oxford: Clarendon, Press, 1963),

vii.

¹¹⁴ N.A.M. Rodgers, *The Wooden World: An Anatomy of the Georgian Navy* (London: Collins, 1986).

examined the major health obstacles that inhibited the Royal Navy.¹¹⁵ Lloyd privileged the health experiences of European sailors, making little attempt to identify, or evaluate experiences for non-Europeans, including African sailors. For instance, Lloyd's chapter "The West African Squadron" in *Medicine and the Navy* only mentions African sailors once and only to explain that they proved useful in carrying out tasks considered inimical to European health.¹¹⁶ Although Lloyd provides a general overview of health and medicine, it is an antiquated and one-sided Eurocentric view.

Scholars have acknowledged the physical and health related dangers inherent in slavery suppression, but the small field of suppression studies is largely interested in the mechanics and politics of suppression, not health.¹¹⁷ Lloyd is the exception to this rule. In his *The Navy and the Slave Trade*, he examines health. The monograph is not exclusively a medical analysis, as Lloyd covers a variety of challenges associated with suppression. In terms of health, Lloyd established the impediments to the Royal Navy exploring how these

¹¹⁵ Christopher Lloyd, *Search for the Niger* (London, Collins, 1973); Christopher Lloyd, *The British Seaman 1200-1860; A Social Survey* (Rutherford: Farleigh Dicksons University Press, 1970); Christopher Lloyd, *The Nation and the Navy; A History of Naval Life and Policy* (London: Cresset Press, 1954); Lloyd, *The Navy and the Slave Trade*; Christopher Lloyd, ed. *The Health of Seaman: Selections from the Works of Dr. James Lind, Sir Gilbert Blane and Dr. Thomas Trotter* (London: Navy Records Society, 1965).

¹¹⁶ Christopher Lloyd, "The West African Squadron," in *Medicine and the Navy, 1200-1900*, ed. John Joyce Keevil, Christopher Lloyd, Jack Leonard Sagar Coulter, vol. 3 (Edinburgh and London: E. & S. Livingstone, 1963), 155-172.

¹¹⁷ William Law Mathieson, *British Slavery and Its Abolition, 1823-1838* (London: Longmans, 1926); William Law Mathieson, *Great Britain and the Slave Trade, 1839-1865* (London: Longmans, 1929); Lloyd, *The Navy and the Slave Trade*; Howard Temperley, *British Antislavery, 1833-1870* (Columbia: University of South Carolina Press, 1972); Phillip LeVeen, *British Slave Trade Suppression Policies, 1821-1865* (New York: Arno, 1977); W.E.F Ward, *The Royal Navy and the Slavers: The Suppression of the Atlantic Slave Trade* (London: Allen & Unwin, 1969), and Paul Michael Kielstra, *The Politics of Slave Trade Suppression in Britain and France, 1814-48* (New York: St. Martin's, 2000).

problems shaped policy. It is a useful starting point, particularly for those exclusively interested in European health. Nonetheless, the field needs an analysis of African health which not only acknowledges the contributions Africans made in suppressing the slave trade but will contribute to an understanding of the interaction of medical practice and perceptions of race during the era of suppression.

The source base for chapter five is derived from two main bodies of evidence. One set of evidence is gleaned from published accounts by the naval surgeons who served in the West African Station. These accounts often centre on the most famous episodes, in particular the effort to ascend the Niger. The texts are focused upon European health problems and especially the highly deadly “African” fevers, whose causes remained a mystery and engendered much debate among medical practitioners. These professional narratives mention Africans in an indirect fashion and usually only as subjects used for comparison with the health experiences of Europeans. In an oblique fashion they reveal how European naval surgeons perceived Africans and their health. The second set of evidence is derived from the Admiralty records held in the British National Archives. All relevant documentation for health and illness for the ships of the West African Squadron, 1800-1861, now extant has been utilized. These sources offer the opportunity to study the health experiences of Africans serving in the Royal Navy. The source base is comprised of muster records, ship’s logs, and medical journals. These records allow both for the identification of African sailors and insight into

African health experiences. Muster records provide the service record of personnel on board each vessel. They also provide a physical description of each member of a ship's complement and important information concerning their age and prior experience. Ships' logs present information on the size of the ship's complement, the changing location of the vessel, and important events (such as engagement with slavers). Medical journals were employed to calculate morbidity and mortality rates, to examine patients' recovery times, and to assess which ailments proved most common, required the longest convalescence, and a host of other useful information. They also provide insight into how surgeons' treated patients suffering from various ailments and are used to determine whether British medical practitioners afforded African and European patients suffering from similar health complaints identical treatment. Surgeons' general remarks, a summary of events most often completed at the conclusion of the tour of duty and contained within medical journals, afford insight into the events, both medical and otherwise, considered most important to the ship's surgeon. Information ranged from weather reports, to summaries of all travel, to the surgeon's musings on disease, environment, and pertinent medical threats.

This is the first scholarly comparative examination of European and African health for the Royal Navy, and a vital one for the study of medical practice in West Africa. The data collected concerning mortality is compared to West African military returns; this contributes to the wider historiography of British military and naval health providing a fuller analysis of health in West

Africa. It provides an examination of the extent to which European and African personnel suffered from similar ailments, types of care provided, and comparative recovery times. There is insight into how African personnel responded to European medicine. Did the employment relationships and martial discipline lead African personnel to accept European medicine, or did they find ways to avoid European care? And, if so, how did European practitioners interpret this avoidance?

The thesis offers a nuanced understanding of conceptions of health and medical interactions in the first half of the nineteenth century, in so far as documents allow us to explore the subject. The focus in the published literature on the second half of the century has left historians with the impression of an imperial medicine capable of re-ordering African lives. The first half of the century offers a different perspective. If British medicine, during this period, is to be viewed as a tool of empire it proved dull and it certainly did not cut deep. Medicine in the first half of the century could be bi-directional. The following study offers an important counterweight to the scholarship of the second half of the century in which European medicine becomes an important and powerful tool of empire. It offers a real opportunity to gain an understanding of the relationship and medical interactions between Britons and West Africans in a period before the formal colonization of West Africa. It is the first study of what the British ‘knew’ about African health and medical treatment, and what they did with that knowledge.

Chapter Two

Narratives of Race: British Scholarship on the African

In 1850 the Scottish surgeon, anatomist, and ethnologist Robert Knox (1791-1862) confidently exclaimed that “race is everything.”¹¹⁸ According to Knox, race explained not only the rise and fall of civilizations but, most importantly, why Europeans were the most advanced people in the world. In this seminal work, *The Races of Men* (1850), Knox asserted that the human race was comprised of distinct species, each with a predetermined level of development. Europeans were placed at the top of his scale of development, while Africans were considered to have the lowest aptitude for civilization. Knox argued that each race was wholly separate,¹¹⁹ immutable,¹²⁰ and naturally antagonistic to one another.¹²¹ What was the history of British conceptions of racial difference, of the African, and of the African body? Knox’s views concerning the human race were the culmination of more than a century of inquiry by investigators, on the continent and in Britain, into the origins of man. Thus, they cannot be viewed as an aberration, but rather the product of a long debate over whether distinct and wholly separate races populated the earth. This chapter will trace the development of notions of race, with an eye to the British experiences and discourses, from the publication of Carl Linnaeus’ (1707-1778) influential

¹¹⁸ Robert Knox, *The Races of Men* (Philadelphia, 1850), 7; 10; 14; 90. First published in London, 1850.

¹¹⁹ Knox, *Races of Men*, 76.

¹²⁰ Knox, *Races of Men*, 12-13.

¹²¹ Knox, *Races of Men*, 24.

Systema Naturae, first published in 1735, to the hardened racist and reductionist theories of Robert Knox.

This discussion does not intend to cover every contribution; instead, it focuses upon the theories that had the greatest impact on British understanding of race and Africa in the first half of the nineteenth century. Attention will be given to the role played by medicine in shaping discourses of race, and in turn question whether these discourses influenced physicians' understanding of the African body. The debate over race and humanity belonged not only to anthropologists, ethnologists, and those with medical and biological training, but was also influenced by literature, Christian ideals, and societal approaches to slavery. These different fields of knowledge will be examined to provide an understanding of how Britons conceived race, and the African body, during the first half of the nineteenth century. This appraisal has important repercussions for the thesis. I argue that during the first half of the nineteenth century, although there was a noticeable hardening of racist thought, enough leeway existed to allow Britons to select and devise theories of race that suited their political and religious beliefs. What is significant here is that those Britons who encountered 'the African' in the first half of the nineteenth century were not schooled in a single method of thought about Africa; they were capable of interpreting the African in a multitude of ways. In the following chapters, this position will explain the variety of British reactions and approaches to Africans, their health, and their bodies. Race was not a settled matter in the first half of the nineteenth century and, thus, the African

was not type-cast but could, and did, play a variety of roles in the British understandings of race and Africa.

Race: Definition and Problems

In the eighteenth and nineteenth centuries “race,” when applied to the human species, was a flexible term with a great variety of meaning. For example, race was used to refer to ethnic, religious, and sometimes national groups. The English were considered a separate race but could just as easily be subsumed in the larger categories of “European” and “Caucasian.”¹²² Likewise, sub-Saharan Africans were clearly a race but so too were “Hottentots” and “Ethiopians,” so much so that in the hands of some commentators Ethiopian was interchangeable with African. This great variance and fluidity of application, although a problem for scholarship today, was not problematized in the past and it is not my goal to do so here. Racial categories, although constantly refined and modified, stayed virtually the same over this period, especially in their categorization of “Europeans” and “Africans.” There was no doubt, in any commentator’s mind, that Africans and Europeans were of different races. The leading question was, did these two races of men share the same origins as prescribed in the Biblical

¹²² Augstein explains that the English word race is of French origin. The term was originally applied in the eighteenth century to French royalty. She explains how the term grew to encapsulate various understanding of the human species, nation, stock and family. Hannah Franzisk Augstein, ed. *Race: The Origins of an Idea, 1760-1850* (Bristol: Thoemmes Press, 1996), xvii.

story of Adam and Eve, or were Africans and Europeans so different as to constitute two unrelated species of humanity?¹²³

For observers of race the most pressing and problematic issue was to explain why the world was populated with people of such physical variety. Central to this discussion was why Europeans were seen as ‘white’ while the rest of the world had different skin colours or tones. European investigators began with the assumption that they were different from the rest of humanity and, as such, did not strive to confirm difference but to understand the causes of these differences. This quest for understanding was placed in the larger context of creationism, which insisted that everyone, including Africans and Europeans, sprung from an original pair. It is within this context that scholars wrestled with the problem of explaining how the world became populated with diversity.

Central to the question of race was the issue of the mutability of the human constitution. For if the body was seen to be fluid and capable of change, then this fluidity and adaptability could explain how, out of an original pair, the world came to be populated by people of different physical appearances. As we shall see, those who argued in favour of creationism insisted on the adaptability of the human constitution and argued, for instance, that skin colour was not fixed but the product of climate and/or culture. However, by the beginning of the

¹²³ The debates between the monogenists and polygenists camps in the eighteenth and nineteenth centuries have received much scholarly attention. Two works which give important insights into these debates are: Carolyn Fluehr-Lobban, *Race and Racism: An Introduction* (Lanham: AltaMira Press, 2006), especially chapters 3-5; Milford Wolpoff and Rachel Caspari, *Race and Human Evolution: A Fatal Attraction* (New York: Simon & Schuster, 2007), especially chapters 3 and 4.

nineteenth century, commentators on race increasingly questioned the adaptability of the human constitution and began to see the body as fixed. This intensified racialized understanding of the body: instead of a single humanity, altered over time by climate and culture, there were different races that were fixed and eternal. These latter authors often subscribed to the theory of polygenism, the idea that the races were created in separate acts of creation. Polygenists argued that the differences among humanity were natural, fixed, and could not be overcome.¹²⁴ What was being contested was not the actual functions of the body. Few investigators cared if the African circulatory system or skeletal shape matched that of the European (although differences in shape and structure were used to emphasize difference). Rather, the question was whether the human constitution could be, and had been, altered by culture and/or climate.¹²⁵ If the world was populated by people of separate creations then it was fair to assume that ‘the African body,’ its shape, and its functions were different, maybe even fundamentally different, from ‘the European body.’ On the other hand, if adaptability and shared origins were proven, the African body had to be similar to the European one and its differences the result of essentially superficial changes engendered by climate and culture. If Europeans and Africans sprung from original progenitors it was logical that Africans could be ‘improved’ and attain the same level of civilization as Europeans. If the body was fixed and Africans were a product of a separate creation, the African was inherently, and had been and

¹²⁴ Knox, *Races of Men*, 123.

¹²⁵ Wolpoff and Caspari, *Race and Human Evolution*, 62.

forever would be, different, and inferior. Thus, the question of shared humanity stood at the heart of debates over slavery, the natural rights of non-Europeans (especially the ‘uncivilized’), and societal improvement.

Historiography

Scholars largely concur on the nature, timing, and development of British racism in the eighteenth and early nineteenth century. Although evidence of a general distaste towards those with black skin may have manifested itself within European society for centuries,¹²⁶ scholars agree that the idea of race and its interpretive role as a category of understanding did not become important until the eighteenth century. During this century, the development of zoology, biology, physiology, and ethnography in combination with a public discussion on the merits of slavery transformed race from a minor intellectual and philosophical issue to one of the most important questions of the period. Although scholars of race and racism in Britain can agree on a general timetable, there is some debate over who to ‘blame’ for the introduction and diffusion of racist ideas in Britain.

Peter Fryer suggests that racial consciousness entered British society via Barbadian planters in the eighteenth century. These planters had convinced themselves that Negroes were more akin to beasts and these attitudes were adopted by Britons who were concerned with miscegenation and the corresponding degeneration of the European race.¹²⁷ Stuart Gilman builds upon

¹²⁶ R.O. Shyllon, *Black People in Britain, 1555-1833* (Oxford: Oxford University Press, 1977).

¹²⁷ Peter Fryer, *Staying Power*, 133-146; Michael Banton, *Racial Theories* (Cambridge: Cambridge University Press, 1987), 11.

the assertion that it was Britons' fear of degeneracy that prompted them to accept the intrinsic inferiority of Africans by outlining the ways in which medicine played up, assisted, and justified these fears of racial degeneration in the nineteenth century.¹²⁸ However, Gilman argued that the origins of British racial thought lay not with Barbadian planters, but can be directly traced to the fears of degeneracy espoused by the Jamaican planter turned writer Edward Long (1734-1813). Long's *History of Jamaica*, first published in 1774, was a virulent racist attack on Africans.¹²⁹ Long, who lived in Jamaica from 1757-1769, argued that Africans were not like the rest of humanity, and close observation of Negroes (from the vantage point afforded to planters) proved that they were much closer in nature and disposition to animals than to Europeans.¹³⁰ Others, especially Philip Curtin and Nancy Stepan, although they acknowledge the importance of Long, argue that racist ideas did not intensify until early in the nineteenth century. For them this intensification was encouraged by a new found sense of British cultural superiority.¹³¹

One of the most difficult questions for scholars to explain is why it took seventy years for the racist diatribe of Long to become the respected views of Knox and others. Leading historians of British attitudes towards 'colonial peoples,' such as Philip Curtin, Nancy Stepan, and Mark Harrison, all agree that the racist doctrines espoused by polygenists were kept at bay by Britons'

¹²⁸ Stuart Gilman, "Degeneracy and Race in the Nineteenth Century: The Impact of Clinical Medicine," *Journal of Ethnic Studies* 10, no. 4 (1983): 27-50.

¹²⁹ Edward Long, *The History of Jamaica*, 3 vols. (London: 1774) *passim*.

¹³⁰ Gilman, "Degeneracy and Race," 30-32.

¹³¹ Curtin, *Image of Africa*, 5; Stepan, *The Idea of Race in Science*, 5.

adherence to the theory of monogenism.¹³² Monogenism was the belief in creationism, the idea that all of humanity descended from an original pair. It was not until the 1840s when monogenism, the long dominant starting point for positions on race, seriously struggled to provide a reasonable explanation for the variety of humanity that the polygenist position, the theory of separate creations, made strong headway in Britain.¹³³ These scholars emphasize the intellectual importance of James Cowles Prichard (1786-1848), a Christian monogenist, who defended the story of creation and the unity of mankind. For Prichard and other monogenists, the Bible was the ultimate authority and to deny the unity of mankind was to deny the word of God. And yet, many did, particularly on the continent.¹³⁴ Polygenists, in particular, Henry Home, Lord Kames (1696-1782), argued that God had created separate races at different times and this, and no culture or climate, explained the difference between the human races.¹³⁵

Other scholars, including James Walvin and Seymour Drescher, see the delay in the overt and fixed British racism that characterized the second half of the nineteenth century as having less to do with the debate between monogenism and polygenism, and more to do with the anti-slavery movement. Walvin argued that the positive attitudes engendered by anti-slavery acted as a brief abeyance from the growing racist beliefs that would eventually find their full expression in

¹³² Curtin, *Image of Africa*, 48, 229-230; Stepan, *The Idea of Race in Science*, 3; Mark Harrison, *Climates and Constitutions*, 215.

¹³³ Stepan, *The Idea of Race in Science*, 3.

¹³⁴ Stephen, *The Idea of Race in Science*, 2.

¹³⁵ Henry Home, Lord Kames, *Sketches of the History of Man* (Dublin: James Williams, 1774); Vincent Sarich and Frank Miele, *Race: The Reality of Human Difference* (Boulder: Westview Press, 2004), 65-66.

the second half of the nineteenth-century.¹³⁶ Walvin does point out, however, that although ultimately successful in ending the slave trade, abolitionists did not convince the public that Africans were equals; abolitionists themselves were not convinced that Africans were the moral or intellectual equal of Europeans.¹³⁷ Nonetheless, Walvin asserted that abolitionist arguments and the sentiments they cultivated among the British public did delay the onset of British racism. Walvin's argument is similar to those of Curtin and Stepan, but instead of attributing Prichard and other monogenists with retarding the inception of British racism, he believes that the anti-slavery movement deserves the credit.

Building upon the work of William Cohen, who examined French attitudes to race in the period 1530-1880, Seymour Drescher compared the ways in which abolitionism in both France and Britain affected each country's approach to race.¹³⁸ Drescher, in a similar vein as Walvin and Curtin, emphasized the importance of continuity: "The age of abolitionism heightened the intensity and frequency of positive and negative African and black imaging, but those images neither were born nor died with that historical epoch."¹³⁹ Drescher wrote: "The rise of scientific racism induced not a radical shift in the characteristics ascribed to Africans or to blacks in general, but a reworking of those characteristics in

¹³⁶ James Walvin, *England, Slaves and Freedom, 1776-1838* (Jackson: University Press of Mississippi, 1986), 84; James Walvin, *The Slave Trade* (Stroud: Sutton Publishing, 1999).

¹³⁷ Walvin, *Slaves and Freedom*, 6-11; Curtin, *Image of Africa*, 54.

¹³⁸ Seymour Drescher, "The Ending of the Slave Trade and the Evolution of European Scientific Racism," *Social Science History* 14, no. 3 (Autumn, 1990): 415-450; William Cohen, *The French Encounter with Africans: White Response to Blacks, 1530-1880* (Bloomington: Indiana University Press, 1980).

¹³⁹ Drescher, "Evolution of European Scientific Racism," 419.

different frames of reference.”¹⁴⁰ This is a useful approach to racism. Like Curtin, Drescher depicted racism as a growing tide that abolitionism briefly delayed. What is important is his emphasis upon political, social, and scientific frames of reference.¹⁴¹ By looking not at the characteristics of racism, which seemed steady and mostly unchanged since the mid point of the eighteenth century, Drescher wished to shift emphasis to the socio-political contexts that may have repressed or encouraged expressions of this deep-seated conception of inequality. Thus, it was the context and not the message itself which magnified or minimized the expression of racism. This conception of inequality was always there, but its true flowering occurred in reference to a growing respect for scientific studies which sought to understand the human body through comparison.¹⁴² Once these racist beliefs became amplified and a part of scientific discourses, they were nearly impossible to refute and helps to explain why the second half of the nineteenth century witnessed a hardening of racism.

In his influential study *Orientalism*, published in 1978, Edward Said argued that for centuries a sense of difference had permeated Western culture, encouraging the West to conceptualize those in the East as the ‘other.’ This was not a latent category used only in abstract intellectual comparison but a real and actual system of understanding. Over time, Said argued, Western systems of

¹⁴⁰ Drescher, “Evolution of European Scientific Racism,” 419-420.

¹⁴¹ Michael Adas has highlighted the importance of European assessment of African technology in constructing hierarchies of civilization. See: Michael Adas, *Machines as the Measures of Men: Science, Technology, and Ideologies of Western Dominance* (New York: Cornell University Press, 1990),

¹⁴² Drescher, “Evolution of European Scientific Racism,” 419-420.

knowledge increasingly ordered the Orient in political and intellectually useful ways which further served to magnify this sense of difference.¹⁴³ Building on the theory of hegemony espoused by Antonio Gramsci and Michel Foucault's understanding of power, Said argued that: "Orientalism is fundamentally a political doctrine forced upon the Orient because the Orient was weaker than the West, which elided the Orient's difference with its weakness."¹⁴⁴ The Orient was unable to resist being 'othered' and thus a universal sense of difference came to pervade all understandings of the East. In the hands of the West, this difference was equated with weakness, and as such all differences in the cultural, social, and political make-up of the Orient were viewed as the source of its weakness. It was this teleological argument that made "orientalism" so powerful and pervasive.

Although not directly interested in race *per se*, Said's work has provided historians with a conceptual framework for understanding the 'other.' His theories have clearly influenced historians including David Arnold who, building upon the constructs of the *Orientalist* thesis, has advanced his own argument that Europeans in the era of contact and colonialism inherently attached a sense of 'otherness' to tropical places.¹⁴⁵ He argued that this "sense of difference was reflected in accounts of plants, animals, climate and topography and in description of indigenous societies and cultures."¹⁴⁶ Arnold depicted the tropics as a

¹⁴³ Edward Said, *Orientalism* (New York: Vintage, 1979), 2-5.

¹⁴⁴ Said, *Orientalism*, 204.

¹⁴⁵ David Arnold, *Warm Climates and Western Medicine: The Emergence of Tropical Medicine, 1500-1900* (Amsterdam: Rodopi, 1996), 5-6; David Arnold, "India's Place in the Tropical World, 1770-1930" *Journal of Imperial and Commonwealth History* 26, (1998): 1-21.

¹⁴⁶ Arnold, *Warm Climates*, 5-6.

conceptual space, constructed by Europeans as outside the norm: “I would argue calling a part of the globe ‘the tropics’ (or by some equivalent term, such as the ‘torrid zone’) was a Western way of defining something culturally and politically alien, as well as environmentally distinctive, from Europe and other parts of the temperate zone.”¹⁴⁷ It was this framing of the tropics as fundamentally different that allowed Europeans to make the natural, largely intuitive, conclusion that those who inhabit tropical regions must also be different. By employing Said’s *Orientalist* perspective, Arnold demonstrated how the ‘othering’ of tropical people separated them from the European normative categorization, thus, making them easy victims of a rising tide of European racism.

In his investigation of British perceptions towards the Indian environment and medical landscape, Mark Harrison eschewed the reductionist approaches of Said and Arnold and instead emphasized Indian agency and the bi-directional nature of medical discourses between Indian and European medical practitioners.¹⁴⁸ He challenged the notion of unequal power and offered his work as a “corrective to certain widely-held assumptions about the nature of the ‘orientalist’ discourse.”¹⁴⁹ Harrison critiqued David Arnold’s position, asserting that in the seventeenth and eighteenth centuries there was no “stark division”

¹⁴⁷ Arnold, *Warm Climates*, 6.

¹⁴⁸ Harrison, *Climates and Constitutions*, v; Mark Harrison, “Medicine and Orientalism: Perspectives on Europe’s Encounter with Indian Medical Systems,” in *Health, Medicine and Empire: Perspectives on Colonial India*, ed. Biswamoy Pati and Mark Harrison (Oxford: Oxford University Press, 1999), 37-87.

¹⁴⁹ Harrison, *Climates and Constitutions*, v.

between notions of the Indian and European body.¹⁵⁰ He explained that although Europeans clearly perceived tropical places as different, most Britons subscribed to the theory of acclimatization, the idea that over time Europeans would adapt to a foreign environment. Some Britons were so sure about the adaptability of the human body that they supported plans for the extensive colonization of India.¹⁵¹ For Harrison, it was the struggle to understand the role of foreign climates in creating, sustaining, and altering the human constitution that largely directed nineteenth-century racial thought. Harrison argued that Europeans initially held a “guarded optimism about acclimatization and the colonization of India prior to 1800,” but that this “gave way to pessimism” resulting in “the alienation of Europeans from the Indian environment; a shift which was closely related to the emergence of ideas of race and the consolidation of colonial rule.”¹⁵² By the 1840s, the high mortality rates coupled with a growing belief in the fixity of man convinced Britons that acclimatization simply was not possible.¹⁵³

Acclimatization had been tied to the belief in the adaptability of mankind. As we shall see, adaptability was the central argument held by the monogenists, for it explained how the earth became populated by peoples of various physical appearances. By the 1840s, it seemed clear that European settlers, after generations of settlement in the West Indies and India, did not experience a

¹⁵⁰ Harrison, *Climates and Constitutions*, v.

¹⁵¹ Harrison, *Climates and Constitutions*, v. For more on adaptability see, Michael Worboys, “Germs, Malaria and the Invention of Mansonian Tropical Medicine: From ‘Diseases in the Tropics’ to ‘Tropical Diseases,’ in *Warm Climates and Western Medicine: The Emergence of Tropical Medicine, 1500-1900*, ed. David Arnold (Amsterdam: Rodopi, 1996), 181-207.

¹⁵² Harrison, *Climates and Constitutions*, 3.

¹⁵³ Harrison, *Climates and Constitutions*, 16-17.

permanent change, nor were they as 'immune' to the disease environments as native residents.¹⁵⁴ One conclusion drawn, states Harrison, is Britons came to believe that race was fixed. He also argued that the inability to acclimatize alienated Britons, resulting in a "hardening of racial categories."¹⁵⁵ Although different in approach, the scholarship of Arnold and Harrison demonstrates that European understanding of the climate and of the tropical world added much to the cultural construction of race. For Arnold, the theoretical framework encouraged Britons to perceive the tropics, and those who inhabited them, as inherently different. This difference, according to Harrison, was bred out of experience and was ultimately the product of frustrated Europeans who, after failing to adapt to the tropical environment, became easy converts to racist perspectives which differentiated the European body from the tropical one.

Philip Curtin asserted that the rise of British racism was the result of a protracted debate between advocates of the monogenist and polygenist camps. Although Curtin emphasized the pervasive strength of the monogenist position, he believed that at the beginning of the nineteenth century there "was a new note of confidence, even of arrogance, emanating from the British people."¹⁵⁶ It was the self-confidence expected from a victorious power after a long war and a smugness cultivated by a growing financial and industrial power. Curtin asserted that from such great heights the British began to conceive of an even larger cultural divide

¹⁵⁴ Harrison, *Climates and Constitutions*, 16; 124.

¹⁵⁵ Harrison, *Climates and Constitutions*, 112.

¹⁵⁶ Curtin, *Image of Africa*, 143.

between their own civilization and the primitive cultures of Africa.¹⁵⁷

Nonetheless, Curtin argued that despite this growing sense of superiority, monogenism kept a growing tide of racism at bay. Indeed, Curtin noted that even in the 1830s Africans had not been “condemned to a permanent state of ‘barbarism’” and that “both [European] science and religion, each in its own way, held the door open to improvement through ‘moral influences.’”¹⁵⁸ However, this belief in the transformative power of culture and civilization began to wane in the face of both science and the popular press. Curtin asserts that the press “summarized, popularized, and transmitted” negative stereotypes about Africa to the public.¹⁵⁹ Travelers to “the Dark Continent” were actively seeking out differences and this not only blinded them to similarities between European and African culture but made them more susceptible and willing to believe popular myths which depicted Africans in a negative light.¹⁶⁰ Accordingly, even “serious scholars of good will,” encouraged by those on the ground and in the face of growing cultural smugness and racialized science, began to accept the connection between race and culture.¹⁶¹ This acceptance undid the monogenists cause, allowing for arguments that unalterably tied race and culture together to come to the forefront. It was, in his mind, the failure of monogenists to continue to ward off the inherently racist doctrines of polygenist writers and theorists that explains why in the 1840s British understanding of Africa took a racist turn.

¹⁵⁷ Curtin, *Image of Africa*, 143.

¹⁵⁸ Curtin, *Image of Africa*, 243.

¹⁵⁹ Curtin, *Image of Africa*, 341.

¹⁶⁰ Curtin, *Image of Africa*, 46.

¹⁶¹ Curtin, *Image of Africa*, 386-387.

Nancy Stepan in her seminal work, *The Idea of Race in Science: Great Britain, 1800-1960*, argued that British racism was a product of both a sense of cultural superiority emanating from British global dominance and a result of negative perceptions engendered by the institution of race slavery.¹⁶² She focused on the new developments in science, such as comparative anatomy, which institutionalized and gave scientific credence to the idea of difference. Despite this emphasis on science, Stepan believes that the growing tide of racism, which naturally influenced scientific studies, was delayed and prevented until the 1840s by Prichard and other monogenists who successfully held both public and scientific opinion.¹⁶³ Similar to Curtin, she viewed the 1840s as the crucial decade, arguing that up until this point: “Prichard’s monogenism stood firm as the basic assumption of racial studies in Britain,” forming “a strong bulwark against the growing tide of facile racism.”¹⁶⁴ Stepan argued that the rise of scientific racism can be traced to a “fatal error” by which Britons chose science, not “ethical theory,” as the method of deciding humanity:

Increasingly, the moral claim of the black and other so-called races, slave and free, to equality of treatment was taken to be a matter not of ethical theory but of anatomy. If all races were found to be anatomically and physiologically alike, then the rights and privileges enjoyed by Europeans would be guaranteed for all people. The appeal to nature in deciding what was in reality a moral issue was fatal, but one made by the anti-abolitionists and eventually the abolitionists alike. Nature was now the arbiter of morality.¹⁶⁵

¹⁶² Stepan, *The Idea of Race in Science*, xii.

¹⁶³ Stepan, *The Idea of Race in Science*, 3.

¹⁶⁴ Stepan, *The Idea of Race in Science*, 3.

¹⁶⁵ Stepan, *The Idea of Race in Science*, xii-xiii.

Stepan emphasized the importance of comparative anatomy, which tended to highlight differences and thus lessen African claims to humanity. At the same time, she stressed the decline of the monogenist camp, which by the 1840s was losing ground in the face of growing scientific doubt about the unity of mankind.¹⁶⁶ Stepan asserted that, by the 1850s the public was willing to read and, with the blessing of science, to ponder the possibility that the African body was so fundamentally different from the European one that it belong to another species altogether.¹⁶⁷ The practitioners of science influenced the public constructing discourses that privileged difference over the unity of mankind.

In “Race and Gender: The Role of Analogy in Science,” Stepan builds upon her extensive knowledge of the origins of scientific racism in Britain by examining how language, particularly that which linked Africans with other negatively understood constructions, contributed to the development of racism in British thought.¹⁶⁸ Influenced by the work of Mary Hesse, Stepan revealed how a set of analogies and metaphors came to dominate the study and cultural creation of race.¹⁶⁹ The language of the early nineteenth century fused specific negative ideas with an understanding of the African. Most importantly, these negative perceptions came to represent ‘the African’ to such a degree that they became synonyms and analogies for one another. For example, Africans were equated

¹⁶⁶ Stepan, *The Idea of Race in Science*, 3.

¹⁶⁷ Stepan, *The Idea of Race in Science*, 4.

¹⁶⁸ Nancy Stepan, “Race and Gender: The Role of Analogy in Science,” in *Science, Race and Ethnicity: Reading from Isis and Osiris*, ed. John Jackson (Chicago: Chicago University Press, 2002), 5-21.

¹⁶⁹ Mary Hesse, *Models and Analogies in Science* (Norte Dame: Notre Dame University Press, 1966).

with the poor of Europe. This trope became so well developed that European poor were “seen in terms strictly applicable only to the ‘Negro’ and vice versa.”¹⁷⁰

This was not a vague analogy: the poor were seen and believed to be “a race apart.”¹⁷¹ The African, meanwhile, was “shiftless, idle, given to drink” and most importantly destined to “be left behind in the march towards progress.”¹⁷²

Stepan’s analysis is useful in explaining why, with the disintegration of the monogenist position, Britons so readily accepted the hardened racism of Knox. In this interpretation, British racism was not the product of the triumph of polygenism over monogenism, but the result of language which slowly and insidiously infested the English language, thus allowing for racist positions to be not only formulated but placed within linguistic and social constructions that could be understood by all Britons.

There exists, therefore, general agreement in the historiography that the 1840s was a time of important change, and that the first half of the nineteenth century overall was both a transitional period and one which included lively interest in topics relevant to race. Scholars have devoted attention to the timing of developments primarily only as an adjunct to their focus upon causation. This present study will do more to emphasize the unsettled, ambiguous nature of the topic in Britain during this half century. No one ideology, or social or cultural perspective, possessed control over race. The contested topic of causation, so

¹⁷⁰ Stepan, “Race and Gender,” 12.

¹⁷¹ Stepan, “Race and Gender,” 12.

¹⁷² Stepan, “Race and Gender,” 12.

prevalent in the historiography, does not lie at the centre of this study (although certainly it could not have been formulated without the insights outlined above, particularly those of Edward Said, Nancy Stepan, Mark Harrison, and Philip Curtin). Instead, the central point is to delineate the ‘flux’ of this period, and explore the meaning of that unsettledness for ‘the African body’ during the half century (not over the long sweep of history).

Race from the Eighteenth through the Nineteenth Centuries

The eighteenth-century classification of nature began in earnest with Carl Linnaeus. Linnaeus elucidated the connection between the Christian God and nature by devising a universal system for the classification of all of creation. In his most influential work, *Systema Naturae*, first published in 1735, Linnaeus divided the natural world into three classifications: the animal, plant, and mineral kingdoms. Linnaeus’ understanding of the natural world was deeply influenced by the Great Chain of Being, an idea rooted in Aristotelean and Neo-Platonic philosophy.¹⁷³ The Great Chain of Being, as understood in the eighteenth century, asserted that all of God’s earthly creations were interconnected and could be placed on a hierarchical scale of development ranging from the elevated position of man down to the simplest animal life. By ordering the world into neat, clearly divisible categories, Linnaeus and his followers believed that they were shining light on the Majesty of God’s creation. This desire to classify gave rise to racial

¹⁷³ For more on the concept of a Great Chain of Being see: Arthur Lovejoy, *The Great Chain of Being: The Study of the History of an Idea* (Cambridge: Harvard University Press, 1953); William Bynum, “The Great Chain of Being after Forty years: An Appraisal,” *History of Science* 13 (1975): 1-28.

classifications which, as Philip Curtin has pointed out, were expanded and reformed in the many editions of *Systema Naturae*.¹⁷⁴ Initially, Linnaeus based these racial hierarchies solely upon skin colour; however in 1758 he divided *genus homo* into two species so as to include orang-outangs.¹⁷⁵

Linnaeus was the first to hint at man's connection with orang-outangs and by doing so came to influence a host of scholars, including Lord Monboddo who insisted on the connection between man and ape.¹⁷⁶ The similarities between orang-outangs and humans became a popular area of study: contemporary scientific and medical journals published a host of articles highlighting the connections, both physical and mental, between orang-outangs and humans.¹⁷⁷ Curtin theorized that the reason Linnaeus included orang-outangs as a subgroup within the *genus homo* was to lessen the gap between man and animal, for the Great Chain of Being assumed that there was a close relationship between all creations:

Since man had a place as the highest term on the scale, the varieties of mankind had also to be taken into account, and the biologists assumed from the beginning that they too could be arranged in hierarchic order.¹⁷⁸

¹⁷⁴ Curtin, *The Image of Africa*, 38.

¹⁷⁵ Curtin, *The Image of Africa*, 37-38.

¹⁷⁶ Curtin, *The Image of Africa*, 42-43; 45.

¹⁷⁷ *The Edinburgh Journal of Science* was the most enthusiastic publisher of orang-outang studies. For example: Clarke Abel, "Account of an Orang Outang, of Remarkable Height, from the Island of Sumatra," 4, no. 8 (1826): 193-201; J. Grant "Account of the Structure, Manners, and Habits of an Orang-Outang from Borneo, in the Possession of George Swinton, Esq. Calcutta," 9, no. 17 (1828): 1-24; Captain Hull, "Account of the Capture of a Female Orang Outang, caught on the coast of Sumatra," 7, no. 8 (1827): 162.

¹⁷⁸ Curtin, *Image of Africa*, 37.

Linnaeus had opened one door for the hierarchical ordering of mankind. Later, polygenist writers would use the Great Chain of Being to suggest a hierarchical ordering of not just nature but of man. This ordering, based on skin colour, ran from the darkest people (Africans) up to the white European. This hierarchy became a pillar of the polygenist and later racist theories articulated by Edward Long and Robert Knox.

In direct opposition to the Great Chain of Being, there developed the climatic school, a group of scholars which included Georges-Louis Leclerc, The Comte de Buffon (1707-1788) and Johann Friedrich Blumenbach (1752-1840), who argued for a shared humanity. These scholars believed that climate, both the environment and social conditions, shaped human development. They argued that the varieties of humans found spread across the globe were the result of superficial changes engendered by the climate.¹⁷⁹ Their most cogent and important assertion is that all men, given the right environment, were capable of equal development, intelligence, and civilization.¹⁸⁰ The climatic argument, often referred to as environmentalism, became the central tenet of monogenism. Much of this development can be attributed to Buffon's ideas on race and climate which heavily influenced and shaped the convictions of the next two generations of investigators. In his *L'Histoire Naturelle*, first published in 1749, Buffon articulated his theory of environmentalism. Buffon concluded that the human

¹⁷⁹ Georges-Louis Leclerc, The Comte de Buffon, *Natural History, General and Particular*, trans. William Smellie, vol. 4, 2nd ed. (London: W. Straham and T. Cadell, 1785), 350-351.

¹⁸⁰ Buffon, *Natural History*, vol. 4, 282.

constitution, including mental capacity, physical characteristics, and skin colour, were shaped by climatic and cultural influences. He believed in the rapid adaptability of man, arguing that: "A savage tribe transported to Europe and fed on European food would gradually become not only civilized but white."¹⁸¹ This sort of comment demonstrates how far from reality some eighteenth-century thinkers were in their understanding of 'the African body.' Buffon attributed physical differences to the most simple of customs or habits. For example, he attributed the flat nose of Africans to the propensity of African women to carry young children on their backs.¹⁸²

Buffon defended the unity of mankind, arguing that for two species to be considered distinct meant that after cross-fertilization the offspring of this match must be infertile. The existence of "racial half breeds" who, like any humans, were capable of reproduction proved the unity of mankind.¹⁸³ For Buffon, humans had originally inhabited the region, "between the 40th and 50th degrees of latitude" and that: "It is from this climate that the ideas of the genuine colour of mankind... ought to be derived. The two extremes [black and white] are equally remote from the truth and from beauty."¹⁸⁴ Buffon's belief that environment determined an individual's development influenced the British abolitionist movement, which used his theories to argue that it was the slave trade that caused

¹⁸¹ Buffon, as quoted in Augstein, *Race: The Origins of an Idea*, xv.

¹⁸² Buffon, *Natural History*, vol. 4, 282; Londa Schiebinger, "The Anatomy of Difference: Race and Sex in Eighteenth Century Science," *Eighteenth-Century Studies* 23, no. 4 (Summer, 1990): 393.

¹⁸³ Herbert Odom, "Generalizations on Race in the Nineteenth-Century Physical Anthropology," *Isis* 58, no. 1 (Spring, 1967): 11.

¹⁸⁴ Buffon, *Natural History*, vol. 3, 205; Odom, "Generalizations on Race," 11.

African barbarity; once this impediment to progress was removed, Africans would quickly become civilized.¹⁸⁵ Abolitionists were also drawn to Buffon's insistence upon rapid improvement which encouraged high expectations concerning Africa and Africans. For them it meant that the 'civilization' of Africans would not take generations but that immediate results could be gained. Buffon's environmental determinism became the central tenet of the monogenist cause, providing the most cogent explanation for the variety of mankind while still defending creationism.

The climatic theory reached its zenith under the guidance of the German scholar, Johann Friedrich Blumenbach. Blumenbach believed that the human body was not fixed, but rather shaped by climate and culture. For example, Blumenbach, following Buffon, asserted "the thick nose and swelling lips of Ethiopians" were the result of mothers carrying young children on their backs while engaged in intensive manual labour.¹⁸⁶ He took this conception further, stating that class would have a direct impact on skin color:

The face of the working man or the artisan, exposed to the force of the sun and the weather, differs as much from the cheeks of a delicate [Caucasian] female, as the man himself does from the dark American, and he again from the Ethiopian.¹⁸⁷

Blumenbach placed an emphasis on climate and culture, while introducing occupation and class into a discussion of race. Blumenbach did not agree with the fixity of the Linnaean system and attempted to remove Linnaeus from the

¹⁸⁵ Curtin, *Image of Africa*, 41.

¹⁸⁶ Johann Friedrich Blumenbach, "On the Natural Varieties of Mankind," in *Anthropological Treatises of Johan Friedrich Blumenbach* trans. and ed. Thomas Bendyshe (London: Longman, 1865), 232; Schiebinger, "The Anatomy of Difference," 393.

¹⁸⁷ Blumenbach, "On the Natural Varieties of Mankind," 108; Schiebinger, "The Anatomy of Difference," 390.

discussion on race by insisting that debate must focus upon bimana, primates with two feet and two hands, rather than all animals.¹⁸⁸ By shifting the focus away from the Great Chain of Being, Blumenbach placed man (bimana) - not man and orang-outangs - at the center of the debate on race. For Blumenbach, a species was not defined by the fertility of 'half-breeds,' as Buffon asserted, but instead was defined by a host of similar factors, including life-span, number of offspring, and how a species interacted with disease.¹⁸⁹ Despite Blumenbach's influence his emphasis on disease did not take, and, except for the case of racial immunities, even those with medical training avoided using medicine as a way of understanding "the races of men."

Blumenbach's research relied upon a much admired and vast collection of human skulls, whose analysis led him to distinguish five basic forms within the human race. Blumenbach played with different names and ways of classifying these five types, but in his 1795 edition of *De Generis Humani Varrietate Natura* he settled on the well-known and understood categories of: Caucasian, Mongolian, Ethiopian [African], American, and Malay.¹⁹⁰ Despite having introduced these categories, Blumenbach insisted that the classifications should not be viewed in a hierarchical manner and that each group was an essential part of a single humanity.¹⁹¹ Blumenbach, whose research influenced him to take up

¹⁸⁸ Augstein, *Race: The Origins of an Idea*, xvii.

¹⁸⁹ Augstein, *Race: The Origins of an Idea*, xvii.

¹⁹⁰ For more on Blumenbach's categorization of these five types of man see: Blumenbach, "Contributions to Natural History," in *Anthropological Treatises of Johan Friedrich Blumenbach*, trans. and ed. Thomas Bendyshe (London 1865), 264-276.

¹⁹¹ Harrison, *Climates and Constitutions*, 98-99.

the abolitionist cause, rejected claims that Africans were natural slaves and lacked the intellectual capacity necessary for improvement:

There is no so-called savage nation known under the sun which has so distinguished itself by such examples of perfectibility and original capacity for scientific culture, and thereby attached itself so closely to the most civilized nations of the earth as the Negro.¹⁹²

Blumenbach, like Buffon, had created a system of classification that acknowledged the varieties of mankind while defending adaptability and unity.

Buffon and Blumenbach were the most widely read monogenist authors of the eighteenth century. Their ideas about the adaptability of races were influential and had repercussions for British debates about slavery. Their climatic arguments, especially concerning the adaptability of mankind, had an important effect on Europeans' understanding of the tropics and their own bodies. The idea that culture and climate, more so than other factors, shaped the human constitution gave hope for not only African slaves but to all the world's peoples. Although they often compared European and African bodies to one another, neither scholar placed much weight in physical appearances, for each believed that what they saw and studied was not a fixed body but rather bodies altered over time by climate and culture. Even when physical examinations suggested difference, for example in Blumenbach's comparison of skulls,¹⁹³ they defended the unity of man by placing emphasis upon climate and culture. As long as

¹⁹² Blumenbach, "Contributions to Natural History," 312.

¹⁹³ Buffon, *Natural History*, vol. 4, 239-240.

monogenists could continue to assert that environment shaped the human constitution they could argue that man descended from an original pair.

Those who placed stock in the uplifting properties of culture were assisted by the prevailing philosophical and literary ideas of the age. Buffon and Blumenbach lived in the age of Montesquieu, an era where the doctrine of environmentalism dominated academic writing. In *The Spirit of Laws* (1748), Charles-Louis de Secondat Baron de la Brede et de Montesquieu (1689-1755) articulated his theory that climate substantially affected the behaviour of humans and influenced the development of society. Montesquieu asserted that the climate had a real and pronounced effect upon the human constitution, pointing out that inhabitants of the colder northern climates were more active in mind and body than those populating the temperate south, who tended to be more hot tempered and malleable.¹⁹⁴ Such ideas were part of an intellectual milieu which used physical environment to explain diversity. These ideas helped frame the tropics and tropical people as both socially and biologically different.

Scholars continue to disagree over the degrees to which Montesquieu's writing and, in particular, the literary construct of the 'noble savage,' aided in improving the European image of the African. The noble savage was a literary tradition based largely upon North American "Indians" but became associated with Africans in the eighteenth century.¹⁹⁵ Philip Curtin stated that: "Beyond any

¹⁹⁴ Charles-Louis de Secondat, Baron de la Brede et de Montesquieu, *The Spirit of the Laws* (London, 1794) vol.1, book XIV, chapters 1-3.

¹⁹⁵ Curtin, *Image of Africa*, 49.

doubt, the use of the savage hero as a literary device helped to create a much more favorable emotional climate for Africans than they would otherwise have enjoyed.”¹⁹⁶ However, Curtin qualified this statement by adding that these writers, despite their positive depictions of Africans “had no intention of suggesting that African were better than Europeans, or that their culture, on balance, measured up to the achievements of Europe.”¹⁹⁷ Banton questioned whether the ‘noble savage’ had any positive impact on how Britons conceptualized Africans, stating:

Little use was made of the image of the black man in the romantic writing about the noble savage because people knew so much more about Africans than about Pacific Islanders and had formed an unfavourable estimate of African society as incapable of developing the region’s potential wealth.¹⁹⁸

For Banton, the damage had already been done to the African character and as such, the trope of the noble savage was saved for lesser known peoples who were not already fixed in the British imagination. Although it is difficult to establish causation and influence, it is clear that the enlightenment philosophies of progress and adaptability created an intellectual strand where it was acceptable to believe in the perfectibility of humanity. The literary tradition, when combined with the arguments of Buffon and Blumenbach, aided in defending the African against racist theories, while emphasizing the uplifting role of culture. Buffon, for instance, went into great detail outlining the accomplishments of a variety of

¹⁹⁶ Curtin, *Image of Africa*, 49.

¹⁹⁷ Curtin, *Image of Africa*, 49-50.

¹⁹⁸ Banton, *Racial Theories*, 9.

Africans who lived in Europe and the Americas. For Buffon, these examples proved the “the perfectibility of the mental faculties and the talents of the negro.”¹⁹⁹ It also offered hope to abolitionists who argued that once the slave trade had been removed Africa and Africans could readily improve.

Eighteenth-century biological racism found its most vigorous supporters in West-Indian planters and polygenists, notably Henry Home, Lord Kames, who stressed the vast physical and intellectual differences that differentiated Africans from Europeans.²⁰⁰ Polygenist arguments found their organizational structure in the works of Isaac de La Peyrere (1596-1676), a French Protestant who in his 1655 work, *Prae-Adamitae*, argued that there were humans before the creation of Adam. Peyrere theorized that it was from this pre-Adamite tribe that Cain selected his wife after his banishment.²⁰¹ This theory was important, for although not explicitly racist it asserted multiple creations. Lord Kames expanded on the notion of separate creations. In his *Sketches of the History of Man*, first published in 1774, Kames developed the idea that the variety found among the races of men was the result of different acts of creation.²⁰² For Kames, each race was created for, and suited to, a particular climate. Kames, was “well aware that his assumption contradicted Scripture,” and did try to appease critics by paying “lip service to the Biblical story of the Tower of Babel” as a possible explanation for

¹⁹⁹ Buffon, *Natural History*, vol. 4, 308.

²⁰⁰ Curtin, *Image of Africa*, 42-43.

²⁰¹ Augstein, *Race: The Origins of an Idea*, xiv. For an examination of Pre-Adamite theory from the postulates of the ancients to Peyrere see: Richard Popkin, *Isaac de La Peyrere (1596-1676) His Life, Works and Influence* (Leiden: Brill, 1987), 26-41.

²⁰² Home, *History of Man*, vol. 1, 38.

the physical varieties found between races of men.²⁰³ His inability to reconcile how climate or culture caused the clear physical differences between Africans and Europeans led him to support polygenism. In many ways, Kames was the forerunner to those in the early nineteenth century who came to reject the acclimatization and adaptability thesis, and began to believe that the European body was fundamentally different from non-European bodies.

Edward Long, a former Jamaican planter, published in 1774 an influential three-volume *History of Jamaica*. Long skillfully employed both the Great Chain of Being and the Linnaean mode of classification, using the two doctrines to support his racist attacks on the character and constitution of the African. Expanding upon the Linnaean system, Long divided the *genus homo* into three species: Europeans; Negroes; orang-outangs. Long used this categorization to elevate Europeans well above Africans, by providing arguments which depicted Africans more as beasts than as a part of humanity. For example, Long claimed that, similar to animals, Africans matured far more rapidly than whites, a perspective that was often repeated.²⁰⁴ Instead of having human hair, Africans have “a covering of wool, like bestial fleece.”²⁰⁵ He stated that Africans were unique not only in their black skin but in “their bestial or fetid smell.”²⁰⁶

Childbirth among Negro women was not like parturition among European women

²⁰³ Augstein, *Race: The Origins of an Idea*, xiv.

²⁰⁴ Long, *The History of Jamaica*, vol. 2, 335. See for instance, William Daniell, *Sketches of the Medical Topography and Native Diseases of the Gulf of Guinea Western Africa* (London, 1849), 98.

²⁰⁵ Long, *The History of Jamaica*, vol. 2, 352.

²⁰⁶ Long, *The History of Jamaica*, vol. 2, 352.

for it had neither the duration nor the pain associated with childbirth among Europeans.²⁰⁷ Particularly damning for the abolitionist cause was Long's argument that association with Europeans had not improved the African. According to Long, despite geographic proximity to Europeans, West Indian slaves showed no trace of civilization and were just as debauched as their brethren in Africa.²⁰⁸ Long agreed with the Scottish scholar David Hume (1711-1776) who had argued in 1753-54 that Africans were unlikely to improve and that there was a real and fixed distinction between Europeans and Africans:

I am apt to suspect Negroes to be naturally inferior to Whites. There never was a civilized nation of any other complexion than white, not even any individual eminent either in action or speculation. No ingenious manufactures amongst them, no arts, no sciences... Such a uniform and constant difference could not happen, in so many countries and ages, if nature had not made an original distinction betwixt these breeds of men.²⁰⁹

Hume commented upon a Jamaican known for his learning: "In Jamaica, indeed, they talk of one Negro as a man of parts and learning; but it is likely he is admired for slender accomplishments, like a parrot who speaks a few words plainly."²¹⁰ From their perspective, the lack of any noticeable advancement amongst West Indian slaves, despite their close proximity to Europeans, proved that Africans were incapable of progress. What Long and other authors proposed instead was that each race of man had been given only a specific, uneven, ability to

²⁰⁷ Long, *The History of Jamaica*, vol. 2, 336.

²⁰⁸ Long, *The History of Jamaica*, vol. 2, 354.

²⁰⁹ David Hume, "Of National Characters," *The Philosophical Works of David Hume. Including all the Essays, and Exhibiting the more Important Alterations and Corrections in the Successive editions published by the Author*, vol. 3 (Boston: Little, Brown and Company, 1854), 228; Curtin, *Image of Africa*, 42.

²¹⁰ Hume, "Of National Character," 229.

develop.²¹¹ Long mocked the idea that Europeans could improve Africans and, thus, his outlook gave explicit support to both the slave trade and the institution of slavery.

Much of Long's success came from his ability to place his arguments within a respected intellectual milieu. We have seen how he used both the Linnaean method and the assumptions of the Great Chain of Being to suggest that Africans had more in common with animals than as a member of a shared humanity. He used Buffon's criteria for species (fertile offspring) to establish that Africans were not of the same species as Europeans. Long was well aware that those in the colonies, as well as those in London, knew that inter-racial procreation could, and did, produce fertile offspring. Thus, he developed Buffon's position by stating that although cases of fertile offspring were known to occur, those mixed-children would have diminished fertility.²¹² Long's theories were often contradictory, for at times he portrayed Africans as mere beasts while at others depicting them as another species of man;²¹³ however, his main goal was to differentiate Africans and to depict them as a lesser race than Europeans.

Neither monogenists nor polygenists made much use of the body as evidence for their claims about the origins of men. Both sides made offhand comments about physical differences and would, where they thought appropriate,

²¹¹ Long, *The History of Jamaica*, vol. 2, 353.

²¹² Long, *The History of Jamaica*, vol. 2, 336.

²¹³ For instance he begins his section entitled the "Negro" (pages 351-383 vol. 2) by depicting blacks as animals but then states that they are also much like Egyptians (355). The whole section comprises this back and forth with Long asserting that Africans are animals and then speaking of their human characteristics.

draw conclusions from physical evidence. Despite, the minor role played by the body, phrenology did inform discussions of race. Phrenology originated in the mental and physiological investigations carried out in the last decades of the eighteenth century by the Austrian Johann Franz Gall (1758-1828). Phrenology was part of a wider movement that sought to analyze the size, function, weight, etc., of different parts of the body in the hope of learning more about the functions of the body and the diversity of mankind. For example, the anatomist Samuel Thomas Soemmerring (1755-1830) argued that intelligence could be calculated by weighing the brain and comparing it to the weight of the body; the more acute the correlation the higher the intelligence.²¹⁴ Dutch theorist Pieter Camper, also working in the late eighteenth century, argued that by taking a series of measurements of the face (known as Camper's Facial Angle) a researcher would discover a graded hierarchy from the ideal of the classical Greek statues to present-day Europeans, down to Africans and finally to lower animals.²¹⁵ Because these investigators were interested in bone structures, and not skin, their research tended to emphasize the unalterable nature of the human constitution. This suggested to some that there was a real and fixed difference between the races of men. The science of measurements, as understood in the late eighteenth and early nineteenth century, added credence to the idea of difference and added support to the idea of separate creations, while also suggesting that there could be no rapid adaptability of man. The science of phrenology played an important role

²¹⁴ Augstein, *Race: The Origins of an Idea*, xx.

²¹⁵ Curtin, *Image of Africa*, 39-40.

in ascribing difference; it was not only non-white males but also white women that phrenology suggested had a lower capacity for development. Nancy Stepan argued that:

women's low brain weights and deficient brain structures were analogous to those of lower races, and their inferior intellectuallities explained on this basis. Woman, it was observed, shared with Negroes a narrow, childlike, and delicate skull, so different from the more robust and rounded heads characteristic of males of 'superior' races.²¹⁶

Although phrenology did much to explain and to assert difference, on the whole, it, like every other evaluation of the body, remained on the fringe of the debate over the origins of humanity.

Phrenology helped re-define the climatic argument by suggesting that differences in men ran deeper than skin colour. Indeed, by the beginning of the nineteenth century, monogenists such as the prominent surgeon, Sir William Lawrence (1783-1867), James Cowles Prichard, and Georges Cuvier (1776-1832) had begun to question whether the everyday effects of the climate could account for the varieties of men. Lawrence, a monogenist, challenged the notion that the climate, particularly the sun's rays, were capable of effecting substantial changes to the human constitution. Lawrence, instead of focusing on the effect of the sun on white bodies, set out to determine the sun's effect on black bodies. In his musing upon the black body, Lawrence, in 1819, concluded that the sun's rays did not influence the human constitution and justified this position by pointing out that the parts of the body that were not exposed to the sun, like the inside of the

²¹⁶ Stepan, *Race and Gender*, 7.

thighs, were the same colour as areas constantly exposed to the sun.²¹⁷

Lawrence's investigations, like those of many other monogenists in the early nineteenth century, led him away from the climatic argument and instead prompted him to accept other reasons for difference. Lawrence, who advocated the abolition of slavery, stressed fixity, concluding that Europeans naturally had a substantially higher intellect than Africans and that it was this difference in intellect that divided the races.²¹⁸ Interestingly, Lawrence believed in the natural, fixed, inferiority of Africans and was nonetheless a monogenist and an abolitionist.

Lawrence's most important contribution, in the present context, was his insistence upon the centrality of the empirical study of the races, rather than the arguments of philosophers or those who merely pontificated on the difference of men. Lawrence pleaded with his fellow researchers that "must be contented to proceed in our examination in the slow and humble, but sure method of observation."²¹⁹ Lawrence called for science, and science alone, to solve the mystery of the variety found among humankind. Despite his sincerity and dedication to scientific method, Lawrence was himself guilty of relying on dubious authorities and looking outside of science for answers. That the champion of empirical study over speculation was known to rely on authorities

²¹⁷ William Lawrence, *Lectures on Physiology, Zoology and the Natural History of Man* (Salem, 1828), 447-448. First published in 1819.

²¹⁸ Lawrence, *Lectures*, 460.

²¹⁹ Lawrence, *Lectures*, 213.

such as Edward Long,²²⁰ explains in part, why the debate over the origins of man was never limited to medical and other scientific authorities and was open to self-proclaimed experts and to contributors with no background in the contemporary sciences.

In 1813 Dr. James Cowles Prichard published his famous, *Researches into the Physical History of Man*. In this work, Prichard, who “dominated British ethnology and anthropology until his death in 1848,”²²¹ set out to defend creationism and the unity of mankind. Prichard, monogenist and friend to the abolitionist cause, rejected the racial constructs of the Great Chain of Being and instead stressed that all humans shared similar characteristics. For Prichard “the characteristics ascribed to the negro” were in fact “distributed to different nations [races] in all manner of ways, and combined in each instance with more or fewer characters belonging to the European or Asiatic.”²²² Thus, humans were in essence the same, as they all possessed a mixture of similar characteristics and, most importantly, came from an original pair. Prichard was not convinced by either the climatic argument or Lamarckian evolution.²²³ The latter is the idea that organisms can pass on attributes acquired during their lifetime.

²²⁰ Curtin, *Image of Africa*, 231.

²²¹ Augstein, *Race: The Origins of an Idea*, xxiii.

²²² James Cowles Prichard, *Researches into the Physical History of Man*, 2 ed. (London: John and Arthur Arch, 1826), 233. First published in London 1813.

²²³ H. F. Augstein, *Race: The Origins of an Idea*, xxii-xxiv. For Lamarck see, Richard Burkhardt, Jr. “Lamarck, Evolution and the Politics of Science,” *Journal of the History of Biology* 3, no. 2 (Autumn, 1970): 275-298; Pietro Corsi, *The Age of Lamarck: Evolutionary Theories in France 1790-1830* (Berkeley: University of California Press, 1988).

Prichard, having rejected polygenism and Lamarckian evolution while being skeptical about the climatic position, was forced to develop his own theory of difference, arguing that only “connate,” characteristics could be passed on to the offspring.²²⁴ Connate was the idea that only characteristics “ingrained into the human fabric before birth” may be inherited.²²⁵ Prichard believed that physical aberrations in offspring were not the result of acquired inheritance or the superficial results of the climate, but were the result of accidental causes. This idea of change as result of accident or calamity provided intellectual space, and a role, for both the Great Flood and the Tower of Babel.²²⁶ Prichard argued that culture and civilization had an important impact on humans just as domestication wrought changes in animals. Prichard was one of the first academics, if even indirectly, to claim that man originated in Africa. Indeed, Prichard argued that man was originally black and that the influence of civilization had turned some men white and encouraged them to breed with white females.²²⁷ Interestingly, although Prichard denied the effects of physical climate - major catastrophes notwithstanding - he clearly believed that culture could alter physical appearance. By suggesting that black was the colour of the primitive man and white reflected

²²⁴ Augstein, “James Cowles Prichard,” in *Oxford Dictionary of National Biography* (Oxford: Oxford University Press, 2004).

²²⁵ H. F. Augstein, *James Cowles Prichard’s Anthropology: Remaking the Science of Man in Early Nineteenth Century Britain* (Amsterdam: Rodopi, 1999), 108.

²²⁶ George Stocking Jr., “From Chronology to Ethnology James Cowles Prichard and British Anthropology 1800-1850” in *Researches into the Physical History of Man* (1813), ed. George Stocking, 4th ed. (Chicago: University of Chicago Press, 1973), xlix; xcv; xcii; xciii.

²²⁷ Prichard, *History of Man*, 233.

enlightened thought, Prichard depicted Africans as a backward and uncivilized 'race.'

Prichard's arguments reflect the problems facing the monogenist camp in the first half of the nineteenth century. The monogenists agreed on only one point: that all men had come from a single pair. The extent to which environment, culture, and civilization shaped the human constitution and race remained widely debated. By the beginning of the nineteenth century, the climatic argument was losing its appeal, as scholars seriously questioned the claim that climate could turn a white man black or vice versa. The high mortality rates among Europeans settling or serving in tropical regions called into question the theory of acclimatization.²²⁸ Despite all these difficulties, Prichard and other monogenists had one advantage: the widespread belief in creationism meant that although many believed in the inferiority of Africans they did not doubt the story of creation and, by default, that Europeans and Africans were related.

The final early nineteenth-century commentator on race to be examined is the French comparative anatomist and monogenist, Baron Georges Leopold Chretien Frederic Dagobert Cuvier. Cuvier employed, and amended, the type-concept of race originally connected with Buffon, arguing that each species of animal possessed a defining, fixed type, from which all species descended. Sociologist Michael Banton has stated that Cuvier's influence, coupled with his employment of the type-concept (the idea that humanity is linked through a

²²⁸ Harrison, *Climates and Constitutions*, 129-132.

common and representative type), shifted the debate on the origins of man away from lineage, the idea that humanity was descended from an original pair, to the idea that mankind was associated through a type-concept.²²⁹ Cuvier placed emphasis on the physical body and in his *Animal Kingdom* attempted to understand and categorize the variety of humans and animals.²³⁰ Cuvier meshed an intense physical investigation with an evaluation of culture. He was both a scientist and one prone to pontificate on culture and society. Banton argued that it was not the eventual disintegration of the monogenist camp that allowed racism to slip into the centre of British thoughts and ideas of race, but Cuvier's insistence on the fixity of the human form coupled with a growing acceptance of the type-concept which served to separate Europeans from Africans.²³¹

Cuvier defended the fixity thesis, asserting that the present varieties of man could not be explained by environmental influences. He argued instead that there were "certain intrinsic causes which appear to arrest the progress of particular races, even though situated amidst the most favourable circumstances."²³² Environment alone could not explain why some races advanced while others did not. Instead, Cuvier argued that the physical varieties found throughout humanity were the result of periodic catastrophes which had resulted in the creation of new species.²³³ Cuvier divided humanity into three sub

²²⁹ Banton, *Racial Theories*, 27.

²³⁰ Baron Georges Cuvier, *The Animal Kingdom* (London: Henry G. Bohn, 1863). First published in London 1817.

²³¹ Banton, *Racial Theories*, 30.

²³² Cuvier, *Animal Kingdom*, 37.

²³³ Harrison, *Climates and Constitutions*, 15.

groups: Caucasian, Mongolian, and Ethiopian [African].²³⁴ The last great catastrophe, the Great Flood, had separated and isolated these three species and the relative lack of interbreeding explained the diversity of appearance, behaviour, and attitude.²³⁵ Although, according to Cuvier, all human were associated through a common-type, he argued that each group developed and would continue to develop at different rates.²³⁶

Cuvier's insistence on fixity and his emphasis on the difference between Africans and Europeans challenged the idea of African improvement. Cuvier argued that the disparity in intellect and culture between these three sub-groups stemmed from physical differences.²³⁷ This coupled with his emphasis on fixity suggested that the Africans could never overcome the hand dealt to them by nature and, thus, were naturally inferior.²³⁸ Cuvier argued that Africans were similar to animals in that they were driven by "the pleasure of the senses."²³⁹ On the other hand Cuvier praised Europeans stating that: "It is not for nothing that the Caucasian race has gained dominion over the world and made the most rapid progress in the sciences."²⁴⁰ Cuvier's suggestion that Africans were closer to animals did much to damage the monogenist case. Indeed, in his epic work *Animal Kingdom*, Cuvier remarked upon the physical similarity between Africans

²³⁴ Cuvier, *Animal Kingdom*, 37-38.

²³⁵ Harrison, *Climates and Constitutions*, 15; Banton, *Racial Theories*, 32-33.

²³⁶ Cuvier, *Animal Kingdom*, 41.

²³⁷ Cuvier, *Animal Kingdom*, 41.

²³⁸ Cuvier, *Animal Kingdom*, 37.

²³⁹ Banton, *Racial Theories*, 30.

²⁴⁰ Banton, *Racial Theories*, 30.

and apes,²⁴¹ a comparison so resented by some English readers that the editors felt compelled in future editions to stress that Cuvier's work did not deny that improvement could be achieved through proper education and civilization.²⁴²

By the 1840s, due in part to the theories of Cuvier, the increasing enthusiasm for phrenology, and the growing doubt over the validity of the climatic position, commentators on race in Britain increasingly argued for a fixed divide that separate Europeans from others. There is no doubt that a sense of racial difference was growing in the 1830s and 1840s. The failure of emancipation to produce immediate, uncontested success contributed to this growing impression of difference as blame for the lack of success and profit in the post emancipation period was placed squarely on former slaves.²⁴³ The monogenist camp had thus far failed to prove the functional role of climate or culture in uplifting Africans. Cuvier and Lawrence, unlike previous monogenists, seemed less sure of African ability to improve. By the 1840s, as a growing belief in difference pervaded British understanding of the world, the monogenist camp had no concrete explanation for the physical or the mental differences that increasingly were believed to divide Europeans from Africans. Difference was conceived in racial terms that separated and isolated 'the African' polity and body from European creation, type, and lineage.

²⁴¹ For instance, Cuvier stated that "the Negro race" is characterized by having "projecting muzzle[s] and thick lips [that] evidently approximate it to the apes." Cuvier, *Animal Kingdom*, 38.

²⁴² Drescher, *Evolution of European Scientific Racism*, 429; Curtin, *Image of Africa*, 235-36.

²⁴³ Drescher, *The Mighty Experiment*, 217-218.

In 1846 Robert Knox embarked upon a popular lecture tour entitled “The Races of Men.” These lectures, delivered in Manchester, Liverpool, and Newcastle upon Tyne, became the basis of his widely read 1850 work of the same name. Much of Knox’s knowledge of “the races of men” was based on the experiences he had while stationed at Cape of Good Hope, 1817-1820. During this time, Knox served as a regimental surgeon to the 72nd Highlanders during what became known as the fifth Xhosa War. In *The Races of Men*, published thirty years after he left Africa, Knox asserted that that the human race was comprised of distinct species, each with a specific aptitude for civilization. Knox left no room for improvement, because race was fixed and eternal. For Knox “race was everything;” he went so far as to explain the revolutions of 1848 as a form of racial conflict.²⁴⁴

Knox scorned the climatic school, stating that it was fanciful to believe that the climate could cause any material change in man. He argued, instead, that the races had differed from each other from the beginning of time and that these differences were fixed for eternity.²⁴⁵ Knox wrote: “He [the black man] is no more a white man than an ass is a horse or a zebra.”²⁴⁶ Knox accepted Buffon’s criteria for separate species (fertility of offspring) asserting that history proves that no hybrid race of man has ever been shown to exist: Races were fixed and could not be created by the efforts of men.²⁴⁷ He argued that there was a naturally

²⁴⁴ Knox, *Races of Men*, 7, 10, 14 and 90.

²⁴⁵ Knox, *Races of Men*, 123; Banton, *Racial Theories*, 56.

²⁴⁶ Knox, *The Races of Men*, 169.

²⁴⁷ Knox, *The Races of Men*, 12-13.

antipathy between races and thus, it was foolish to assume that the races were capable of co-operating with each other. In fact, nature ensured that there was to be no co-operation, for Knox argued that each race was made for a specific climate and this natural barrier was supposed to ensure that there would be no intermingling.²⁴⁸

By the 1850s the climatic camp was in complete disarray and unable to provide creditable evidence as to the reason for the human variation. This failure provided an opportunity for Knox's racist arguments to gain attention. His theory that each race was made for a particular climate made sense in the face of the number of deaths among Europeans travelling to, or residing within, tropical climates. Knox's theories may also have found support among those who feared racial degeneration, for he argued that each race was to remain separate and had been given their own part of the globe.²⁴⁹ Eveleen Richards has pointed out that Knox used his theories to criticize imperialism.²⁵⁰ Indeed, Knox despised slavery and his work exhibited a xenophobic tone that lent itself to an isolation policy free from colonialism. Nonetheless, despite the anti-imperialistic undertones of Knox's writings, Knox asserted that the races of men were separate and very different, and by doing so authored "the first fully-fledged exposition of a biologically founded racial theory."²⁵¹ As Nancy Stepan notes: "By the middle of

²⁴⁸ Knox, *The Races of Men*, 91-92.

²⁴⁹ Knox, *The Races of Men*, 91-92.

²⁵⁰ Clare Taylor, "Robert Knox" in *Oxford Dictionary of National Biography*; Eveleen Richards, "The 'Moral Anatomy' of Robert Knox: the Interplay between Biological and Social Thought in Victorian Scientific Thought," *Journal of History of Biology* 22 (1989): 379.

²⁵¹ Augstein, *Race: The Origins of an Idea*, xxx.

the nineteenth century, everyone was agreed, it seems, that in essential ways the white race was superior to non-white races.”²⁵²

Medicine and Race

Anatomy, zoology, biology, physiology, and ethnology were the branches of science that were directly tied to explorations on and the debates over race. Little intellectual room was left, or needed, at that time for the less theoretical and applied science of medicine. Although physicians, including Robert Knox, Thomas Winterbottom, and especially James Cowles Prichard, played important roles in the public debates on the meaning of race, discussions customarily centred not upon medical knowledge or assumptions, but upon Biblical sources and deductive reasoning. For example, Prichard, who had an important impact on the discussions of race, rarely applied his medical training or scientific studies either to formulate or reinforce his racial theories. Driven by the desire to prove that science and scripture were compatible and to defend the unity of mankind, Prichard relied upon deductive reasoning and all encompassing theories that neither needed, nor were rooted in, medical investigations.

Medical practitioners were involved in the debates, but few relied upon empirical medical investigations and inductive reasoning in formulating their arguments. Thus, medicine remained on the sideline of the debates. Philip Curtin was correct to state that this emphasis upon “the creation of a large-scale system

²⁵² Stepan, *The Idea of Race in Science*, 4.

tended to distract attention from the systematic study of [physical] man.”²⁵³ As we shall see, medicine’s main role was to elucidate the difference in mortality rates for Europeans and Africans residing in tropical regions, and to point to possible racial immunities to disease. In doing so, practitioners, like the noted naval surgeon, physician, and author James Lind (1716-1794), suggested, or implied, that there existed a real difference between the functions of African and European bodies. Despite the efforts of Winterbottom and Lawrence to focus upon ‘proven’ medical facts and a judicious comparison of the African and European bodies, most commentators were not interested in medical comparisons and when they did refer to a particular function of the body it was to reinforce their own, pre-established conclusions. Because of this approach, the potentially valuable medical knowledge of Winterbottom and others, carefully collected in Africa over years of study, remained outside, and not at the core, of Britons’ understanding of race and the African body.

An investigation of a large number of scientific and medical journals of the period suggests that most published British physicians were not interested, or at least rarely participated, in any racialized research or discussion in medicine.²⁵⁴ Even when discussing topics where an evaluation of race and health seems appropriate, British medical practitioners ignored race. Tropical diseases, for

²⁵³ Curtin, *The Image of Africa*, 37.

²⁵⁴ The journals examined were: *Edinburgh Medical Journal*, 1855/56-1860; *Edinburgh Philosophical Journal*, 1819-1826; *Edinburgh Journal of Science*, 1824-1832; *Edinburgh New Philosophical Journal*, 1855-1860; *The Lancet*, 1823-1850; *London Medical and Surgical Journal*, 1832-1835; *London Medical Gazette*, 1827/28-1849; *Medical-Chirurgical Review*, 1826-32; *Medical Times and Gazette*, 1842-1843 and 1852-1853; *British and Foreign Medico-Chirurgical Review*, 1848-1870; *British and Foreign Medical Review*, 1836-47.

instance, did not engender discussions of the racialized body. Surgeons were more interested in the causes of fever, especially whether it could be classed as a contagious disease, and how to both prevent and treat fever. In these accounts, non-European people were rarely mentioned and comparisons to non-Europeans were not made.²⁵⁵ In some instances, it was assumed that ‘tropical people’ had a natural defense against tropical climes and that they should be employed to carry out tasks considered especially injurious to European health.²⁵⁶ The comparisons ended there. The reason for the absence of race in discussions of tropical medicine is unknown but may be the result of a lack of direct observation of the ‘black body’ coupled with a narrow and intense focus upon European health.

James Lind provided early medical sanction to the idea that Africans and Europeans experienced disease in different ways.²⁵⁷ Although West Indian planters had long held this understanding, Lind in, *An Essay on Diseases Incidental to Europeans in Hot Climates* (1768) began with the premise that racial immunities existed and that Europeans would have to take extra care in their colonial ventures to avoid the fevers that inhibited their efforts in West Africa and the West Indies.²⁵⁸ This became common wisdom with numerous practitioners stating that Africans and Europeans experienced what would later be termed

²⁵⁵ William Balfour Baikie, “On Remittent Fever, especially as it appears on the West Coast of Africa; With some Remarks on the term, “Fever,” *Edinburgh Medical Journal* 2 (July 1856 to June 1857): 803-815; William Belcher, “Observations on the Tropical Fever, commonly termed the Yellow Fever of the West Indies, during the year 1823,” *Edinburgh Medical and Surgical Journal* 23 (1825): 246-257.

²⁵⁶ D. J. H. Dickson, “On the Causes of the Tropical Endemic, or Yellow-Fever,” *Edinburgh Medical and Surgical Journal* 3 (1817): 51.

²⁵⁷ Curtin, *The Image of Africa*, 84.

²⁵⁸ Lind, *Diseases Incidental to Europeans in Hot Climates*, 224-225.

“tropical diseases” in different ways.²⁵⁹ Lind suggested that European garrisons in West Africa be reduced and that most of the work in Africa be carried out by African agents and labourers. He stated that capable Africans “should be naturalized; should be entitled to rise to a certain rank in the government or army; and they should be entitled to the other privileges of British subjects.”²⁶⁰

Although Lind maintained that qualified Africans should be entitled to promotion and privilege; this was necessary solely because Africans were superior in their experience of ‘hot climate’ diseases. Lind believed that Europeans could take steps to reduce risk to health in the tropics, but they would always be more susceptible than indigenous populations.²⁶¹ His analysis was premised upon observed difference in mortality and morbidity, generalized as racial in origin.

Four of the most influential commentators, Robert Knox, William Lawrence, Charles White (1728-1813), and Thomas Winterbottom (1766-1859), were accomplished medical practitioners. It is worth reviewing their theories and paying particular attention now to their linking of racial theories with physiology. Charles White was an eminent surgeon, actively engaged in the debates over the question of a single or separate creations. He first served as an apprentice to his father Thomas White, surgeon and man-midwife, before studying in London

²⁵⁹ Robert Clarke, *Sierra Leone. A Description of the Manners and Customs of the Liberated Africans: With Observations upon the Natural History of the Colony and a Notice of the Native Tribes* (London: James Ridgway, 1846), 86; J. P. Schotte, *A Treatise on Synochus Atrabiliosa, A Contagious Fever which Raged in Senegal in the Year 1778* (London: J. Murray, 1782), 104-105; Marcus Allen, *The Gold Coast or, A Cruise in West African Waters* (London: Hodder and Stoughton, 1874), 136-137.

²⁶⁰ Lind, *Diseases Incidental to Europeans in Hot Climates*, 224-225; Curtin, *The Image of Africa*, 86.

²⁶¹ Lind, *Diseases Incidental to Europeans in Hot Climates*, 224-225.

under obstetrician William Hunter. White became fascinated with Pieter Camper's facial angle and the anatomical studies made by Samuel Thomas von Sommerring. A polygenist, White took his impetus from these two scholars and studied race through physiology. White revived the Great Chain of Being and hoped to show in, *An Account of the Regular Gradations in Man* (1799) a natural and subtle gradation from the lowest animals to Europeans. White rejected the climatic argument, asserting that neither environment nor culture had been proven to alter the constitution of man.²⁶² He defended the unalterable nature of the human form, pointing out that "Gypsies" regardless of whether living under "the burning sun of Africa" or in the "temperate climes of Europe" retained their "swarthy complexion."²⁶³ If culture regulated skin colour, White reasoned that the ancient Gauls and Britons, who lived in "a very savage state," would have been much darker and would not have had the same light skin as their descendants.²⁶⁴

White primarily focused his arguments on anatomical examinations which he believed proved a natural gradation. His main evidence were bones, he focused on the skull size of humans and animals. He gained access to these bones through his lifelong friend John Hunter, brother to William Hunter, and by observing and measuring the diverse populations that entered the port city of

²⁶² Charles White, "An Account of the Regular Gradation in Man," in *Concepts of Race in the Eighteenth Century*, ed. Robert Bernasconi, vol. 8 (Bristol: Thoemmes Press, 2001), 101.

²⁶³ White, *Gradation in Man*, 105.

²⁶⁴ White, *Gradation in Man*, 114.

Liverpool.²⁶⁵ White focused on a variety of different physical attributes from skull size, to teeth, hair, the shape of the chin, and the length and shape of various bones to facilitate his argument of separate and distinct species. His gradation placed Africans as the link between the rest of humanity and apes.

White used the skeletal remains to illustrate the “vast” physical differences between European and African bodies. The African was closely related to lower creations; he compared them to apes, monkeys, and dogs.²⁶⁶ Through this comparison White elevated the European “from the brute creation” and emphasized the existence of separate species of man.²⁶⁷ White, who admitted that “we know so little of the physiology of the brain,”²⁶⁸ placed emphasis on skull size arguing that the lower intelligence of Africans was linked to their smaller skulls.²⁶⁹ White’s mode of offering evidence followed a defined pattern. He would select an area of examination, for example, foot size and shape, explain how this area of the body differed in Europeans and Africans and then conclude by stating that the African shape closely resembled that of the ape or another lower form of being. For instance after discussing how African teeth, the angle of their lower jaw, their power of mastication, and how their nose and chin differed from Europeans, White asserted that: “In all these points it [the African] differed from the European, and approached the ape.”²⁷⁰ Although he did not deny

²⁶⁵ White, *Gradation in Man*, 54.

²⁶⁶ White, *Gradation in Man*, passim.

²⁶⁷ White, *Gradation in Man*, 134-135.

²⁶⁸ White, *Gradation in Man*, 64.

²⁶⁹ White, *Gradation in Man*, 63.

²⁷⁰ White, *Gradation in Man*, 43.

African humanity, White argued that they had less capacity for knowledge and civilization.²⁷¹

Thomas Winterbottom, a physician who arrived in Sierra Leone in 1792, as a surgeon to the Sierra Leone Company, published upon his return to Scotland *An Account of Native Africans* (1803), an important medical treatise that sets out to counter what he considered to be numerous misconceptions about Africans and their bodies.²⁷² Winterbottom, who graduated from Glasgow University the very year he traveled to Sierra Leone, emphasized similarity amongst humans and cautioned his audience not to dwell on difference. He believed that an unfounded sense of difference had developed because many commentators ignored the subtle gradations of colour that marked all humanity. Winterbottom argued that, when comparing the skin colour for inhabitants of different European nations “climate is considered as a sufficient cause for the variety of tints.”²⁷³ However, for Africans this “dissimilitude appears so great, that recourse is had to the unscriptural, and, I may add, unphilosophical idea, of different races of men having been originally created.”²⁷⁴ He further stated that “these two extremes [Europeans and Africans] of colour are approximated by such a variety of tints, and so exquisitely blended that we pass from one to the other by almost

²⁷¹ White, *Gradation in Man*, 63-64.

²⁷² Thomas Masterman Winterbottom, *An Account of the Native Africans in the Neighbourhood of Sierra Leone, to which is added an Account of the Present State of Medicine Among Them*, 2 vols. (London: John Hatchard, 1803).

²⁷³ Winterbottom, *An Account of Native Africans*, vol. 1, 182.

²⁷⁴ Winterbottom, *An Account of Native Africans*, vol. 1, 182.

imperceptible gradations.”²⁷⁵ Winterbottom had skillfully taken White’s argument of gradations out of its hierarchical context and used it to argue for a unified humanity. He directly questioned the emphasis upon skin colour as a means of separating species:

If, as an intelligent writer observes, the human race be divided into species merely from their colour, it must necessarily follow, that if negroes form a specific class because they are black, those of an olive and tawny complexion must form another class, because they are not white; and from the same cause, the Spaniards and Swedes would form two distinct species of men.²⁷⁶

Winterbottom believed that Jews were an ideal example of how skin colour was altered by climate:

The most striking example we have of the influence of climate is to be found among that persecuted race of people the Jews; dispersed over the chief parts of the civilized globe, but prevented by religious motives from mixing with the rest of mankind, they still retain their features, though they have assumed the complexion of every country they inhabit. Thus they are “fair in Britain and Germany, brown in France and in Turkey, swarthy in Portugal and in Spain, olive in Syria and in Chaldea, tawny or copper-coloured in Arabia and Egypt,” and nearly black in Abyssinia.²⁷⁷

Winterbottom attempted to normalize difference by expounding upon the routine variety of physical forms found within all cultural and ethnic groups. He warned his reader to keep this in mind and not to be fooled by previous depictions of Africans:

As a great variety of features occurs among these peoples [Africans] as is to be met with in the nations of Europe: the sloping contracted forehead, small eyes, depressed nose, thick lips, and projecting jaw,

²⁷⁵ Winterbottom, *An Account of Native Africans*, vol . 1, 182.

²⁷⁶ Winterbottom, *An Account of Native Africans*, vol . 1, 187.

²⁷⁷ Winterbottom, *An Account of Native Africans*, vol . 1, 187.

with which the African is usually caricatured, are by no means constant traits: on the contrary, almost every gradation of countenance may be met with, from the disgusting picture too commonly drawn of them, to the finest set of European features.²⁷⁸

Winterbottom impressed upon his readership that all of humanity were derived from a single pair and insisted that the variety within humanity was due to the environment and not separate species or creations.

Winterbottom challenged many of the “myths” which had been formulated, or transmitted by Charles White. Winterbottom so disliked White’s approach and arguments he added an Appendix to his *Account of Native Africans* devoted to dismissing White’s claims.²⁷⁹ Winterbottom admitted that he could offer little to counter White’s comments about African skeletal size, shape, etc. for he “had no opportunity of examining the skeleton of a negro.”²⁸⁰ Nonetheless, he warned that it would be foolish to assume that the few skeletons examined by White were representative of the whole.²⁸¹ Winterbottom emphasized that White’s limited study could not account for the significant physical diversities found within every nation. Furthermore, while White had never been to Africa, Winterbottom emphasized the valuable experience and first-hand knowledge he gained from his years of service. Winterbottom challenged from observed experiences all White’s substantial claims. For example, he questioned White’s assertion that Africans never sweat.²⁸² Winterbottom, stated that when an African

²⁷⁸ Winterbottom, *An Account of Native Africans*, vol . 1, 197-198.

²⁷⁹ Winterbottom, *An Account of Native Africans*, vol . 2, 254-274.

²⁸⁰ Winterbottom, *An Account of Native Africans*, vol . 2, 255.

²⁸¹ Winterbottom, *An Account of Native Africans*, vol . 2, 255.

²⁸² White, *Gradation in Man*, 58.

worked under a hot sun “rivulets of sweat” are produced.²⁸³ In a similar fashion he challenged the assertion that pregnancy was easier for African females,²⁸⁴ that African women menstruated in larger quantities than European women,²⁸⁵ that Africans, similar to animals, aged at an accelerated pace, and numerous other claims that sought to separate Africans from Europeans.²⁸⁶ Those with medical training could, and did, take radically different approaches to Africans, their physiology, and place within humanity.

Other writers applied the concept of a natural resistance to specific contagious diseases in order to amplify or suggest difference. For instance, J. P. Schotte, a French medical observer, built upon Lind’s investigations in order to explain the different responses of Africans and Europeans to hot climate diseases. He suggested that the reason Africans better avoided the health risks of the African environment because they “are constitutionally better adapted” which allowed them to expel “rank and noxious matter” which plague European bodies.²⁸⁷ Later, Marcus Allen, who served as a naval surgeon in West Africa during the third Anglo-Ashanti War (1873-74), reasoned that Africans “expelled” disease and healed much faster than Europeans because they have superior constitutions:

And not only is the native constitution so robust in resisting the forces that ordinarily engender illness, but it is endowed with the

²⁸³ Winterbottom, *An Account of Native Africans*, vol. 2, 255.

²⁸⁴ Winterbottom, *Account of Native Africans*, vol. 2, 271.

²⁸⁵ Winterbottom, *Account of Native Africans*, vol. 2, 255-259.

²⁸⁶ Winterbottom, *Account of Native Africans*, vol. 2, 263.

²⁸⁷ Schotte, *Synochus Atrabiliosa*, 104-105; Curtin, *The Image of Africa*, 85.

most extraordinary recuperative powers, and this enables it to make a remarkably rapid convalescence from injury and disease.²⁸⁸

Robert Clarke, a long serving assistant surgeon in Sierra Leone, asserted that:

“The Africans, like other dark races of man, indeed the whole of the coloured population, are not liable to the infection of remittent and yellow fevers.”²⁸⁹

Clarke further maintained that if the population of West Africa was solely comprised of Africans then “yellow fever would altogether disappear.”²⁹⁰ Most medical authorities believed that Africans could contract tropical diseases, but thought that they possessed a form of natural resistance which provided them significant protection.²⁹¹ The writings of almost all medical practitioners who chose to write on this subject differentiated the African body from the European one. This may have arisen out of, and encouraged, a racialized approach to medical practice. Curtin believed that medical investigations remained on the periphery of debates about race since “most authorities... simply took it for granted that in some way or other the African were differently constituted.”²⁹²

This does appear to be true, for most commentators did not see the need to include medical observation to bolster their arguments. Thus, there was no scholarly rush to examine the functions of the body. However, it is significant that some, trained in medicine, did take on aspects of this task. These discussions were important, for, as will be seen; at the heart of this debate lay the question of the adaptability

²⁸⁸ Allen, *A Cruise in West African Waters*, 136-137.

²⁸⁹ Robert Clarke, *Sierra Leone*, 86.

²⁹⁰ Robert Clarke, “Sketches of the Colony of Sierra Leone and Its Inhabitants,” *Transactions of the Ethnological Society of London* 2 (1863): 347.

²⁹¹ Curtin, *The Image of Africa*, 84.

²⁹² Curtin, *The Image of Africa*, 85.

or fixity of the human constitution, which was the crux of the racial debates of the day.

Despite the popularity of Lind, not all practitioners subscribed to the idea of complete or partial racial resistance to tropical diseases. For example, Dr. Morris Pritchett, one of the most vocal and well respected commentators on African health, denied that race had a role in resistance to disease. During his employment among the slaves of the West Indies, Pritchett observed that Africans had no special resistance to fever or other tropical diseases.²⁹³ During the 1841 Niger Expedition, Pritchett determined that employees of African descent who had been born outside, or were no longer domiciled in Africa, had none of the alleged racial resistance to tropical disease and that the fever, which eventual halted the expedition, had first started among these very members.²⁹⁴ For Pritchett, protection against the African climate was not a question of race, but one of acclimatization. This was an important distinction - one which arose directly from first-hand experience in West Africa. Acclimatization meant mutability and the potential for improvement.

The discussion over resistance to fever as with every other issue concerning race in the late eighteenth and early nineteenth centuries, escaped the confines of the medical community and was debated by churchmen, philosophers, and other interested parties. The opinions of Reverend Anthony Benezet are suggestive. Benezet theorized that God had given Africans, but not Europeans,

²⁹³ Pritchett, *Some Account of the African Remittent Fever*, 2.

²⁹⁴ Pritchett, *Some Account of the African Remittent Fever*, 4.

resistance to tropical fever so that Africans could live their lives without the interference of Europeans.²⁹⁵ This belief, which is strikingly similar to Knox's theory of natural spheres, formed the basis for his critique of the slave trade. He suggested that by neglecting to give Europeans resistance to the African environment that Africans were to be left alone and that any interference in African affairs, including the slave trade, was against God's will.²⁹⁶ Benezet's notion was adopted by some British humanitarians who, by accepting that racial resistance did exist, left themselves vulnerable to polygenist writers who used this to argue that Africans were so fundamentally different that they constitute a separate species of mankind.²⁹⁷ Despite the attraction of these arguments for explaining difference, surgeons in Africa (as will be seen in chapters 4 and 5) remained unsure about the question of resistance, and when it arose they tended to support the notion of acquired resistance. This made sense to practitioners for it explained why Europeans were most vulnerable in their first few years of residence in the tropics and why those such as Clarke, who served for upwards of eighteen years in Africa, appeared as able to handle the health challenges of the tropical environment as his African patients.

Conclusions

The African was largely conceptualized within Britain without medical knowledge between 1800 and 1850. This absence of a link between medicine and

²⁹⁵ Anthony Benezet, *Some Historical Account of Guinea* (London: J. Phillips, 1788), 3-4; Curtin, *The Image of Africa*, 84.

²⁹⁶ Benezet, *Account of Guinea*, 3-4.

²⁹⁷ Benezet, *Account of Guinea*, 3-4; Curtin, *The Image of Africa*, 84.

racial theories contrasts with the second half of the century when medicine emerges as the chief agent in constructing the overseas body. Although those with medical training, such as Knox and Prichard, were important contributors to the construction of Africans and racial ideas, they did not rely upon medical knowledge in creating their arguments but other sciences, deductive reasoning, and the scriptures. The construction of the Africans during this period was not complete for European commentators continued to debate the very essence of humanity. During the first half of the nineteenth century, no position held a monopoly in public discourse on any of the important topics involving race. This left Britons to select a theory of race that suited their religious or political outlook.

The absence of a single intellectual paradigm explains in part the variety of approaches and understanding of Africans provided by the British in West Africa. This variance governed medical practice in Africa. Despite the demise of the climatic thesis and the increasing creditability ascribed to fixity and difference, medical practitioners in Africa, as we will see, were relatively free to develop their own ideas about Africans and their bodies. British medicine had not as yet spoken authoritatively on the topic of race. The lack of a developed medical discourse on race and disease meant that individual practitioners had to decide whether skin colour should guide their individual practices of medicine. The significance here is that Africans, who were widely derided for their lack of a coherent experience-based medical system, were treated by practitioners who had little accurate medical knowledge concerning the African body and were not

guided by a single accepted medical theory capable of directing their therapeutics. In the absence of a racialized macro system of medicine such as that which was formed at mid-century, medical men who came into contact with Africans in the early nineteenth century made their own observations about Africans and disease.

Chapter Three

“Only Jesus Can Make Medicine for Me:” British Missionaries and their Perceptions of and Involvement with the Health of Africans, 1804-1850

In 1821, Henry During, missionary of the Church Missionary Society at Freetown, Sierra Leone, wrote on the state of health of a group of Africans liberated from slavers:

they were so injured by the treatment which they met with on board the slave vessels, that no care, or tenderness could recover them: they sunk into the grave in the midst of their countrymen, rescued too late from the hands of the barbarians, who must one day answer for their blood.²⁹⁸

Missionaries were drawn to these unfortunate sufferers, denouncing all those who participated in slave trading. In the 1820s, after years of labour in Africa, the pitiful condition of ex-slaves encouraged British missionaries, for the first time, to take real note of, and to become involved with, the health concerns of Africans. Not surprisingly, missionaries and their London-based leadership, which was already convinced that the slave trade contributed to African barbarism, were quick to connect this “nefarious” trade with the poor health of all Africans.²⁹⁹ Slavery was viewed as a sickness that was eating away and destroying the African body and soul. The essential cure was the introduction of Christianity to these troubled lands.³⁰⁰ By the 1820s those who were sent to proselytize amongst the liberated Africans, recaptured ex-slaves landed at Freetown, could not help but to

²⁹⁸ *Proceedings of CMS*, 1821-22, 64.

²⁹⁹ *Proceedings of CMS*, 1801, 14.

³⁰⁰ *Proceedings of CMS*, 1803, 202-203.

notice the state of the unfortunate victims, used the evidence of their poor health to rail against the slave trade, and despite their apprehensions, to take an interest in the physical - not just the spiritual - health of Africans. It was in Freetown that the CMS and the WMMS had found this purpose.

This chapter examines the British churches' direct interactions with, and perceptions of, the West African people and climate in the first half of the nineteenth century. The purpose is to explore how Britons understood and became involved (or not) with the concerns and problems of African health. Two British missionary societies were active and influential in sub-Saharan Africa during the half century: the Wesleyan Methodist Missionary Society (WMMS); and the Anglican Church Missionary Society (CMS). For the half century, 1800-1850, missionaries were uniquely positioned to observe and their reports provide abundant perceptions by members of one culture on members of another. Of particular value to this study is missionaries' involvement with schools, their presence in hospitals, and appearances at death beds. Interaction with a multitude of Africans, in different locales and circumstances, makes this an important area in exploring the medical and health-related encounters in West Africa. The argument presented below relies heavily on the proceedings of the annual CMS meetings. These records are the most detailed and revealing for this topic and, in particular, they provide numerous excerpts from missionary letters sent from Africa to the central CMS. The Wesleyan records are comprised of synod minutes, which include missionary correspondence and the records of the various

missionary outposts sent home to London. These sources are buttressed by Church bulletins and individual missionary narratives. The documentation suggests that for a variety of reasons, including the high mortality rate of European missionaries and the belief that Africans would be willing converts to Christianity, missionaries and their societies, during the first half of the nineteenth century, consistently neglected to exploit the advantages of western medicine as a means of spreading the gospel. This, however, is not to suggest that missionaries had no involvement in the health concerns of Africans. As will be demonstrated, despite a reluctance to involve themselves in the health of Africans, missionaries discovered that their activities as ministers and schoolmasters, as well as their daily interactions with converts and those to be converted, involved them in some important features of African health.

The Context for British Missions in West Africa

A growing tide of evangelicalism and the passionate sentiments of the campaign to end the slave trade helped sustain conversion efforts. The growth of evangelical convictions and anti-slavery in the late eighteenth-century can be attributed to theological and political changes within Britain and its Protestant Churches, along with a more general awareness of the world beyond the British Isles. These cultural drives advanced a new sense of Christian interconnectiveness and community and encouraged Britons to reconsider their

place within the world and especially Britain's involvement in the slave trade.³⁰¹

The theological impulses came mainly from evangelicals who believed that an outwardly acceptance of Christ's Love could 'awaken' members of the Church of England.³⁰² Methodists encouraged "many hundreds of men and women to leave their home shores and venture out into the furthest corners of the British Empire and beyond."³⁰³ This awakening was assisted by Britain's expanding colonial borders and an influx of geographical and ethnographical information that captured the imaginations of a variety of Britons who wished to explore, conquer, educate, and/or convert.³⁰⁴ In the final decade of the eighteenth century, evangelicals formulated plans to introduce Christianity into this growing non-European colonial expanse and it was this desire to spread Christianity that engendered the formation of new missionary societies, including the CMS, the non-denominational London Missionary Society, and the (Baptist) Society for the Propagation of the Gospel amongst the Heathen, and aided in the revival and reinvigoration of the already established WMMS.

Founded on 12 April 1799, the CMS dedicated itself to the social improvement of Britain, the abolition of the slave trade, and world evangelicalism. These three goals were in agreement with the outlook of its founding members, many of whom were participants within the influential

³⁰¹ Drescher, "The Long Goodbye," 44-69; David Eltis, "Europeans and the Rise and Fall of African Slavery," *American Historical Review* 98, no. 5 (December, 1993): 1399-1423.

³⁰² Nigel Scotland, *Evangelical Anglicans in a Revolutionary Age 1789-1901* (Great Britain: Pasternoster Press, 2004), 288.

³⁰³ Scotland, *Evangelical Anglicans*, 288.

³⁰⁴ Andrew Porter, *Religion versus Empire*, 41; Zoe Laidlaw, *Colonial Connections*, passim.

abolitionist group known as the Clapham sect. The CMS selected West Africa for its first overseas mission. By selecting this field, the Society steered clear of other missionary organizations such as the Baptists, who focused their missionary energies primarily in India, the London Missionary Society, which was preoccupied with the Pacific and the Cape Colony, and the Methodists, who were involved in British North America and the British West Indies.³⁰⁵ Initially, the CMS secured little support from Church leaders and its clergy. In fact, so cold was this reception that “no Bishops would join its General Committee or preach an anniversary sermon until Bishop John Ryder in 1814.”³⁰⁶ None of the ordained Anglican clergy volunteered to join the mission to Africa, forcing the CMS to rely on German Lutheran seminaries to produce the first missionaries. This reliance on German missionaries defined the early missions; up until the end of 1813 only three of the first fifteen missionaries accepted for work in Africa were English.³⁰⁷

In 1804, the CMS settled its first mission on the banks of the Rio Pongas, a river located approximately one hundred miles north of Sierra Leone. The Rio Pongas, which had long had been visited by Europeans, supported numerous European trading firms.³⁰⁸ The CMS hope to profit from the experiences of two small Scottish missionary societies based in Glasgow and Edinburgh, which in 1797 had combined to send out six missionaries to settle on the Rio Pongas amongst the Susu. The mission was a disaster. Three men had died, including

³⁰⁵ Andrew Porter, *Religion versus Empire*, 52.

³⁰⁶ Andrew Porter, *Religion versus Empire*, 53.

³⁰⁷ Andrew Porter, *Religion versus Empire*, 56.

³⁰⁸ Bruce L. Mouser, “Trade, Coasters, and Conflict in the Rio Pongas from 1790 to 1808,” *The Journal of African History* 14, no. 1 (1973): 46, 48.

Peter Grieg who was murdered by a Fulani raiding party; one turned slave-trader, only two returned home.³⁰⁹ Having suffered such considerable setbacks the mission was abandoned.³¹⁰ However, Henry Brunton of the Edinburgh Missionary Society learned the Susu language and, upon his return, published a series of catechisms in Susu. His efforts, especially his depiction of the Susu peoples as kind and willing to learn, inspired and assisted the CMS which selected the Susu as its first target for conversion.³¹¹ This first mission was a small enterprise, as the shortage of missionaries and the high incidences of death and disease severely restricted missionary efforts. As Eugene Stock, the Victorian chronicler of the CMS, commented:

The Susoo Mission was a very humble enterprise...It was little more than two or three schools, in which German missionaries, while still trying to pick up Susoo, were teaching English – also a language they understood very imperfectly – to a few African boys who were clothed and fed at the expense of the Mission.³¹²

Early missionaries struggled against the climate: cold and chilly support from the Church at home; hot and often hostile reception from both Africans and the African climate. Despite difficulties, the impulse to expand was strong and by 1812 the CMS had established a station among the Bulloms. The Bulloms were a second obvious choice, geographically close to the first mission and believed to share a similar culture, religion, and language with the Susu. Both these stations, due in part to a re-invigoration of the slave trade and in part from the

³⁰⁹ Fyfe, *Sierra Leone*, 75; Stock, *History of the Church Missionary Society*, 156.

³¹⁰ Stock, *History of the Church Missionary Society*, 156.

³¹¹ *Proceedings of the CMS*, 1803, 142-150; Stock, *History of the Church Missionary Society*, 157.

³¹² Stock, *History of the Church Missionary Society*, 157.

inconvenience of being located so far from Freetown, were abandoned in 1818.³¹³

Missionaries emphasized the role of the slave trade in causing this failure:

The suspension of the Susoo and Bullom parts of this Mission, principally in consequence of the late revival of the iniquitous Traffic... there is no hope of their renewal, with any prospect of extensive and permanent success, till that Trade shall receive its last blow...³¹⁴

Thereafter the CMS was to blame many setbacks in Africa on the slave trade.

The mission moved south to Sierra Leone, with Freetown as focal point. By the 1820s the CMS had cemented its operations in Freetown, while establishing stations dispersed through the colony. In the 1840s, it founded a mission among the Temne of northern Sierra Leone while the increasing attention afforded to Lagos paid dividends as two permanent stations in Badagry (1845) and Abeokuta (1846) were established.

The WMMS had first attempted to proselytize in West Africa in 1786. This effort, however, proved fruitless as poor planning and a hostile climate caused the mission to be soon abandoned.³¹⁵ Antislavery campaigns revived an interest in Africa and, at the instigation of Dr. Thomas Coke, the WMMS established a mission to Sierra Leone in 1811.³¹⁶ This was a logical choice, as prior to arrival in Sierra Leone many of the Nova Scotia settlers had already converted to Methodism, providing the Wesleyans with a system of support and a

³¹³ *Proceedings of CMS*, 1819-20, 68.

³¹⁴ *Proceedings of CMS*, 1819-1820, 68.

³¹⁵ For a description of early missionary efforts and interactions between European Christians and Africans see, Ogbu Kalu, *The History of Christianity in West Africa* (London: Longman, 1980).

³¹⁶ Thomas Coke, *An Interesting Narrative of a Mission, Sent to Sierra Leone, in Africa, by the Methodists, in 1811* (London: Paris & Son, 1812).

base for further operations.³¹⁷ Although the WMMS lost many of its early missionaries to the deadly disease environment, it did not share the CMS's difficulties in attracting missionaries for work in Africa. The only exception occurred in 1812 when it took two years to find a replacement for George Warren, who died after serving the mission for eight months.³¹⁸ Thereafter, no matter how unlikely it seemed that a WMMS missionary would be able to survive his term, finding recruits to serve in Africa was never difficult.³¹⁹ The fact that the WMMS limited foreign appointments to three years, and the CMS did not, may have affected recruitment.³²⁰ All of the first five CMS missionaries sent to Africa died there; the longest serving, Gustavus Nylander, fell victim to the disease environment after nineteen years.³²¹ On Nylander's advice, given in 1822, the CMS henceforth allowed missionaries in Africa to return home after the completion of a six-year term.³²² The WMMS shared the CMS's enthusiasm for expansion, and by 1821 had established a second station in the Gambia. In 1834 a third station was opened up in the Gold Coast. The WMMS had also placed missions in South Africa. Reverend John McKenny, the first Methodist missionary to arrive in South Africa, established a station at Namaqualand in 1814. In 1820, the WMMS expanded its focus to include the slave population in

³¹⁷ Clarke, *Sierra Leone*, 39. For an analysis of African religion in Sierra Leone see: Arthur Porter, "Religious Affiliation in Freetown, Sierra Leone," *Africa: Journal of the International African Institution* 23, no. 1 (Jan., 1953): 3-14.

³¹⁸ Moister, *A History of Wesleyan Missions*, 166.

³¹⁹ Moister, *A History of Wesleyan Missions*, 174.

³²⁰ Fyfe, *A History of Sierra Leone*, 181.

³²¹ Stock, *History of the Church Missionary Society*, 88.

³²² *Proceedings of CMS*, 1822-23, 74.

the Cape Colony. In 1822, the Methodists established a station in Bechuanaland and in 1841 accompanied British troops to Natal.

The Missions and the African Climate

The British public received from the leaderships and its missionaries different views concerning the risks of the African environment. The CMS preferred to depict the climate as healthy or at least constantly improving for Europeans. Their missionaries, however, highlighted the dangers of the African climate. For example, Sarah Hartwig, the well-respected wife of CMS missionary Peter Hartwig, stated:

It is probably right that I should return to this country [England], rather than fall a victim to the unwholesomeness of the [African] climate, as my constitution, I fear, is not better, but rather worse able to sustain repeated attacks of fever, than it once was.³²³

Hers was a frequent admission. Missionaries (and their families) accepted that service in Africa meant constantly enduring attacks of fever. Mrs. Hartwig was proved right: neither she nor her husband survived the year. Although there is an element of sacrifice running through many comments in Mrs. Hartwig's letters, the glory of sacrifice is better communicated by Leopold Butscher, who in 1816 drew attention to the issue of sacrifice when discussing the deaths of this missionary couple:

News like these, may rather seem discouraging to the well-wishers of Christ's cause: yet, did we but understand the gracious designs which our Divine Master has in view, we should probably call them "Good news..."³²⁴

³²³ *Proceedings of CMS*, 1815, 616.

³²⁴ *Proceedings of CMS*, 1816, 81.

During the early days of the mission, CMS missionaries often entered service with their wives whose voices were muted and their actions rarely captured in the documentation. However, their deaths and those of their children were used to highlight the sacrifice made by missionaries and their families:

This afflicting intelligence [the deaths of Mr. and Mrs. Hartwig] was soon followed by that of Mrs. Butscher. A few months after Mr. and Mrs. Schluzze with their infant child, and Mr. Sperrhacken with his infant, followed their friends into eternity.³²⁵

During the first decade of the mission, the CMS, which struggled to find suitable missionaries, tended to downplay the dangers of West Africa. The CMS often asserted that the West African climate was no more deadly than, say, the West Indies.³²⁶ However, after a decade of CMS presence in West Africa and in the face of so many deaths, this position became untenable and the leadership admitted the dangers of African service: “In truth, the Society’s Missionaries on this coast have long encountered, and are still called to encounter, difficulties from the climate.”³²⁷

Although the CMS acknowledged the deadliness of the West African disease environment, its leadership did not completely abandon the position that service in Africa could be safe. By the 1820s, the leadership articulated a new position which stated that although the African climate was injurious to the health of Europeans, if missionaries followed the advice of the leading medical

³²⁵ *Proceedings of CMS*, 1816, 80.

³²⁶ *Proceedings of CMS*, 1802, 152.

³²⁷ *Proceedings of CMS*, 1815, 548.

authorities, they could enjoy reasonable health in the field. One consequence of this position was that the CMS began to blame the death of missionaries on their own conduct. For example, in 1824, the CMS faulted John Pope for not heeding advice: rather than slowly adjusting to the climate, in an alleged over-abundance of enthusiasm he immediately went out to work. The lesson was clear:

New comers [in reference to John Pope], just arrived with full European strength think themselves competent to greater labour than the climate will allow; and, in consequence, expose themselves more than they should do on their first arrival.³²⁸

The missionaries themselves, however, did not attribute the high death rates to their own actions. When a missionary died it was God's will, not the product of poor planning or want of attention. As stated, missionaries highlighted the dangers of the climate to emphasize their dedication to Christ. This may be viewed as a public relations maneuver, utilized to acquire support for the missions. An unidentified "active and zealous supporter" of this missionary perspective argued in 1819 that:

I firmly believe that three-fourths of the zeal for Missions now evident among us was first excited by the state of Africa. Go and tell of the rains, of fevers, of graves, of deaths, of Missionaries dead, of Missionaries dying, of Missionaries fainting under the burden and the heat of the day, tell of the good already done, and that others are panting to enter into this very field – these things will produce even more beneficial effects... they will produce sufficient funds... not only for the African Mission, but of the whole.³²⁹

³²⁸ *Proceedings of CMS*, 1824-25, 45.

³²⁹ *Proceedings of CMS*, 1818-19, 70.

Missionaries, therefore, tended to believe it was their sacrifice that encouraged Britons to contribute to the cause. Despite missionaries playing up, or playing too, the deadliness of Africa, the CMS, continued to stress the relative safety of service in West Africa. In the same Committee Report as the quotation from this “active and zealous supporter,” the CMS issued this statement:

The Committee begs to state that much misapprehension prevails partly, from the exaggerations which have appeared; and partly from the fatal effects of a want of strict and watchful attention, on the part of new comers, to the requisite rules and cautions.³³⁰

The leadership could utilize multiple perspectives if these still advanced the mission. The missionary perspective on sacrifice was useful for raising funds, while the leadership’s emphasis on improving conditions helped to allay the fears of potential recruits.

The WMMS records are not as instructive on this topic. The WMMS, possible because it did not experience the same recruiting problems that hindered the CMS, spent less time commenting upon the disease environment or worrying about how to depict the African climate. The surviving WMMS records focus on the logistics of the mission, particularly the challenges associated with education. It is important to note that despite this interest in logistics, health was rarely mentioned and was treated as simply one of a number of challenges in proselytizing in Africa.

The foregoing description highlights a common thread in the debate between leadership at home and those on the ground in Africa. This dialogue

³³⁰ *Proceedings of CMS*, 1818-19, 71.

between the metropole and periphery defines much of our understanding of the pre-colonial and colonial worlds.³³¹ The perception of Africa and its climate was conceived of differently by those at home and individuals on the ground although multiple positions were allowed since each had a role in advancing the mission. The making of Africa, in the European mind, was a product of this dialogue which was an open discussion.³³² In the missionary case, the leadership of the CMS and WMMS controlled publication and most avenues of communication, and thus had the power to promote their vision of Africa, not that of the missionaries (but they likely allowed the publication of an alternative position when they found this useful). The public, Parliament, and, one could argue, even the leaderships themselves became inculcated with the idea that medicine, technology, and adherence to ‘proven’ methods would ensure the safety of Europeans in Africa so much so that Britons downplayed the realities of the African disease environment. This helps to explain why numerous different interest groups threw their support behind and financially backed perilous adventures, such as the Niger Expedition of 1841.

Missionary Understanding of Health and the African Body

Missionaries, like all European travelers to Equatorial Africa, placed great importance upon properly ‘acclimatizing’ themselves to the tropical climate.³³³ This included the necessity of contracting, and surviving, a seasoning fever (a

³³¹ Catherine Hall, *Civilizing Subjects: Colony and Metropole in the English Imagination, 1830-1867* (Chicago: Chicago University Press, 2002); Catherine Hall, *At Home with the Empire: Metropolitan Culture and the Imperial World* (Leiden: Cambridge University Press, 2006), 10.

³³² Philip Curtin, *Images of Africa*, vi.

³³³ For example: *Proceedings of CMS*, 1804, 341.

malarial fever).³³⁴ This fever, best acquired within the first few weeks of arrival, was believed to ‘season’ an individual to the climate by affording resistance to the deadly fevers of West Africa. So important was this seasoning fever that John Martin of the WMMS, who arrived in Africa in the mid-1840s, was relieved to report that upon arrival he had immediately contracted a seasoning fever.³³⁵ Despite a plethora of literature and advice from travelers and missionary societies on how best to adapt to the African climate, missionaries did not expect to be healthy. Thomas Dove, a Wesleyan missionary, explained that good health as understood by those living in England was not the same as good health in Africa:

When however, I say good health I do not mean that which mean good health in England but in regards to good health in West Africa we have sometimes attacks of the chills and fever after returning home from the Village, but we are not confined to the House perhaps more than a few hours.³³⁶

Most missionaries did their utmost to protect their health. A primary concern was to avoid getting wet for that could lead to a bout of the ‘chills.’³³⁷ These ‘chills’ were most likely the result of an attack of malaria. In fact, so eager were missionaries to avoid getting wet, that Leopold Butscher of the CMS hired a guide to carry him on his back when crossing a river.³³⁸ If efforts to remain dry failed, Butscher suggested that missionaries immediately light a fire “to draw the wet and damp” from both their body and their clothes as a means of protecting health.³³⁹

³³⁴ WMMS, box 259/260, no. 1146: John Martin, Cape Coast, 2 February 1844.

³³⁵ WMMS, box 259/260, no. 1146: John Martin, Cape Coast, 2 February 1844.

³³⁶ WMMS, box 280, no. 1869: Thomas Dove, Freetown, 30 January 1839.

³³⁷ *Proceedings of CMS*, 1806, 67.

³³⁸ *Proceedings of CMS*, 1810, vol. 3, 89.

³³⁹ *Proceedings of CMS*, 1812, 89.

Missionaries, like other travelers to Africa, theorized that certain locales were naturally more harmful to European health and that, if sick, they could recover their health by leaving these sickly places for a supposedly healthier locale.³⁴⁰ This could involve returning to England, or travel within Africa. For example, after suffering repeated attacks of fever while in Sierra Leone, CMS missionary Peter Hartwig went to the Rio Pongas to recover his health.³⁴¹ Hartwig's wife also suffered from continuous attacks of fever and had been advised to return to England to recover her health.³⁴² When Johann Gottfried Prasse fell victim to fever in 1809, his death was attributed by his companion Melchior Renner to the inability to get "the bark" to settle on his stomach.³⁴³ It is unclear whether Prasse had been employing cinchona, or Jesuit bark, as a prophylactic or as a remedy. If employed as a prophylactic, this application would have been decades ahead of the Royal Navy, which, in the 1840s, on the advice of Alexander Bryson and other naval authorities began employing the extract quinine as a prophylactic.³⁴⁴

The CMS theorized that the interior of Africa was much healthier than the coastal regions, for they believed it to be more elevated and less swampy.³⁴⁵ Such was the power of this belief that in 1804, with barely a foothold in Africa, the

³⁴⁰ For example, *Proceedings of CMS*, 1806, vol. II, 51.

³⁴¹ *Proceedings of CMS*, 1806, 51-52.

³⁴² *Proceedings of CMS*, 1806, 52.

³⁴³ *Proceedings of CMS*, 1809, 471.

³⁴⁴ Curtin, "The End of the "White Man's Grave?," 74; Alexander Bryson, *Report on the Climate and Principal Diseases of the African Station* (London, 1847), 218-219.

³⁴⁵ *Proceedings of CMS*, 1804, 341. The image of a healthy interior was a long held and enduring notion. Curtin, *Image of Africa*, 353.

CMS had already set its gaze towards the interior, arguing that this region was better suited for a mission than the coastal areas:

The interior is free, in proportion as it recedes from the coast, from the vices, machinations, and dangers consequent upon the slave trade; and is both more populous and as it appears, more healthy, from its greater elevation.³⁴⁶

The several advantages capably laid out in this report - including health - encouraged missionaries to dream of setting up stations in the interior. This aspiration was part of a wider plan to Christianize all Africa, but due to the fact that missionaries could barely gain a foothold on the coast and that in the first half of the nineteenth century the interior remained mostly ‘undiscovered’ by European travelers, proselytizing in the interior remained a dream. The Niger Expedition of 1841 was supposed to fulfill this dream by setting the groundwork for future proselytizing in the interior. CMS missionary, James Frederick Schon, who accompanied the 1841 Expedition, subsequently challenged the notion that the interior was healthier than the coast:

Having now advanced upward of three hundred miles into the interior in search of comparatively healthier stations than those along the coast, and being obliged to sum up my investigations in this single sentence “I have seen none.”³⁴⁷

Although Schon’s conclusions influenced how both Africa and European involvement in Africa was understood, the 1841 Niger Expedition’s greatest impact (as will be seen) was that its failure made a strong case for Africans playing a larger role in spreading Christianity.

³⁴⁶ *Proceedings of CMS*, 1804, 344.

³⁴⁷ Schon and Crowther, *Expedition up the Niger*, 183.

The CMS and the WMMS stressed that the soul took precedence over the health of Africans and European missionaries. “It will moreover be admitted,” wrote Thomas Biddulph, a leading evangelical in Bristol in 1804 “that the human soul is of more value than the body, and that the concerns of the former are of infinitely greater consequence than those of the latter.”³⁴⁸ This outlook meant that religious conversion was privileged over the temporal health concerns of Africans. Missionaries who traveled to Africa were constantly ill, worn down by the rains and fevers of Africa.³⁴⁹ The experiences of Reverend Dawson of the WMMS confirm the deadliness of the environment. Within only a few months, he noted, eight of the eleven people with whom he arrived in 1828 had died of fever, while the other three were so sick that they had to return home.³⁵⁰ Philip Curtin has calculated the mortality rate for the 89 CMS missionaries sent to West Africa between 1804 and 1825 to be 606.7 per thousand. The WMMS sent out 67 missionaries to West Africa during the years 1838-1850, of whom 25 died, resulting in a mortality of 373.1 per thousand.³⁵¹ Missionaries focused on their own health not that of Africans. This focus was evident in the letters of both Anglicans and Wesleyans. These letters frequently began with missionaries explaining the state of their own health and those of their brethren. Gustavus Nylander, for example, began a letter in 1823 by reporting that: “I have kept my health tolerably well, since I wrote to you last; but my constitution is so broken,

³⁴⁸ Stated by Thomas Biddulph, *Proceedings of CMS*, 1804, 289.

³⁴⁹ Stock, *History of the Church Missionary Society*, 160.

³⁵⁰ WMMS, box 293, no. 829: Reverend Dawson, Bathurst, 10 June 1828.

³⁵¹ Curtin, *Images of Africa*, 484; 486.

that a very little exertion obliges me to lie down to rest.”³⁵² None of these letters discussed African health. Although health was an important topic of discussion, this interest was restricted to the health concerns of the mission, not of converts or those to be proselytized.

Missionary correspondence is void of racial discussions concerning ‘the African body.’ Missionaries tended to take it at face value that Africans were better suited than Europeans for the African environment. Influenced by a shared sense of brotherhood, missionaries stressed the spiritual equality of all. This understanding of the African dominated missionary outlook in the first half of the century. According to Richard Price, the “evangelical notion of the equality of the human spirit” proved so strong that missionaries had to be taught to view potential converts “in other ways, such as through race and class.”³⁵³ This emphasis on equality left little room for race and racialized bodies.

Medical Missionaries

The CMS and its missionaries emphasized the respect and authority which Africans were said to give to European physicians. In a letter of 1804 written by the CMS’s leadership to its first missionaries, Melchior Renner and Peter Hartwig, the CMS explained that the respect and love afforded to Dr. Thomas Masterman Winterbottom, the long-serving physician to the colony of Sierra Leone, by Africans proved that: “Natives have the most profound reverence for

³⁵² *Proceedings of CMS*, 1822-23, 74. For more examples see, *Proceedings of CMS*, 1804, 449; *Proceedings of CMS*, 1805, 451.

³⁵³ Price, “One Big Thing,” 620-621. See also: Jane Samson, “Are You What You Believe? Some Thoughts on Ornamentalism and Religion,” *Journal of Colonialism and Colonial History* 3, no. 1 (Spring 2002), n.p.

those who practice [European] medicine.”³⁵⁴ Edward Bowdich, who embarked on a mission to the King of the Ashanti in 1817, had also come to this conclusion, asserting that assistant surgeon Henry Tedlie had “awed and conciliated the people by the importance of his cures, and thus contributed to the success of the enterprise.”³⁵⁵ Hugh Clapperton, a renowned traveler, stated that Africans were so drawn to, and interested in, European medicine that it is quite the error to give advice and medicine for nothing. If a European does so, they “would never have a moment’s peace for patients.”³⁵⁶ Given that the CMS and the WMMS believed that Africans respected Europeans who practiced medicine, why did the societies not enlist healing to help spread the gospel? Why, in an age when medical missionaries were sent to China and India, were medical missions not sent to Africa?

The traditional understanding is that medical missionaries were a product of the second half of the nineteenth century. Peter Williams and Rosemary Fitzgerald represent this approach, asserting that during the first half of the nineteenth century medical missionaries were of little interest to British Protestant missionary societies.³⁵⁷ Williams points out that by 1852 there were only thirteen

³⁵⁴ *Proceedings of CMS*, 1804, 344-345.

³⁵⁵ Edward Bowdich, *Mission from Cape Coast Castle to the Ashantee: With a Description of that Kingdom* (London: Murray, 1819), 370.

³⁵⁶ Hugh Clapperton, *Journal of a Second Expedition in the Interior of Africa from the Bight of Benin to Soccatoo* (London: Carey, Lea and Carey, 1829), 104.

³⁵⁷ Peter Williams, “Healing and Evangelicalism: The Place of Medicine in Later Victorian Protestant Missionary Thinking,” *The Church and Healing*, ed. W. J. Shields (Oxford: Basil Blackwell, 1982), 271-86; Rosemary Fitzgerald, “‘Clinical Christianity’: The Emergence of Medical Work as a Missionary Strategy in Colonial India, 1800-1914, in *Health, Medicine and Empire: Perspectives on Colonial India*, ed. Biswamoy Pati and Mark Harrison (London: Sagam, 2001), 88-136.

active missionaries in all the Protestant missionary fields that could be considered medical missionaries.³⁵⁸ For Williams it is these low numbers, combined with the fact that missionary societies were much more concerned with the health of Europeans than that of potential converts, that severely hindered the development of medical missionary in the first half of the century. This development belongs to the latter half of the century.³⁵⁹ Fitzgerald supports Williams' argument and points to the opinions of Reverend Henry Venn, clerical secretary of CMS, 1846-71, who in 1861 counseled a potential missionary against medical training, stating "it seldom answers any good purpose."³⁶⁰ Venn's remark reminds us that it was not until the later decades of the century that medicine, due to advances in "knowledge and practice," had increased its standing among the public.³⁶¹ Fitzgerald argued that it was the growing prestige of medicine coupled with the numerous failures in traditional missionary fields that prompted missionary societies in the final decades of the nineteenth century to support medical missionaries.³⁶²

Christoffer Grundmann challenged the traditional approach. In *Sent to Heal*, he argued that the development of modern medical missionaries originated in the early nineteenth century.³⁶³ Grundmann examined all missionary fields; however, despite the global dimensions of his study, he omitted mention of Africa

³⁵⁸ Williams, "Healing and Evangelicalism," 271.

³⁵⁹ Williams, "Healing and Evangelicalism," 271.

³⁶⁰ Fitzgerald, "Clinical Christianity," 94.

³⁶¹ Fitzgerald, "Clinical Christianity," 95.

³⁶² Fitzgerald, "Clinical Christianity," 95; 98.

³⁶³ Christoffer Grundmann, *Sent to Heal! Emergence and Development of Medical Missions* (New York: University Press of America, 2005).

for the first half of the nineteenth century. Instead, Grundmann primarily focused on Asia, where evidence of this phenomenon does exist for this early period.³⁶⁴ In the first half of the nineteenth century, China, India, and other parts of Asia were viewed as locations for British medical missionaries and Africa was not. The reasons are not entirely clear. Grundmann argued that the reason China received the most medical missionaries was a result of the treaties and agreements thrust upon China that forced the country to open its borders to foreign powers.³⁶⁵ This explanation is inadequate: Sierra Leone was a British colony and its borders were completely open to British missionaries. Access to the local population certainly played a role in why medical missionaries were concentrated in some areas and not in others. However, as an explanation for this phenomenon it falls well short.

Even by the end of the nineteenth century, Africa had received 82 Protestant medical missionaries compared to China and India which had received 239 and 201 respectively.³⁶⁶ It is difficult to know why even in the later half of the nineteenth century Africa became home to so few medical missionaries. A likely explanation for this phenomenon may lie in the fact that the African climate, particularly in the first half of the nineteenth century, proved far too deadly for missionaries to even entertain the idea that they could heal the African body, considering that they struggled so desperately to preserve their own lives. Missionary societies may have judged that in Africa medical missionaries would

³⁶⁴ Grundmann, *Sent to Heal*, 56-90.

³⁶⁵ Grundmann, *Sent to Heal*, 162.

³⁶⁶ Grundmann, *Sent to Heal*, 162.

be a wasted resource, just as likely to succumb to the deadly disease environment as a missionary with no medical training. The fact that the societies tended to depict Africans as open and ready for conversion may have also have worked against sending medical missionaries.³⁶⁷ They gave little thought, especially in the early years of their respective missions, to the idea that Africans might resist converting to Christianity. This perception meant that the medical focus was always on European health: If only the missionaries could be kept healthy, then they could bring Africans under the Grace of God. In China and India, an argument could be made for enlisting medicine because the well-organized dynasties and reluctant hostile populations seemingly made conversion an uphill struggle that required all the arts available.³⁶⁸

Missionary Experiences with African Health

In the early 1820s both the CMS and the WMMS turned to Sierra Leone and in particular the growing number of liberated Africans who were settled there. Liberated Africans offered the floundering CMS a second chance. After failing among the Susu and Bulloms the CMS turned to a disrupted people largely dependent on Europeans. Liberated Africans provided the opportunity for the WMMS and the CMS to engage and hopefully convert those who had experienced slavery. Missionaries recognized that they were now amongst the victims of slavery and they used the distressed state that liberated Africans arrived

³⁶⁷ J. S. Coleman, *Nigeria: Background to Nationalism* (Berkeley: University of California Press, 1960), 93.

³⁶⁸ Grundmann, *Sent to Heal*, 66.

in to attack the slave trade. Missionaries and their societies believed that a plethora of problems could be blamed on this trade.³⁶⁹ When liberated Africans showed little interest in missionaries or conversion, the fault was determined not to lie with Christianity (or the missionary) but was placed squarely on the horrors of the slave trade which “benumbed” these Africans and placed them beyond the reach of “rational feeling.”³⁷⁰ Blaming the slave trade for the lack of missionary success had a long tradition, for even during the early Susu and Bullom missions, frustrated missionaries asserted that it was this evil trade that had corrupted Africans who, under normal circumstances, would have been more receptive to their message.³⁷¹

To relay the horrors of this trade to those back home, missionaries often focused on the physical abuses experienced by enslaved women. William Johnson, a highly successful missionary who developed a strong Christian community between 1817 and 1823 among the liberated Africans settled in Regent’s Town, emphasized the suffering of women, and health consequences:

Among the number of victims received by us at Regent’s Town were two women, who, becoming pregnant by two white men, slave dealers, were sold by these men as soon as they discovered the situation of the women. These women suffered so much on board the slave vessel, that they were both delivered, soon after their arrival, of still-born mulatto children, and both women died.³⁷²

Johnson believed that none suffered as severely as females at the onset of puberty:

³⁶⁹ For example, *Proceedings of CMS*, 1819-20, 68; WMMS, box 266, no. 37 1842: Synod Minutes; Coke, *An Interesting Narrative of a Mission*, 35.

³⁷⁰ *Proceedings of CMS*, 1822-23, 226.

³⁷¹ *Proceedings of CMS*, 1820, 68.

³⁷² *Proceedings of CMS*, 1821-22, 64.

Girls from ten to twelve years of age, who die very fast: having arrived at that age when African females come to a state of maturity, that change, with the hardships which they have undergone, proves too much for them and they sink under the afflictions.³⁷³

This emphasis on the suffering and compromised health of young girls and women was seen to be a powerful tool in invoking public sympathy. Johnson explained to readers, in 1823, that there was no need to exaggerate the horrors of the slave trade and its terrible impact on its victims: “Were it not Christian principle which keeps me on the spot, I think I would rather be shut up in a dungeon than hear the sighs and dying groans of these unhappy victims.”³⁷⁴ After a decade of futile efforts to establish Christianity among the Susu and Bullom peoples, the slave trade brought missionaries in direct contact with sick and dying liberated Africans in Sierra Leone. By involving themselves in the affairs of these Africans, missionaries (for the first time) took real note of, and got involved with, the health of Africans.

An important health care role played by missionaries was to refer sick Africans to an European physician or hospital for diagnosis and care. In Sierra Leone, sick Africans were generally instructed to seek medical aid at Kissy Hospital, a colonial institution located on the east side of Freetown. In certain situations, missionaries requested that physicians travel to the site of the problem. This approach was most commonly used when contagious diseases had broken out amongst a large number of Africans, or when distance made the travel of the

³⁷³ *Proceedings of CMS*, 1822-23, 226.

³⁷⁴ *Proceedings of CMS*, 1822-23, 226.

physician more convenient than moving a group of sickly individuals.³⁷⁵ The colonial government fully expected missionaries to direct their charges to medical personnel. Missionaries who were believed to be negligent in forwarding Africans for care were reprimanded by officials, especially the governors, who were anxious to protect the health of the populace.³⁷⁶ Often missionaries were the first Europeans to assess African health complaints, and despite being inexperienced and untrained in medicine, this responsibility intimately involved missionaries in the health concerns and health care management of British West Africa in the first half of the nineteenth century.

Missionaries spent abundant resources converting African children. Missionaries determined that children were much more likely to adopt Christianity than adults, and that the key to their conversion lay in “proper” education.³⁷⁷ Missionary education in Africa faced many challenges. Three principal concerns were the lack of finances, the inability to attract qualified instructors, and the need, in certain locales, to win over both parents and African authorities.³⁷⁸ In most cases, local authorities supported mission schools; however, in some areas, like Kumasi, it took time to gain the trust and approval of the king.³⁷⁹ Some parents prohibited their children from attending these institutions out of a fear of Europeans or an unwillingness to lose the labour of

³⁷⁵ *Proceedings of CMS*, 1823, 225.

³⁷⁶ National Archives, CO 267/104: Alexander Findley to Robert William Hay, Sierra Leone, 6 October 1830.

³⁷⁷ Edward Berman, “Christian Missions in Africa,” in *African Reactions to Missionary Education*, ed. Edward Berman (New York: Teachers College Press, 1975), 7-8.

³⁷⁸ WMMS, box 297, no. 1, 1842-1845: Synod Minutes.

³⁷⁹ WMMS, box 266, no. 35 1842-1843: Synod Minutes.

their children. Traditional elites saw European education as threat to the social order and some tried to dissuade others of its value. Many parents perceived the value of a free education and enrolled their children in missionary schools.³⁸⁰ Schoolmasters were cognizant of the importance of image and placed a great emphasis on outwardly appearance. The WMMS recommended that children who attended their schools dressed well; the Society supplied clothing to any school children who did not meet its standards.³⁸¹ By assuming responsibility for school children, missionaries involved themselves in children's health.

Sickness impeded education and the conversion of young Africans. Missionaries were constantly sick and school children, particularly those who had experienced slavery, were prone to illness as well. A CMS survey of 31 December 1817 of the schools for the education of liberated African in Regent's Town, Sierra Leone, revealed 12.8% of the 226 children (104 females and 122 males) enrolled in the school were absent due to illness. Of the twenty-nine students too ill to attend class, twenty were girls.³⁸² One missionary, Henry During, frustrated by African illness, reported that these constant absences from school impeded students' progress and undermined missionaries' work. He stated: "The schools make progress in reading and arithmetic; but have, of late, much decreased in number, on account of the dysentery and other sickness among

³⁸⁰ National Archives, CO 267/203: Norman William MacDonald to Henry George Grey, 3rd Earl Grey, Sierra Leone, 25 July 1848.

³⁸¹ WMMS, box 266, no. 35, 1842-1843: Synod Minutes.

³⁸² *Proceedings of CMS*, 1818, 138.

the people.”³⁸³ African health became an important issue, for if children were too sick to attend the schools, how could the missionaries teach these children to walk with Christ?

Neither the CMS nor the WMMS stated what the exact duties of the missionaries were in regards to African health care, but it was a recognized assumption that the missionaries, often the only European adults in the school houses, were responsible for managing the health concerns of sick or injured school children. Missionaries were not provided with medical or teacher training. Inexperience left both missionaries and their children vulnerable and susceptible to mistakes. For example, one Mr. Davies, a missionary at the Bathurst station, Sierra Leone, was blamed for the death of seventy-nine African school children in 1830.³⁸⁴ According to Lieutenant Governor Alexander Findley, Davies, upon discovering a serious outbreak of disease, decided not to send these sick children to Kissy Hospital. He justified his inaction by alleging that the children could be healed in the village. His error proved deadly as the villages lacked the supplies and medical personnel capable of dealing with numerous sick children. Eventually, Davies recognized the error and ordered the sick children to Kissy Hospital. Unfortunately, the unidentified disease had reached such a severity that many of the children died on their way to the hospital or in the first or second day after their admission.³⁸⁵ This event was taken very seriously. Findley believed it

³⁸³ *Proceedings of CMS*, 1821-22, 90.

³⁸⁴ N.A., CO 267/104: Findley to Hay, Sierra Leone, 6 October 1830.

³⁸⁵ N.A., CO 267/104: Findley to Hay, Sierra Leone, 6 October 1830.

wise to correct Mr. Davies and inform him about his mistakes “so strikingly was this inattention that I had to point out this evil to Mr. Davies.”³⁸⁶ It is possible that Findley was right and the death of these seventy-nine children should be blamed on Davies’ inattention and poor decision making, but it is perhaps as likely that Davies, who had no medical training, was overwhelmed by the situation. He came to Africa to save souls, not to deal with African sickness. However, as will be discussed, the limited number of British medical practitioners meant that medical duties were thrust upon others. Missionaries had little direct interest in, and for the most part, did not want to involve themselves in the health of Africans but their role as ministers, school teachers, and the like forced them to confront African illness. They were not trained to deal with issues of health but could still be reprimanded for not properly dealing with the health complaints of Africans in their care.

Missionaries tended to place the Church’s needs above the physical well-being of themselves and Africans. For example, William Johnson was well aware of the dangers of the rainy season and yet insisted on holding Church service during periods of torrential downpour.³⁸⁷ This would not have been a concern had the Anglican Church in Sierra Leone had a roof. Each Church member participated in open-air services, in all weather. Missionaries recognized this risk to health and appealed to those back home to send umbrellas to protect parishioners during the service:

³⁸⁶ N.A., CO 267/104: Findley to Hay, Sierra Leone, 6 October 1830.

³⁸⁷ *Proceedings of CMS*, 1822-23, 227.

I could not help feeling for such as had infants in their arms, cold and wet. A few umbrellas for those who cannot afford to buy them, would be very acceptable, as sitting two hours in wet clothing generally gives them bad colds.³⁸⁸

Despite the danger for both preacher and parishioner, divine services took precedence over health concerns. Missionaries followed the directive from their governing body that “the human soul is of more value than the body, and that the concerns of the former are of infinitely greater consequence than those of the latter.”³⁸⁹ However, at least in this instance, valuing the soul meant providing care for the body.

Missionaries visited hospitalized Africans and administered burial rites to converts who had died. Most clergymen took seriously the latter duty and spent much of their time administering prayers to the ill and conducting funerals. However, just who was eligible for spiritual attention or the sacraments was contentious. One Reverend Morgan neglected to visit the sick and reserved Christian burials for Africans whose family and friends could prove that the deceased had been baptized.³⁹⁰ Morgan refused a Christian funeral for a young liberated African woman despite requests from friends and family who swore that she was a Christian. Gravediggers, not Morgan, delivered her last prayers.³⁹¹ His

³⁸⁸ *Proceedings of CMS*, 1822-23, 227.

³⁸⁹ *Proceedings of CMS*, 1804, 289.

³⁹⁰ National Archives, CO 267/139: Sir Neil Campbell to Baron Glenelg, Sierra Leone, 8 August 1836.

³⁹¹ N.A., CO 267/139: Campbell to Glenelg, Sierra Leone, 8 August 1836.

decision to reject Africans' testimony of the women's conversion (likely baptism) was unpopular with converts and missionaries alike.³⁹²

Visiting Africans on their death-bed was an essential part of a missionary's duties; pending deaths were ideal occasions for a missionary to confirm that individual was sincere about conversion. Missionaries never explained to audiences back home exactly what action confirmed a Christian death. Limited evidence suggests that missionaries anxiously hoped that these converts would appeal to God and not to greegrees and other charms for their protection. Missionaries affirmed the value of their sacrifices when they wrote home that converts had died as true Christians.³⁹³ Missionaries demonstrated little concern for the African bodies or health when preparing dying Africans for the afterlife. Missionaries enthusiastically recorded positive death-bed experiences, that is, ones that highlighted a converted African's devotion to God. One dying convert was reported to have said:

My sickness and pain of body is better for me than health. God has done me a great good, by sending me this long sickness. Which has made me think much upon Christ's trouble for us poor sinners.³⁹⁴

The above quotation illustrates the missionary approach to the distinction between the soul and body. Missionaries stressed that disease was a trial and that comfort could be taken in having died "a noble death" in the arms of the Lord.³⁹⁵ Another deathbed account echoes this sentiment: "My body, I know, is only dust; but my

³⁹² N.A., CO 267/139: Campbell to Glenelg, Sierra Leone, 8 August 1836.

³⁹³ *Proceedings of CMS*, 1839, 38.

³⁹⁴ *Proceedings of CMS*, 1839, 38.

³⁹⁵ Stock, *History of Church Missionary Society*, 181.

soul is precious and it is in the hands of my Father: medicine now can do me no good; man cannot help me: only God can help me, and in Him I trust.”³⁹⁶ CMS missionaries framed the passing of Africans who were secure in their faith as a “happy” occasion: “One of the Candidates for Baptism was lately called to her endless reward: her happy death cheered my spirit.”³⁹⁷ WMMS missionaries also depicted the final bodily tribulations of believers as a joyous experience: “I had the happiness of visiting her in her sickness.”³⁹⁸ Reports of “happy deaths” expressed a sincere faith that implied that African health was not an unworthy goal but secondary to saving souls.

A few, isolated, examples of missionaries attempting healing can be found in the records. William Johnson of the CMS reported administering treatments to Africans. In one case he administered spirit of nitre to a female servant who had been stung by a scorpion and had come to him in “violent pain.”³⁹⁹ By rubbing this solution into the wound, Johnson numbed the girl’s arm, reporting that the pain then abated.⁴⁰⁰ Healing the African was not a priority of the leadership so it is understandable that few instances of missionaries administering to the health concerns of sick or injured Africans can be found in the records. This suggests that missionaries did not believe it was their responsibility, felt unable, or were simply more comfortable referring sick Africans to hospital care. Missionaries’ main role in healing was to refer sick Africans to the proper medical authorities

³⁹⁶ *Proceedings of CMS*, 1839, 37.

³⁹⁷ *Proceedings of CMS*, 1834, 33.

³⁹⁸ WMMS, box 266, no. 40, 1842: Synod Minutes.

³⁹⁹ *Proceedings of CMS*, 1822-23, 224.

⁴⁰⁰ *Proceedings of CMS*, 1822-23, 224.

and to follow up these cases by visiting the sick and, if an African convert died, to officiate at the burial service.

Missionaries through improper conduct could find themselves intimately involved in the health of Africans. One notorious example involved George William Emmanuel Metzger, a CMS missionary accused of having “a criminal [sexual] connection with a female who had been a servant with him.”⁴⁰¹ In addition to the allegation of sexual misconduct, Metzger was accused of having “furnished the husband of the said female with medicine to do away with the effects of that connection.”⁴⁰² Although the veracity of these events was never proven, according to Lieutenant Governor Findley, most in Wellington, the village where the events had taken place, believed the story.⁴⁰³ It is interesting that so few references to missionaries in West Africa administering medicine exist for the first half of the nineteenth century, and in this case, if it is true, the medicine was not for the good of a patient but to protect the reputation of the missionary and his mistress.

What the foregoing episodes establish is the tangential ways in which missionaries became involved in the health of Africans. The examples also highlight missionaries’ lack of experience with issues of health and show that at times missionaries were given health responsibilities well beyond their training and abilities. Not surprisingly Africans at times suffered because of this

⁴⁰¹ *Church Missionary Society Archive*, Section IV Part 1 (Reel 16), Alexander Findley to Reverend Haensel.

⁴⁰² *CMS Archive*, (Reel 16) Findley to Haensel.

⁴⁰³ *CMS Archive*, (Reel 16) Findley to Haensel.

inexperience. Missionaries expressed concerns about the health of Africans, particularly liberated Africans, but the priority lay elsewhere. They saw their mission as a spiritual one, and as such the body was of much less importance. This explains why missionaries held Church services in the open during torrential downpours despite their belief that the rains caused illness and death. Their approach to health was even-handed: neither their health nor that of the Africans was considered as important as the mission itself.

Missionaries did believe that acceptance of Western medicine was a mark of an African who was willing to participate more fully in western culture. Reverend Christian Friedrich Schlenker of the CMS related how he administered medicine to a sick school boy who later told his mother “your medicine is of no use to me: only Jesus can make medicine for me.”⁴⁰⁴ Missionaries did not consider those who continued to resort to African healing practices as being true Christians.⁴⁰⁵ The convert had to openly accept European cultural norms; medicine was but one of these norms. As well, Africans who placed their fate in Christ and prayed for health instead of resorting to ‘heathenistic’ practices confirmed the sincerity of their conversion.⁴⁰⁶ Despite the pleased reporting of “happy deaths,” missionaries were aware that at times of sickness converts had difficulty staying true to Christ, because “the infliction is ascribed by their superstitious friends to the anger of their idols for their desertion of their former

⁴⁰⁴ Christian Friedrich Schlenker, *Church Missionary Gleaner* 5, no. 9 (September 1843): 114-115.

⁴⁰⁵ *Church Missionary Record* 5 (1834): 123.

⁴⁰⁶ *Proceedings of CMS*, 1824-25, 53.

belief.”⁴⁰⁷ Reverend Schon lamented that too frequently African converts who faced death or a debilitating illness had employed healing charms called greegrees.⁴⁰⁸ Inexplicably, even communicants, whose faith in Christ was thought by missionaries to be unshakable, had been known to resort to this form of healing.⁴⁰⁹ Missionaries had little patience for this backsliding, and provided accounts that highlighted their triumphal destruction of these African charms. For instance, when an unnamed WMMS missionary saw a young African school boy wearing a greegree he snatched the necklace and smashed it.⁴¹⁰ In another case, Reverend Graf told of a Christian visitor who was so disgusted by an African’s attachment to his greegrees that he “marched” into his house “grabbed” all of his charms and threw them into a brook. The visitor then informed the sick African that his charms would not heal him.⁴¹¹ These dramatic scenes were often recorded in detail and sent home for the leadership’s enjoyment and approval. Missionaries, at least in the surviving documentation, did not destroy greegrees and then provide health care advice but merely prevented the ‘heathenistic’ practice from being repeated. These interactions were primarily sites of religious contestation, not opportunities to draw the lapsed, or potential, convert to Christ through European medicine.

⁴⁰⁷ *Church Missionary Gleaner* 2, no. 8 (August 1847): 87.

⁴⁰⁸ *Church Missionary Record* 5 (1834): 123.

⁴⁰⁹ *Church Missionary Record* 5 (1834): 123.

⁴¹⁰ WMMS, box 293, no. 829: R. Hawkings, Bathurst, 18 September 1825.

⁴¹¹ John Ulrich Graf, *Church Missionary Record* 17, no. 1 (June 1846): 35.

The Niger Expedition and African Advancement

Since the time of Pliny, Europeans had speculated that the Niger River was the best means of reaching the African interior.⁴¹² Commercial interests and missionaries alike eagerly backed plans that sought to ascend the river. Although private attempts were undertaken, most famously in 1832 by Macgregor Laird, by the late 1830s plans for a government-funded expedition were discussed. In 1841, the British government provided the funds for the famous Niger Expedition. The stated purposes of the expedition were to promote British trade, to encourage the spread of civilization, and to fulfill the dream of bringing Christianity into the heart of Africa. The expedition was a complete failure. Disease, especially fever, caused a mortality rate of 265 per thousand among the crew. The high mortality combined with widespread morbidity encouraged the survivors to turn back prematurely, having achieved none of their goals.⁴¹³ The fiasco of the Niger Expedition forced many who supported the expansion of commerce or saving of souls to concede that Africa was such a deadly environment for Europeans in order to achieve any of their goals they required the active participation of Africans. The CMS conceded that Africa was too injurious to European health to expect European missionaries to effect change without the aid of Africans:

It has long been felt by the Committee, that the climate of West Africa presented an insuperable barrier to the extensive propagation of the Gospel in that country by European Agency.

⁴¹² For an analysis of European and Arab constructs of the Niger River in classical times see: Law, R.C.C., "The Garamantes and Trans-Saharan Enterprise in Classical Times," *The Journal of African History* 8, no. 2 (1967): 181–200.

⁴¹³ British Parliamentary Papers, *Papers relative to Expedition to River Niger*, 1843 [472], 54; Temperley, *White Dreams, Black Africa*, 114–116.

The truth has been painfully illustrated by the results of the Niger Expedition.⁴¹⁴

Hopes for Christianizing Africa now centred upon native agency.⁴¹⁵ Samuel Abraham Walker, a contemporary chronicler of the mission in Sierra Leone, believed that the Niger Expedition definitely settled the issue of European involvement and confirmed the work of Divine Providence:

One fact was now established that, whatever work of spiritual or moral improvement was henceforth to be attempted in the interior of Africa, it could not be by European agency. Most probably the circumstances of the Niger Expedition were providentially intended to set this point to rest.⁴¹⁶

Missionaries now supported African participation and attempted to dispel the assertion that Africans would fail to be impressed by, and would ignore, missionaries with Black skin:

I had frequent opportunities to observe, that the chief objection raised - that the natives would pay no attention to [what] their own country-people might tell them - is without foundation. They listened to those who were with us very attentively; and often asked them to remain with them, and to teach them better things.⁴¹⁷

The WMMS and the CMS downplayed the catastrophic influence of the Niger Expedition on European proselytizing by focusing attention on the likely successes that native action would produce. The CMS spoke proudly of how well trained its African workers had become, writing proudly of Samuel Crowther, a

⁴¹⁴ *Proceedings of CMS*, 1843, 40.

⁴¹⁵ Many Britons interchanged the terms 'Native' and 'African.' Native was commonly used when discussing agency.

⁴¹⁶ Samuel Abraham Walker, *The Church of England Mission in Sierra Leone; Including an Introductory Account of that Colony, and a Comprehensive Sketch of the Niger Expedition in the year 1841* (London: Seeley, Burnside and Seeley, 1847), 495.

⁴¹⁷ Schon, as quoted in Walker, *The Church Mission*, 496.

liberated Africa from Yoruba country who had converted as a boy and had completed his missionary education in England.⁴¹⁸ The CMS asked Crowther to give services in both English and his native tongue and was anxious to send Crowther as a missionary to his birthplace.⁴¹⁹ The Niger Expedition's demonstration of the disease environment had opened one door for greater African inclusion. The premise had to be: Africans – even without recourse to Western medicine – enjoyed superior health outcomes relative to Europeans.

Within this new emphasis upon native participation many Africans remained in subordinated positions. Frustrated and annoyed by their lack of advancement, these communicants could also use the deadliness of the African climate as a justification for more authority and freedom. Samuel Crowther, who became Bishop of Sierra Leone in 1864, was a long-time advocate of African agency. His journal, which recounts his involvement in, and observations of, the 1841 Niger Expedition, is unique, for while every other surviving account of this expedition was primarily concerned with European health, Crowther was far more concerned with using the disaster to promote native missionary agency.⁴²⁰ For Crowther, the high European mortality which characterized the Niger Expedition confirmed the necessity of an African ministry. He asserted that only those able to survive the climate would be able to carry out the mass conversion of Africans.⁴²¹ Charles Knight, an African missionary working in Sierra Leone,

⁴¹⁸ *Proceedings of CMS*, 1844, 28.

⁴¹⁹ *Proceedings of CMS*, 1844, 28.

⁴²⁰ Schon and Crowther, *Expedition up the Niger*, *passim*.

⁴²¹ Schon and Crowther, *Expedition up the Niger*, 349-350.

complained, in 1847, that the WMMS had yet to ordain him and argued that this impeded his work. His plea to the WMMS to advance his work by allowing him to travel to England to receive ordination is instructive:

Our climate as you know is not congenial to European constitutions and often I am unexpectedly called upon to take charge of a circuit where the Holy Sacraments must be regularly administered and ministerial duties performed which in my humble opinion renders ordination proper and necessary.⁴²²

Knight and Crowther were in agreement. For the mission to achieve its goals, Africans required the authority, status, education, and respect to operate independently. Crowther and Knight are examples of Africans who realized that during the 1840s, missionary societies were having new doubts about what Europeans could achieve in such a deadly climate, and used this as leverage to improve their own professional positions. Africans too could use 'the climate,' just as missionaries and the governing bodies had, as a way of defending a particular outlook or course of action.

T.J. Bowen: The First Medical Missionary?

The first missionary who demonstrated sustained interest in West African health and healing was T. J. Bowen. Bowen, an American and member of the Southern Baptist Convention who arrived at Liberia in 1849, represented a new form of missionary, one keen to prove that white missionaries could endure the African climate and that Africans were a healthy and productive people. He had no formal medical training. Prior to his religious awakening he had been a soldier

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WMMS, box 281, no. 1899: Charles Knight, Sierra Leone, May 1847.

in Florida and Texas. In the wake of the Niger Expedition the CMS and the WMMS had pledged themselves to encouraging African participation in the missions, but they did little to rehabilitate, in the short-term, the public's perception of Africa and African bodies. After decades of highlighting the terrible dislocation and health conditions of liberated Africans, it would have been easy for the British public to have confused liberated Africans with other Africans and to have assumed that all were sickly. Bowen was of a different mind. Africans, he maintained, were strong and healthy. In his work, *Adventure and Missionary Labours in Several Countries in the Interior of Africa from 1849-1856*, Bowen described the medical conditions of Western Africa (called the interior) while attempting to establish a mission amongst the Fulani.⁴²³ This proved a challenging field as the Fulani were devout Muslims who had recently experienced a wave of militant Islamic reform movements which crystallized their faith and made conversion unlikely.⁴²⁴ Due to the civil wars raging in what is now Nigeria, Bowen had difficulty reaching the Fulani. Therefore many of his observations were made from Abeokuta, one of many towns founded by those who fled the wars and slave raiding afflicting Yorubaland after the disintegration of the Oyo Empire.⁴²⁵ On his travels from the coast of West Africa, Bowen described at length both the health of Africans and their healing methods. His publication describes in detail hundreds of different native cures and documents

⁴²³ T.J. Bowen, *Adventures and Missionary Labours in Several Countries in the Interior of Africa from 1849-1856* (London: Sheldon and Blakeman, 1857).

⁴²⁴ Iysle Meyer, "T. J. Bowen and Central Africa: A Nineteenth-Century Missionary Delusion," *The International Journal of African Historical Studies* 15, no. 2 (1982): 250.

⁴²⁵ Meyer, "T. J. Bowen and Central Africa," 252.

every-day medical interactions that he either witnessed or in which he was a participant. In his account, Bowen demonstrated Africans' interest in medicine and was careful to depict them as perfect and willing patients.

Bowen reported that Africans were inherently healthy and reintroduced the adage that if missionaries would adhere to the directives devised by knowledgeable European medical authorities they too could brave the climate.⁴²⁶ He qualified this statement by pointing out that while the African environment may be rather innocuous to Africans, Europeans should only stay in this environment for a maximum of four to five years.⁴²⁷ Bowen argued that although Africans did experience illness none amounted to large-scale epidemics with great loss of life: "The country is visited by no choleras, plagues, or other epidemics."⁴²⁸ Such a position was wholly untrue and contradicted by numerous European medical authorities and by Bowen's own account, which noted the prevalence of smallpox among African populations.⁴²⁹ On the whole, Bowen judged local cures to be beneficial. He conceded that in some cases, such as the propensity to use a gunpowder mixture for asthma, it is unlikely that the cure accomplished any good.⁴³⁰ Bowen was not impressed by African explanations of disease, complaining that too often they blamed intestinal worms for their sundry

⁴²⁶ Bowen, *Adventures and Missionary Labours*, 234.

⁴²⁷ Bowen, *Adventures and Missionary Labours*, 234.

⁴²⁸ Bowen, *Adventures and Missionary Labours*, 232.

⁴²⁹ Daniell, *Native Diseases of the Gulf of Guinea*, 49; Bowen, *Adventures and Missionary Labours*, 233.

⁴³⁰ Bowen, *Adventures and Missionary Labours*, 232.

health complaints.⁴³¹ Bowen believed that the greatest health benefit employed by Africans was their frequent bathing, which he stated was at the heart of their good health.⁴³² He asserted that he had learned many African treatment methods, including a cure for gonorrhea which he believed was quite beneficial.⁴³³ Bowen observed an African cure for dysentery which consisted of the patient taking an infusion of roots and herbs while abstaining from meat and all hot foods.⁴³⁴ In some cases, such as smallpox, he recorded that African healers believed it is best not to attempt a cure and to let the disease run its course.⁴³⁵

Bowen involved himself in African health concerns and frequently administered medicine and advice to ill Africans. He depicted Africans as near perfect patients, willing to endure treatment without much complaint.⁴³⁶ By taking an interest in, and in many ways defending African health and health care, Bowen had done what the CMS and WMMS neglected to do. He reinvigorated an old understanding of Africa, one in which Africans were healthy and missionaries could work in the interior. Certainly Bowen was not alone in proving that Europeans could travel in the interior. His position was aided most handsomely by David Livingstone, the famous British missionary turned explorer, whose travels between 1852-56 and 1858-1864 and publications highlighted to an enthusiastic public the possibilities, benefits, hardships, and effects of traveling

⁴³¹ Bowen, *Adventures and Missionary Labours*, 233.

⁴³² Bowen, *Adventures and Missionary Labours*, 241-242.

⁴³³ Bowen, *Adventures and Missionary Labours*, 233.

⁴³⁴ Bowen, *Adventures and Missionary Labours*, 232.

⁴³⁵ Bowen, *Adventures and Missionary Labours*, 233.

⁴³⁶ Bowen, *Adventures and Missionary Labours*, 233.

through the interior. Although Bowen cannot be considered the first medical missionary in Africa, for he lacked any formal medical training, he contributed to the development of medical missionaries by demonstrating the value of paying attention to, and later, exploiting health and healing as a means of conversion. Africa finally became a site for medical missionaries in the last third of the century.⁴³⁷

Conclusions

There is no evidence to suggest that the CMS and the WMMS had different approaches to African health in the first half of the nineteenth century. Neither organization exhibited sustained interest in the general health concerns of the majority of West Africans. Missionaries became directly involved in the health and/or healing of West Africans in specific contexts: schoolchildren; converts as patients in hospitals; liberated Africans. These were not roles at the centre of the mission, and at times missionaries' inexperience and lack of medical training may have contributed to unintentional negligence. At the sick bed, missionaries focused on the soul not the body. The few examples of missionary treatments, in particular their use of cinchona as a cure for fever, demonstrates awareness of contemporary medication. They were not completely without medical knowledge. Missionary documentation tells us less about what missionaries thought about African health, and more about the ways in which missionaries employed the health challenges of the West African environment to

⁴³⁷ Grundmann, *Sent to Heal*, 167-168.

justify a particular vision or understanding of Africa. Thus, missionaries' perception of the African climate and even African health was not only based on observed conditions, but occur in the documentation sporadically, as a tool to promote the mission in Britain, to champion causes connected with the end of the slave trade, and to explain underachievement in the conversion of West Africa.

Chapter Four

British Health Care and West African Patients and Therapeutics

This chapter explores the relationship between British medical practitioners and African patients and healers within the colonies of British West Africa. It examines British attempts to develop and operate a European hospital-based system of medicine in West Africa, 1800-1860. The British encountered numerous difficulties in establishing 'European' medicine in Africa causing the medical system to fall well short of British expectations. British medicine was characterized by compromise. Practitioners frequently stated that while liberated Africans often avoided treatment, native Africans were willing patients who solicited care. The reasons for this difference will be explored. British medical practitioners in print focused upon the diseases that they judged to most threaten the future of Africa, instead of those most commonly attended to in the colonies. Practitioners' understanding of and interaction with African practitioners and their therapeutics is an important topic. At least some British medical practitioners were interested in learning from African practitioners, and in using this new knowledge to supplement and expand their therapeutics. The interaction between British medical practitioners and West Africans provides insights into the themes of race, health, and empire in an important and understudied period.

The Medical Marketplace of Sierra Leone

In the early nineteenth century Sierra Leone was a diverse society.

Numerous ethnic groups including Britons, Nova Scotian black loyalists, liberated Africans (from a multitude of ethnic and linguistic groups), European traders of various ethnic backgrounds, Maroons from Jamaica, 'black poor' largely from London and indigenous Africans all lived in the colony. A variety of languages and traditions co-existed. This multiplicity can be seen in the medical marketplace. The medical marketplace was vibrant hosting a variety of traditions. Indigenous traditions ran strong and operated alongside a Western-based system centered on the hospital at Kissy. This milieu offered a multitude of overlapping and competing traditions. Despite the limited documentation, it is clear that the diversity that marked the colony in respected to language, politics, and society also shaped the medical marketplace.

The medical marketplace provided a variety of different practitioners and therapeutic approaches. While the primary responsibility of British medical practitioners was to their respective government employer, they were allowed to operate in private for fee-paying patients. Travel, especially to the villages, was also an important part of their work and thus European methods of treatment were not restricted solely to the capital. There were both male and female African practitioners operating in British West Africa. European commentators for the

most part, held female healers in higher regard than their male counterparts.⁴³⁸

While British medical practitioners criticized African healers (both male and female) for their lack of a scientific approach and/or the religious aspects of practice, they agreed that African healers were well versed in local herbal remedies.⁴³⁹ The medical marketplace was also divided along religious lines. Muslim patients reportedly sought out Muslim healers,⁴⁴⁰ and Daniell stated that in geographical areas where Islam predominated the practice of medicine was limited to Muslim healers.⁴⁴¹ Likewise, Christian converts were expected to adopt Western medicine and seek out European care.⁴⁴² Most Africans were accustomed to seeking out various practitioners from multiple healing traditions.⁴⁴³ Throughout the period 1800 to 1860, the medical marketplace in British West Africa offered a wide variety of traditions and approaches to healing.

Some aspects of the diversity of the medical marketplace can be gleaned from European officials who sought out African healers. One example is William Whitaker Shreeve, a member of the Mixed Courts of Commission in Sierra Leone, who, after little success with European methods, sought African care for his rheumatism. Shreeve, who had lived in the colony for six years, selected a healer whom he referred to as the “Doctress Yimba.” Her reputation was sufficient for him to travel to Matacong, a small island located near the present

⁴³⁸ William Whitaker Shreeve, *Sierra Leone: The Principal Colony on the Western Coast of Africa* (London: Simmonds and Co, 1847), 76.

⁴³⁹ Collier and MacCarthy, *West African Sketches*, 19.

⁴⁴⁰ Shreeve, *Sierra Leone*, 76.

⁴⁴¹ Daniell, *Native Diseases of the Gulf of Guinea*, 71.

⁴⁴² *Church Missionary Record*, vol. 5 (1834), 123. See above, Ch. 3.

⁴⁴³ Jacobson-Widding and Westerlund, “General Introduction,” 11.

northern border of Sierra Leone, to ask for treatment. Having accepted Shreeve as a patient, her treatment regime included massages, repeated baths, poultices composed of medicinal leaves taken from the “bush,” and a decoction of wood.⁴⁴⁴ Shreeve was pleased with the treatment he received, paid the “Doctress” what he estimates to be the equivalent of forty shilling worth of cloth and, after three months of treatment, returned to the colony, having judged himself healed.⁴⁴⁵ We know from this example that medical systems, in Sierra Leone, were, at times, overlapping and in competition with each other for patients. British medical practitioners believed that the multitude of options available to Africans delayed their seeking out of European care and thus had a negative effect on the health of the colony.⁴⁴⁶ We may presume that many of the African groups present in Sierra Leone possessed a more positive view.

The creolization of medical practices is an important topic of historical interest. The cultural melding that occurred in nineteenth-century Sierra Leone is a well documented historical process with the advent of the Krio language, derived from the mixing of the various languages, as one of this period’s lasting legacies.⁴⁴⁷ However, direct evidence of medical adaptation in British West Africa, 1800-1860 is difficult to find. It is clear that some African healers learned European techniques for smallpox vaccination and that some British medical

⁴⁴⁴ Shreeve, *Sierra Leone*, 77.

⁴⁴⁵ Shreeve, *Sierra Leone*, 77.

⁴⁴⁶ Clarke, *Sierra Leone*, 84. See below, pp. 174-176.

⁴⁴⁷ Abdul K. Bangura, “The Krio Language: Diglossic and Political Realities,” in *New Perspectives on the Sierra Leone Krio*, ed. Mac Dixon-Fyle and Gibril Cole (New York: Peter Lang, 2006), 151-166.

practitioners adopted local substitutes for European medicinal compounds and African approaches for treating fever into their therapeutics.⁴⁴⁸ It could be said that British practitioners, by adopting this approach, were engaging, to some extent, in the cultural melding that defined Sierra Leone society at the time. Nonetheless, British medical practitioners saw themselves also in competition with African practitioners and it may be that this competition delayed or inhibited cultural sharing and melding. Also, the limited opportunities for such exchanges may too have inhibited cultural diffusion. The process of liberation brought various African groups, including healers, together. It is unknown whether this process accelerated cultural dissemination and adaptation among African healers. Although very patchy evidence suggests that some ‘medical creolization’ may have occurred, this remains suggestive rather than concrete. The evidence for a competitive marketplace is more pervasive.

The British Medical System

Crown-managed health care in British West Africa up to the mid-century was largely restricted to: Freetown, Sierra Leone; Cape Coast Castle, Gold Coast; and Bathurst, the Gambia. Medical departments were too small and British control too weak to extend care any further. The primary purpose of care was to keep the colonial infrastructure functioning and to produce healthy workers. The medical system in British West Africa depended upon the mandatory examination of liberated Africans. Examinations occurred largely in three contexts: on board

⁴⁴⁸ For instance, Daniell, *Native Diseases of the Gulf of Guinea*, 120 and 128-129; Gordon, “Some Observations on Medicine and Surgery,” 532. See below, pp. 204-207.

captured slave vessels before their captains had been tried before the courts, in the King/Queen's Yard (a temporary housing depot for liberated Africans), and in the scattered villages, established for re-settlement in Sierra Leone. These mandatory examinations were carried out to assess the health of the new populations, to discover signs of epidemic disease, and to send patients with chronic or life threatening illnesses to the hospital for further treatment.

Medical departments were the local bodies directly responsible for health. Each department was led by a colonial surgeon who had upwards of four assistant surgeons under his charge. The medical departments in the Gold Coast and the Gambia were usually staffed by a colonial and a single assistant surgeon. Although pay varied throughout the period of investigation, by 1828 a colonial surgeon could command a salary upwards of five hundred pounds and an assistant surgeon three hundred pounds a year.⁴⁴⁹ The main responsibility of these surgeons was to tend to the small European population, Africans who were in the service of the government, and liberated Africans. They also administered care to distressed seaman, injured or sick soldiers, residents of the colonies, and native Africans who solicited care. Less is known about the practice of medicine in the Gambia and Gold Coast for neither produced the volume of correspondence and records created in Sierra Leone.

In Sierra Leone, the medical department was to be staffed by five British medical practitioners. The colonial surgeon resided in Freetown. In addition to

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N.A., CO 267/94: Samuel Smart to Sir George Murray, Sierra Leone, 5 September 1828.

heading the medical department, he was also responsible for the health of Freetown, filing medical returns, and other financial and health related reports. Under the command of the colonial surgeon were assistant surgeons who were given a range of responsibilities in different locales within the colony. One assistant surgeon, posted to the Court of Mixed Commission in Sierra Leone, was responsible for attending to Africans awaiting their liberation. A second assistant surgeon was in charge of Kissy Hospital, the main hospital for the treatment of liberated Africans. The third assistant surgeon toured the villages, areas designated for the settlement of liberated Africans, to attend to the health concerns therein. This surgeon sent patients deemed to require further care to Kissy Hospital. Little effort was made to extend crown-managed medicine to the neighbouring African polities, with the exception of periodic vaccination programs inspired by in-land exploration. At times, the Liberated African Department employed its own physician, who attended to the health of liberated Africans in the King's/Queen's yard.⁴⁵⁰

The medical department also employed an apothecary and hired native Africans to serve as dressers.⁴⁵¹ The apothecary's main responsibilities were to keep an appropriate store of medicines, to prepare medical compounds, and to

⁴⁵⁰ For a detailed description of the state and organization of the British medicine in Sierra Leone see: National Archive, CO 267/233 fo.136: Robert Clarke to Henry Pelham-Clinton, Duke of Newcastle, Sierra Leone, 8 July 1853.

⁴⁵¹ The following is a summary based upon, National Archives, CO 87/6: Dr. Tebbs to George Rendall, Bathurst, 15 December 1832; National Archives, CO 87/1 fo.10: Alexander Findley to Robert William Hay; Bathurst, 30 April 1828; National Archives, CO 267/103: Report Submitted by Andrew Foulis Surgeon to the Liberated African Department, Sierra Leone, March 1830; National Archives, CO 267/209 fo.93: William Aitken to Henry George Grey, Earl Grey, Sierra Leone, 24 October 1849; National Archives, CO 267/209 fo.93: Report submitted by B.C.C. Pine, Sierra Leone, 12 November 1848.

protect these medicines from the climate. The apothecary was rarely mentioned in the colonial correspondence. Dressers were hired to attend to a variety of health complaints both at Kissy Hospital and in the villages. It is unknown who hired dressers but it seems likely they were given their positions by the colonial surgeon. Dressers employed at Kissy Hospital worked under the direction of the colonial and assistant surgeons while those employed in the villages were under the charge of the visiting surgeon and the village manager. Dressers attended to a host of minor and non life-threatening ailments and, as their name suggest, often dressed wounds, ulcers, and other complaints. Those employed in the villages had the additional responsibility of sending serious cases to Kissy Hospital.

Little is known about who provided palliative care to patients in West Africa. Neither British correspondence nor the extant hospital records mention who bathed and provided food to liberated Africans entering the system and hospital patients. Nor is it known for certain who was responsible for cleaning accommodations and hospital wards. The existing documentation does not mention nurses but it seems likely that nurses were hired to aid in the hospital, and that female nurses attended to the needs of female patients. In his 1860 discussion of the Gold Coast, Robert Clarke stated that “strictly speaking” there were no trained nurses and though the medical department hired elderly African women to act in this capacity, Clarke warned there was no guarantee that they

would do their duties.⁴⁵² Whether this was true for Sierra Leone and the Gambia is unknown. It is possible that dressers were expected to bath and feed patients. Someone undertook these responsibilities and it may be that recovering patients or family members were responsible, or became responsible, for administering palliative care and keeping wards clean. An expense sheet for Kissy Hospital listed six ward keepers for 1852. These keepers presumably managed palliative care, arranged for the cleaning of the wards, and may have also been responsible for feeding patients.⁴⁵³ Also, a return showing how various liberated Africans were disposed of from 15 January to 16 April 1830 reveals that of the sixty-four men liberated from the slaver *Noa Sendia*, nine were hired or placed as hospital labourers.⁴⁵⁴ None of the liberated African women or children in this instance were employed in the hospital. The picture that emerges is one in which the colonial administration, through a variety of methods, attempted to manage palliative care by using low cost labourers such as liberated Africans. To this extent, palliative care could be considered a Crown responsibility, although the system may have allowed for, or at times required, patients' own initiative. The lack of discussion on the care of convalescence patients in the limited existing records may suggest that palliative care was dealt with in such a proficient, or at least competent, manner that it was not noteworthy.

⁴⁵² Robert Clarke, "Remarks on the Topography and Diseases of the Gold Coast," in *Transactions of the Epidemiological Society of London* 1, no. 1 (1860).

⁴⁵³ N.A., CO 267/229 fo.133: Return of Cases of Diseases treated in Colonial Hospital at Kissy 1852.

⁴⁵⁴ N.A., CO 267/102: Return of the Disposal of the Africans received into the charge of the Liberated African Department, 1830.

Medical departments in British West Africa laboured under a series of difficulties which inhibited the construction of a system of medicine capable of meeting all of its objectives, including convincing Africans to accept European medicine and practice. The most serious and persistent problem facing the medical departments in the three colonies of Sierra Leone, Gold Coast, and the Gambia was the constant shortage of physicians. The surviving records indicate that due to high morbidity and mortality rates, rarely were medical departments fully staffed. The number of European practitioners in government service in British West Africa was very small. It is not clear whether the allotted practitioners would have been capable of properly attending to all their assigned duties even if all were in place and healthy.

Due to the expense and difficulty in recruiting medical practitioners for service in Africa and the high levels of mortality and morbidity, the medical establishment rarely operated as intended.⁴⁵⁵ For example, it was not unusual for the colonial surgeon of Sierra Leone to be forced to assume the responsibilities of the assistant colonial surgeon posted to the Court of Mixed Commission in Freetown.⁴⁵⁶ This meant that liberated Africans, suffering ill-health from enslavement, were often not given the care that was intended and required. Likewise, an assistant surgeon responsible for the villages was often in practice considered an unaffordable luxury. More often than not, the responsibilities of

⁴⁵⁵ N.A., CO 267/233 fo.136: Clarke to Newcastle, Sierra Leone, 8 July 1853; R. L. Cheverton, "A History of Community Medicine in West Africa" (unpublished manuscript held at Rhodes House Library, Oxford, 1979), 133.

⁴⁵⁶ N.A., CO 267/233 F 136: Clarke to Newcastle, Sierra Leone, 8 July 1853.

this work fell to the assistant surgeon posted to Kissy Hospital who, in addition to his hospital duties, was expected to tour the villages. In 1848, acting governor B.C.C. Pine stated that he would have liked to have sent a practitioner to permanently tend to the villages but feared that it would leave the medical system in Sierra Leone short. The solution was to have the assistant surgeons take turns attending to the villages.⁴⁵⁷ Available resources, particularly the labour of the practitioners themselves, were overstretched. The responsibilities that devolved on assistant surgeon Robert Clarke in 1853 are illustrative. When hired in 1837, Clarke's chief responsibility was to tend to Kissy Hospital which could contain upwards of eight hundred patients.⁴⁵⁸ For over four years Clarke managed this responsibility alone. In 1840, a second assistant surgeon was deemed to be a necessity but the candidate died after only a few weeks of service. A replacement was not hired until December 1841. He too quickly succumbed to disease.⁴⁵⁹ By 1853, Clarke, in addition to his hospital duties, was expected to aid in coroner's inquests that required him to travel upwards of twenty-five miles.⁴⁶⁰ Clarke was expected to prepare the medical returns for the hospital and to supervise and correct the accounts of the hospital accountant. He also traveled to several villages once a month to inspect the health of liberated African children. Finally, whenever the colonial surgeon fell ill, Clarke, in addition to his own

⁴⁵⁷ National Archives, CO 267/209 fo.76: B.C.C. Pine to Henry George Grey, Earl Grey, Sierra Leone, 2 September 1848.

⁴⁵⁸ N.A., CO 267/233 fo.136: Clarke to Newcastle, Sierra Leone, 8 July 1853.

⁴⁵⁹ N.A., CO 267/233 fo.136: Clarke to Newcastle, Sierra Leone, 8 July 1853.

⁴⁶⁰ N.A., CO 267/233 fo.136: Clarke to Newcastle, Sierra Leone, 8 July 1853.

responsibilities, performed his duties as well.⁴⁶¹ No individual, regardless of abilities or level of commitment, could properly attend to all these tasks. Not surprisingly, the excessive responsibilities had a marked effect not only upon the quality of health care provided but also on the practitioners themselves. Clarke received leave in 1847 after an attempt at suicide and in 1853, Clarke, although only forty years of age, was reported to be worn out, having the health of a much older man.⁴⁶²

The dearth of practitioners put the medical system under pressure. Although healthy practitioners were expected to cover for ill or expired colleagues, the extent of responsibility meant that it was not always possible to cover all the required duties. For instance, in 1849 the assistant surgeon responsible for Kissy Hospital, one Mr. Deane, fell ill and a Dr. Guthrie was then charged with attending to the Hospital. Because of his other duties, Guthrie could manage only one visit a day. Patients who arrived after this time had to wait until the next day to be examined.⁴⁶³ At times, in all of Sierra Leone, only a single British medical practitioner was in place and well enough to attend to patients. Not surprisingly, shortages overwhelmed practitioners and the medical system as a whole. In 1847 Clarke, the only surgeon fit for work, notified the governor that he could not handle all the duties that devolved upon him and most importantly

⁴⁶¹ N.A., CO 267/233 fo.136: Clarke to Newcastle, Sierra Leone, 8 July 1853.

⁴⁶² National Archives, CO 267/199 fo.154: Norman William MacDonald to Henry George Grey, Earl Grey, Sierra Leone, 8 October 1847.

⁴⁶³ National Archives, CO 267/209 fo.93: William Aitken to Andrew Nicol, Sierra Leone, 11 March 1849.

that he did not have the time to attend Kissy Hospital every day.⁴⁶⁴ Anna Crozier in her study of colonial medicine in East Africa from the late nineteenth century to 1939 has also drawn attention to the shortage of European physicians in Africa.⁴⁶⁵ In 1837, Richard Doherty, the governor of Sierra Leone, stated bluntly to the Colonial Office: “The medical means are not adequate to the exigencies of the population.”⁴⁶⁶ Medical responsibilities were much larger than the British ability to provide for the population.

Keeping areas of treatment clean proved to be a great difficulty. Kissy Hospital serviced upwards of eight hundred patients a day. The bulk of patients were liberated Africans who often arrived in a very reduced state.⁴⁶⁷ Although cognizant of the importance of sanitation, medical officers allocated the limited personnel available to medical care, not to maintenance and cleanliness. At Kent, a village for liberated Africans, the sick room had become so filthy that on his tour of the village in 1836, lieutenant governor Sir Neil Campbell stated: “I was extremely shocked at the filthy state of the room in which the sick boys were living the smell being so offensive that we could not enter it.”⁴⁶⁸ The “filthy state” of treatment rooms may have deterred some Africans from submitting to

⁴⁶⁴ N.A., CO 267/199 fo.154: MacDonald to Grey, Sierra Leone, 15 August 1847.

⁴⁶⁵ Anna Crozier, *Practising Colonial Medicine: The Colonial Medical Service in British East Africa* (London: I. B. Tauris, 2007), 87-88.

⁴⁶⁶ National Archives, CO 267/141: Richard Doherty to Charles Grant, Baron Glenelg, Sierra Leone, 20 July 1837.

⁴⁶⁷ N.A., CO 267/233 fo.136: Clarke to Newcastle, Sierra Leone, 8 July 1853.

⁴⁶⁸ National Archives, CO 267/139: Sir Neil Campbell to Charles Grant, Baron Glenelg, Sierra Leone, 8 August 1836.

care and did little to advance the image of the superiority of European hospital-based care. Clarke explained the difficulty in keeping Kissy Hospital clean:

When large numbers of the sick were suffering from dysentery, the condition of the wards and yards in the morning was extremely loathsome. This was, in a great degree, unavoidable, as the sick were too weak to crawl from their mats to the commode, although everything was done under the surgeon's orders to endeavour to keep the wards as clean and wholesome as the crowded state of the hospital would admit.⁴⁶⁹

The problem with maintaining and keeping treatment areas clean shared the same root causes as most other problems within the medical service: a lack of manpower and a rudimentary organization.

It was impossible to predict how many Africans would be freed from slavers each year. This meant that colonial administrators had the unenviable task of managing a fluctuating number of patients, recruits for the Army, and workers in the villages. As William Fergusson, who served as a colonial surgeon and later governor of Sierra Leone pointed out in 1845: "It's very difficult to set up a medical system when because of the processes of the slave trade suppression it is impossible to really know how many slaves would be liberated and when."⁴⁷⁰ For example, in 1844, the government planned for approximately five hundred liberated Africans, and by year's end a total of 3610 had entered the system.⁴⁷¹

⁴⁶⁹ Robert Clarke, "Short Notes of the Prevailing Diseases in the Colony of Sierra Leone, with a Return of the Sick Africans sent to the Hospital in eleven years, and Classified Medical Returns for the Years 1853-4. Also Tables showing the Number of Lunatics Admitted to Hospitals in a Period of thirteen years and the number treated from 1st April 1842 to 31st March 1853," *Journal of Statistical Society of London* 18, no. 1 (March 1856): 66.

⁴⁷⁰ National Archives, CO 267/189 fo.72: William Fergusson to Edward George Geoffrey Smith-Stanley, Earl of Derby, Sierra Leone, 18 September 1845.

⁴⁷¹ N.A., CO 267/189 fo.72: Fergusson to Stanley, Sierra Leone, 18 September 1845.

This forced the medical department to exceed its yearly budget by over 787 pounds.⁴⁷² Liberated Africans could enter British care at inconvenient or dangerous times, such as during an epidemic or when the medical department was incapacitated by death or disease. Those liberated in 1837 and 1839, for example, arrived in a colony struggling to contain a smallpox epidemic which ravaged the liberated African population.⁴⁷³ At times, several slavers were brought to Sierra Leone concurrently, which meant the immediate injection of hundreds of patients into an already stretched medical system. The system often could cope only at a rudimentary level.

Winterbottom and other practitioners emphasized the importance of learning local substitutes for common European cures.⁴⁷⁴ The problems associated with acquiring smallpox vaccine are illustrative of the difficulty in procuring medicine. Vaccinating liberated Africans was considered an essential medical duty and much effort went into trying to vaccinate this vulnerable population. Commenting upon the threat posed by smallpox, colonial surgeon James Boyle stated that:

There is no part of the world in which this very destructive malady has committed such dreadful ravages, *time immemorial*, as in Africa; and, as might be supposed, amongst the [liberated] slaves, when it does break out, the most dire consequences ensue.⁴⁷⁵

⁴⁷² N.A., CO 267/189 fo.72: Fergusson to Stanley, Sierra Leone, 18 September 1845.

⁴⁷³ Clarke, *Sierra Leone*, 85

⁴⁷⁴ Thomas Winterbottom, as quoted in G. R. Collier and Charles MacCarthy, *West African Sketches: Compiled from the Reports of Sir G. R. Collier, Sir Charles MacCarthy and Other Official Sources* (London: Seeley and Son, 1824), 19; Daniell, *Native Disease of the Gulf of Guinea*, 128-29.

⁴⁷⁵ James Boyle, *A Practical Medico-Historical Account of the Western Coast of Africa* (London: 1831), 400.

Despite a commitment to vaccination, authorities struggled to acquire and maintain a supply of vaccine. In 1835, Lieutenant Governor Henry Dundas Campbell complained to the Secretary of State for War and the Colonies, George Hamilton-Gordon, the Earl of Aberdeen that the vaccine continually failed “because it was shipped improperly” and argued that it would be better to transmit the vaccine in glass bottles or to place it between sheets of glass.⁴⁷⁶ The Colonial Office seemed incapable or unwilling to heed this advice as the vaccine sent out was often of no use. There was no set plan for shipping vaccine and this made organizing vaccination difficult.⁴⁷⁷ The difficulty of acquiring an effective vaccine continued to inhibit vaccination efforts, for as late as 1848 Governor Norman William MacDonald stated: “The colony seldom if ever possesses any effective vaccine matter the supply sent out periodically turning out in 99 instances out of every 100 wholly insufficient.”⁴⁷⁸ The vaccination difficulties highlight the organizational problems associated with British medicine in Africa. The Colonial Office was unable to ensure regular shipment of a working vaccine and even when available, the lack of practitioners must have made organizing a drive difficult. Furthermore, even when these two obstacles were circumvented, vaccination (as will be discussed below), did not always find a receptive audience.

⁴⁷⁶ National Archives, CO 267/128: Henry Dundas Campbell to George Hamilton-Gordon, Earl of Aberdeen, Sierra Leone, 11 March 1835.

⁴⁷⁷ N.A., CO 267/128: Campbell to Hamilton-Gordon, Sierra Leone, 11 March 1835.

⁴⁷⁸ National Archives, CO 267/203 fo.10: William Norman MacDonald to Henry George Grey, Earl Grey, Sierra Leone, 27 July 1848.

The problems associated with smallpox vaccination demonstrate the structural problems associated with British medicine in West Africa.

The small number of medical practitioners made it impossible to implement a system of medicine capable of convincing Africans of the unqualified benefits of European medicine. Because of the lack of resources, while there was the desire to expand medical practice and control,⁴⁷⁹ there was little progress made up to 1850 in extending state-run medicine to the neighbouring African polities, with the exception of periodic smallpox vaccination programs inspired by inland exploration. On balance, the lack of British medical practitioners, the difficulty in procuring medicines, especially smallpox vaccine, and the problem with creating and maintaining treatment facilities had a negative affect on the British capacity to care for liberated Africans.

The Colonial Office's interest in and its relationship with health and medicine in British West Africa reveals some of the structural problems that inhibited care. The Colonial Office largely directed medicine in British West Africa and ensured that colonial officials carried out its directives. It handled employment, promotion, and even decided how practitioners should be distributed throughout the three colonies.⁴⁸⁰ The Colonial Office kept a close watch on costs and this supervision led to questions concerning the expenditures of the medical department. In 1828, questions arose over spending by William Fergusson, a

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For example, Allen and Thompson, *A Narrative of the Niger Expedition*, vol. 2, 119-20. N.A., CO 267/209 fo.93: Aitken to Nicol, Sierra Leone, 11 March 1849.

surgeon working in the Liberated African Department (the department responsible for organizing those recently liberated from slavers). Fergusson was forced to defend his expenditures stating that “accounts will shew that those principals of economy which have been so strongly urged have not been incompatible with a due regard to the comfort of the sick.”⁴⁸¹ This desire for economy led to clashes with, and, indeed, accusations against, physicians. In 1839, the Secretary of State for War and the Colonies, John Russell, Earl Russell, wondered if the wine that was stated to have been used at the Kissy Hospital had been consumed elsewhere.⁴⁸² Blame fell on Robert Clarke who defended the high expenditure by informing the Colonial Office that palm wine was a useful cure and that the unusually large number of smallpox patients justified the high expenditure.⁴⁸³ Clarke’s justification made sense, as he believed in the therapeutic benefits of a “liberal” application of palm wine.⁴⁸⁴ This level of interrogation inhibited local initiative. Clarke complained in 1853, after sixteen years of service, that although he had toiled for many years, he was once again overlooked for promotion.⁴⁸⁵ This meant that men who had never practiced medicine in African were promoted over practitioners who had direct and valuable experience with African patients.

⁴⁸¹ National Archives, CO 267/94: William Fergusson to Dixon Denham, Sierra Leone, 31 March 1828.

⁴⁸² National Archives, CO 267/154: John Russell, Earl Russell to Robert Doherty, Sierra Leone, 26 December 1839.

⁴⁸³ National Archives, CO 267/154 fo.80: Norman William MacDonald to Robert Doherty, Sierra Leone, 6 November 1839.

⁴⁸⁴ Clarke, *Sierra Leone*, 98-99.

⁴⁸⁵ N.A., CO 267/233 fo.136: Clarke to Newcastle, Sierra Leone, 8 July 1853.

The Colonial Office left little room for governors, medical practitioners, or Africans themselves to formulate medical policy. The governor and the colonial surgeon could, to a limited degree, promote or discourage specific policies, such as medical inspections of the villages, but lacked the power to create new approaches to medicine in British West Africa. Policy, promotion, and hiring were all decided in London. The governor's chief duty respecting the medical system was to ensure that the directives formulated by the Colonial Office were being implemented in the colony. They also forwarded, with or without his support, medical practitioners' complaints, ideas, and petitions to the Secretary of State. Liberated Africans appear to have had no formal role in formulating medical policy and their best method of showing dissatisfaction was through avoidance. If they, or any of their leaders, were canvassed about how to improve health care, or if they ever protested, this occurrence is not reflected in the records.

While the Colonial Office discouraged local initiative, it was not always clear about expectations. Practitioners stated that they were, at times, not aware of Colonial Office's expectations. James Boyle, who became the colonial surgeon of Sierra Leone in 1827, stated that: "Regarding, the extent of my own duties or the mode of performing them, I have never had any instructions and have therefore followed the previous usages...."⁴⁸⁶ Whether his interpretation was consistent with the desires of the Colonial Office is unknown. Although

⁴⁸⁶ National Archives, CO 267/94: James Boyle to Dixon Denham, Sierra Leone, 13 May 1828.

discouraged from local initiative, medical practitioners who wrote to the Colonial Office asking for clarification, to complain, or requesting supplies were often ignored. Mr. Higgins, the dissatisfied colonial surgeon who offered his resignation at Freetown in 1810, stated that when he first arrived in the colony he found no medicine and his complaints to the Under-Secretary of State brought no reply.⁴⁸⁷ Although the official desire for a productive and healthy Africa was well known, individual practitioners were not told exactly how they were expected to achieve this vision. When they encountered difficulties they could not trust that their communications would even meet with a response. In another example, (which will be dealt with in more detail below) Dr. Boyle complained of overwork and stated that the colony needed to stop offering free medicine to any applicant.⁴⁸⁸ It took nearly twenty years before the Colonial Office offered any comment on this practice.⁴⁸⁹ The Colonial Office allowed the medical system to drift with those at the top rarely providing sufficient direction, while those on the ground lacked the power or resources to act as they saw fit and, in some cases, had limited opportunities for promotion. This led to the creation of a system that was, lacking in cohesion, funding, and imagination. Africans were provided with a system that could not be responsive to their specific, individual, and diverse needs, even if the desire to provide this was present in West Africa.

⁴⁸⁷ Cheverton, "A History of Community Medicine," 133.

⁴⁸⁸ N.A., CO 267/94: Boyle to Denham, Sierra Leone, 13 May 1828.

⁴⁸⁹ National Archives, CO 267/199 fo.110: Norman William MacDonald to Henry George Grey, Earl Grey, Sierra Leone, 22 August 1847.

The relationship between colonial medical practitioners and the Colonial Office illuminates the tensions between a desire to run the empire from afar and colonial realities. Thomas Richards has pointed to the inherent disjuncture between the metropole and the periphery in the nineteenth century, concluding that colonial policy was not the product of careful planning and is best characterized as a “collective improvisation.”⁴⁹⁰ Richards stated that the empire was sustained more by a “fictive thought of an imperial control” than any real and actual command.⁴⁹¹ He argued that: “The Empire was too far away, and the bureaucrats of Empire had to be content to shuffle papers.”⁴⁹² While it is true that the distance between the metropole and periphery did limit the Colonial Office’s effective power, when it did weigh in on policy decisions its viewpoint was decisive. This was not limited solely to the larger questions of imperial policy but to very particular and minute decisions. For example, the Colonial Office, not the governor, nor the colonial surgeon, determined where medical practitioners were posted.⁴⁹³ The Colonial Office held the decisive voice in organizing medicine in British West Africa. However, distance, the Colonial Office’s lack of understanding of local realities, and the reliance upon ‘men on the ground’ to keep it informed were a check on the exercise of power. When issues were brought to the attention of the Colonial Office its power to enforce its will on its officials was near total. However, much could be afoot in the colonies, unofficial

⁴⁹⁰ Thomas Richards, *The Imperial Archive: Knowledge and the Fantasy of Empire* (London: Verso, 1993), 3.

⁴⁹¹ Richards, *The Imperial Archive*, 2.

⁴⁹² Richards, *The Imperial Archive*, 3.

⁴⁹³ N.A., CO 267/209 fo.93: Aitken to Nicol, Sierra Leone, 11 March 1849.

policies and practices, willful ignorance of known policies, and abuses of authority, of which the Colonial Office had no knowledge of, or control over, until brought to its attention. The Colonial Office may be viewed as a dominant but often absentee force in West Africa that relied upon officials and subjects to inform it of abuses and any new developments or practices. Moreover, it was a force generally not receptive to locally inspired innovation. In these circumstances systemic development or reform were unlikely.

Due to the large gaps in policy and at times the lack of direction given to medical practitioners, tradition played an important role in filling in the gaps of official policy. Tradition encouraged the practice of free and universal care in Sierra Leone. This practice may have been introduced by Thomas Winterbottom who as surgeon to the Sierra Leone Company, in the era before crown control, provided care (to the best of his ability) to any patient regardless of status.⁴⁹⁴ In 1828, James Boyle questioned the logic behind providing free medical care to all Africans complaining that they had developed an undeserved sense of entitlement.⁴⁹⁵ Boyle theorized that putting an end to free care would create,

a beneficial influence over the minds of many of the more indolent of natives, who hitherto have been too apathetic as to the consequences of diseases arising from a conviction on their part of being entitled to medicines and attendance when ill.⁴⁹⁶

Boyle's views on this issue were possibly coloured by his desire to profit from private practice. Boyle's desire for profit became clear when he complained to

⁴⁹⁴ Winterbottom, *An Account of Native Africans*, vols. 1-2, *passim*.

⁴⁹⁵ N.A., CO 267/94: Boyle to Denham, Sierra Leone, 13 May 1828.

⁴⁹⁶ N.A., CO 267/94: Boyle to Denham, Sierra Leone, 13 May 1828.

the governor in the same communication that the colonial apothecary provided not only free medicine but medical advice as well.⁴⁹⁷ Clearly, Boyle's private practice would suffer if patients received free medical advice. Boyle's concerns were ignored. In 1847 when the Colonial Secretary Henry George Grey, Earl Grey, finally reviewed the policy, he decreed that the giving of "free medicine and free advice is not hurting anyone."⁴⁹⁸ Tradition and later Grey's ruling encouraged the colonial government and medical practitioners to provide free and universal care, to all applicants who were unwilling or unable to pay, throughout the first half of the nineteenth century.

While tradition helped to fill gaps in official policy, the lack of direction coupled with the structural problems made the implementation of a functional colonial health system very difficult. Because those on the ground were not given the power to create policy or to use their own judgment, the medical system was slow to react to African needs. It also meant that those in the imperial centre who had never set foot in Africa were to judge what measures were best for African health.

Scholars have paid increased attention to the fragile nature of the British Empire. This realization is a natural outgrowth of increased scholarly attention to the themes of indigenous agency and resistance combined with British parsimony that have served to undermine the notion of a unified colonial power. One of the exponents of this revised approach is Richard Price who emphasized the "constant

⁴⁹⁷ N.A., CO 267/94: Boyle to Denham, Sierra Leone, 13 May 1828.

⁴⁹⁸ N.A., CO 267/199 fo.10: MacDonald to Grey, Sierra Leone, 22 August 1847.

work required to maintain the sinews of imperial power.”⁴⁹⁹ Price argued that while most scholars recognize the limits of empire, it is nonetheless “seldom treated as an inherently brittle construct.”⁵⁰⁰ In West Africa, ‘brittleness’ prevented the creation of a fully functional system of medicine. The fledgling economy, lack of infrastructure, and the small number of British officials inhibited British medicine. European mortality limited the effectiveness of colonialism, and proved so high that there was some truth to the popular saying that Sierra Leone always possessed two governors; one living and the other returning to England to die.⁵⁰¹ The organizational problems and lack of manpower stymied British efforts to expand the system. The system was one in near-constant crisis, with one or two health practitioners trying to attend to patients in facilities that could be lacking in cleanliness, good repair, and supplies. British medical practitioners were aware of these problems and may have had some practical and useful solutions but were beholden to the Colonial Office which had control over policy.

Relations with African Patients

The interaction between British medical practitioners and Africans is an important topic. Two African groups are examined: liberated and native Africans. British medical practitioners in Sierra Leone stated that liberated Africans, when given the choice, preferred African healers to European medicine and care.

⁴⁹⁹ Price, “One Big Thing,” 608.

⁵⁰⁰ Price, “One Big Thing,” 608.

⁵⁰¹ Thomas Hutchinson, *Impressions of Western Africa with Remarks on the Diseases of the Climate and A Report on the Peculiarities of Trade Up the Rivers in the Bight of Biafra* (London: Longman, 1858), 37.

Essential to this analysis are dressers, hired African medical attendants who managed minor health concerns and dispatched African patients to Kissy Hospital. Practitioners outside of British West Africa reported a fundamentally different experience with native Africans, who were described as willing and eager patients. What does European/African medical interactions tell us about the implementation of European medicine and the ways in which Africans understood and interacted with this medicine?

The treatment of liberated Africans occurred in two contexts, as immediate arrivals in the colony and as colonial subjects. In the former context liberated Africans had little power. They were subjected to mandatory health inspections and if judged to require medical care were immediately treated or sent to Kissy Hospital for further care. British medical practitioners did not report any resistance to the inspection system or subsequent care. However, some practitioners noted the natural fear that liberated Africans had of Europeans which they insisted made it difficult to inspect these patients.⁵⁰² One commentator suggested that the captains of slavers fed this fear by telling slaves lies about what would happen if they fell into the hands of the British government.⁵⁰³ New arrivals were entirely dependent on the British, having on hand few or no friends or family to act on their behalf. They lacked control over their immediate care. In contrast, liberated Africans living in Freetown or the many villages scattered

⁵⁰² Alexander Bryson, as quoted in Cheverton, "A History of Community Medicine," 213-14.

⁵⁰³ Shreeve, *Sierra Leone*, 26.

across Sierra Leone were not at such a disadvantage and had more control over their health. How they wielded this power and the decisions they made will be evaluated below.

Liberated Africans often arrived in poor health, scared, and reluctant to accept British authority. Many required immediate access to food, clothing, and medical care. Freeing slaves could be a tedious process that began with the capture of a slaver and continued until the handing down of a guilty verdict by the Mixed Courts of Adjudication. Getting the captured slaver to Freetown could be time consuming, requiring weeks or even months. Until a judgment had been reached, 'liberated' Africans, still considered the slavers' property, could not be placed within the medical system. Therefore, all early health care had to occur on, or in practice, at least near, the slaver until a guilty verdict was delivered. Care frequently occurred in the King's/Queen's Yard, a depot established for the short-term housing of liberated Africans. Liberated Africans often spent a few months in the depot before finding housing in Freetown or being placed in one of the villages. If a guilty verdict was reached, liberated Africans were divided into groups, based upon their ability to work. Those judged too ill to labour were ordered to Kissy Hospital. Men healthy enough to work were expected to join the army, apprenticed, or given laborious tasks such as weeding and breaking up rocks. Children were apprenticed, put in a school, or sent to the villages to help

with agriculture. Women were encouraged to marry, tend to surviving children, or placed in the school system.⁵⁰⁴

Many liberated Africans arrived in the colony requiring immediate medical attention. European practitioners took note of the poor state of health and multitude of diseases that afflicted the recently liberated:

Vast numbers are afflicted with contagious disorders such for instance, venereal, small pox, measles, craw craw, yaws, together with various others not perhaps equally dangerous in the nature as it respects to contagion, but equally distressing such as dysentery, diarrhea, ophthalmia and a variety of others in which names I am not acquainted with by name.⁵⁰⁵

Attending to the health care needs of liberated Africans was considered to be an especially difficult medical undertaking. Liberated Africans represented a unique health care problem, as no British model existed for dealing with the health care complaints of such a debilitated class of patients. Members of the medical department expressed this sentiment:

It would be superfluous and a waste of your Lordship's valuable time for me to attempt to enter into the harrowing details of suffering and disease cured or relieved at the Kissy hospital but it becomes me to say that no other hospital either at home or in the colonies, can exhibit such a rare combination or formidable disease concentrated with such fearful intensity and this circumstance requires no further demonstration than a recapitulation of the well ascertained causes producing such profound mental and physical depression viz long confinement in the slave Barracoons, scanty food, want of water, ventilation and cleanliness whilst cooped up onboard.⁵⁰⁶

⁵⁰⁴ For more on the processes of liberation see: Leslie Bethell, "The Mixed Commissions for the Suppression of the Transatlantic Slave Trade in the Nineteenth Century," *The Journal of African History* 7, no. 1 (1966): 89; Fyfe, *A History of Sierra Leone*, 229-30.

⁵⁰⁵ National Archives, CO 267/94: Samuel Smart to Sir George Murray, Sierra Leone, 20 September 1828.

⁵⁰⁶ N.A., CO 267/209 fo.93: Aitken to Grey; Sierra Leone, 24 October 1849.

Physicians considered the treatment of newly arrived liberated Africans an especially difficult medical challenge, one that required the utmost medical skills. To explain to their readership the difficulty of treating such a debilitated class of patients, practitioners provided lengthy, gruesome descriptions of liberated Africans' sickly state:

Great numbers of individuals landed from the slave vessels, arrive at the Hospital so deplorably emancipated, that the skin appears to be tensely stretched over, and tied down to the skeleton. The expression of the countenance indicates suffering, moral and physical, of the most profound and agonizing nature.... The belly is as it were tacked to the back, whilst the hip bones protrude, and give rise to foul sloughing and phagendemic ulcers. The hand and skinny fingers seem much elongated, by the great neglected growth of the nails, which in such cases resembled talons. The squalor, and extreme wretchedness of the figure, is heightened in many cases, by the party-coloured evacuations with which the body is besmeared. The legs refuse to perform their functions, and with difficulty support the emaciated, tottering and debilitated body. Many of them labour under extensive gangrenous ulcerations, situated on the extremities, often detaching the soft parts from the bones, which becoming carious, are exfoliated. This truly pitiful state of the newly arrived Liberated Africans, must have been observed by every member of the profession who has had the opportunity of seeing them.⁵⁰⁷

It is important to note that the surgeons' sense of exceptionality was not based upon racial considerations but upon how thoroughly reduced these patients were.

Because of the shortages in manpower and the difficulties associated with treating liberated Africans, the medical system relied heavily upon African dressers.⁵⁰⁸ Dressers were hired to attend to a variety of minor health complaints

⁵⁰⁷ Clarke, *Sierra Leone*, 85.

⁵⁰⁸ N.A., CO 87/6: Tebbs to Rendall, Bathurst, 15 December 1832.

both at Kissy Hospital and in the villages. It is unknown who hired dressers but it seems likely they were given their positions by the colonial surgeon. Little is known about the training of dressers. The limited evidence suggests that dressers were expected to learn by watching British medical practitioners.⁵⁰⁹ How long such ‘training’ took place before they ‘graduated’ to unsupervised practice is unknown. Dressers were viewed as necessary, even though practitioners had little faith in their medical abilities and judgments.

British medical practitioners did not trust the medical skills of dressers whom they routinely criticized for their lack of medical knowledge. As Sir George Murray bluntly put it “dressers know nothing of medicine.”⁵¹⁰ Dressers were believed to neglect their duties when not under British supervision. William Aitken stated that when there was no supervision of dressers they neglected patients “hail[ing] such occasions as affording freedom from duty, and an opportunity for the undisturbed enjoyment of their indolent habits.”⁵¹¹ The theme of insolence and neglect of duty was a frequent one. Dr. Boyle complained that he was “forced” to dismiss one dresser who he described as being “no less distinguished for his idle habits than his insolence.”⁵¹² British medical practitioners did not necessarily trust dressers or have much faith in their medical skills but because of the shortages were forced to rely upon these care givers.

⁵⁰⁹ N.A., CO 87/1 fo.10: Findley to Hay, Bathurst, 30 April 1828.

⁵¹⁰ National Archives, CO 267/103 fo.7: Robert William Hay to Sir George Murray, Sierra Leone, 28 August 1830.

⁵¹¹ N.A., CO 267/209 fo.93, 60: Aitken to Nicol, Sierra Leone, 24 October 1849.

⁵¹² N.A., CO 267/103: Report Submitted by Andrew Foulis, March 1830.

One chief complaint leveled at dressers was that they waited too long before sending a patient to Kissy Hospital. Thomas Cole stated in 1837 that the consequence of using dressers and not trained European assistants was “that cases of ulcers, and other malignant diseases to which they [liberated Africans] are subject, are allowed to remain until they reach such severity that medical assistance when they arrive at the Hospital is of no avail.”⁵¹³ When physicians inspected the villages, practitioners were rarely happy with what they saw. They complained that these dressers mishandled even the simplest of complaints.⁵¹⁴ The “ignorance” of dressers served as a convenient excuse for the high mortality rates sustained at Kissy Hospital.⁵¹⁵ This was a common theme. Physicians in British Guiana, for instance, also blamed local medical intermediaries for the colony’s poor health statistics.⁵¹⁶ In West Africa, British medical practitioners believed dressers to be an imperfect solution to the problem of limited manpower, which at times did more harm than good. They would have preferred European assistants but their petitions for more practitioners and better assistants were not successful.⁵¹⁷

Medical practitioners reported that overall liberated Africans settled in Sierra Leone were largely unwilling to submit to a European course of treatment.

⁵¹³ National Archives, CO 267/141 fo.16: Report Submitted by Colonial Secretary Thomas Cole, Sierra Leone, 5 July 1837.

⁵¹⁴ N.A., CO 267/209 fo.93: Aitken to Grey; Sierra Leone, 24 October 1849.

⁵¹⁵ N.A., CO 267/209 fo.93: Aitken to Grey; Sierra Leone, 24 October 1849.

⁵¹⁶ Juanita De Barros, “Dispensers, *Obeah* and Quackery: Medical Rivalries in Post-Slavery British Guiana,” *Social History of Medicine* 20, no. 2 (2007): 250.

⁵¹⁷ National Archives, CO 267/141 fo.16: Richard Doherty to Charles Grant, Baron Glenelg, Sierra Leone, 20 July 1837.

Anna Crozier stated that in East Africa, African resistance to European care was most commonly expressed by “non-attendance at clinics.”⁵¹⁸ She stated that: “As late as the 1930s, doctors found antipathy, and sometimes even outright hostility, to [European] medicine.”⁵¹⁹ In West Africa, British medical practitioners complained that those who did solicit care did so only after they had attempted a variety of African cures. According to these accounts this had unfortunate consequences as, more often than not, by the time liberated Africans finally presented themselves to a European physician, the complaint was no longer curable.⁵²⁰ In 1830, Alexander Findley, the newly appointed lieutenant governor of Sierra Leone, informed the Secretary of State, Sir George Murray, about the extent of this avoidance, stating that “owing to the reluctance of the people of the colony to have recourse to European medical treatment the disease of persons brought to the hospital from the villages are often incurable.”⁵²¹ This habit of delay, all agreed, contributed to the poor record of the medical system.

Liberated Africans’ belief in witchcraft as a source of disease and their preference for healing amulets and African healers was judged to be proof of the backwardness of African culture. Conversely, Africans who did seek out European aid were praised as being intelligent, and if appropriate, used as examples of progress.⁵²² Employing a willingness to undergo hospital-based

⁵¹⁸ Crozier, *Practising Colonial Medicine*, 93.

⁵¹⁹ Crozier, *Practising Colonial Medicine*, 93.

⁵²⁰ N.A., CO 267/209 fo.93: Aitken to Grey, Sierra Leone, 24 October 1849, 12-13.

⁵²¹ National Archives, CO 267/103 fo.7: Alexander Findley to Sir George Murray, Sierra Leone, 28 August 1830.

⁵²² Clarke, “Prevailing Diseases,” 74.

treatment as the gauge of civilization was problematic as Europeans were known to delay admission to Kissy Hospital. Kissy was overcrowded, often understaffed, and thus both Europeans and Africans had good reason to delay, if not avoid, hospital treatment.⁵²³ While they acknowledged that the shortage of practitioners restricted care, British medical practitioners maintained that much of the colony's medical problems were the result of African ignorance and lack of civilization. Yet, they remained hopeful. Practitioners asserted that with time, Africans would come to accept European medicine. T. H. R. Thompson, who was part of the 1841 Niger Expedition, believed that medicine had an important role in 'civilizing' Africans. He stated: "I feel confident, that medicine and surgery, judiciously exercised, will form important elements in any endeavour to civilize the tribes on the banks of the Niger. The same will obtain, I believe, throughout Africa."⁵²⁴ Clarke, so anxious to remove African ignorance, suggested that periodic lectures be held as Kissy Hospital aimed at instructing Africans on the benefits of European medicine.⁵²⁵ By emphasizing African ignorance, surgeons shifted blame from the medical system to the patients (both potential and actual) by asserting that it was Africans more than the medical system that required change.

Surgeons saw themselves as important agents of change and hoped that their efforts would culminate in a healthy and productive future. This interest in

⁵²³ Cheverton, "A History of Community Medicine," 203.

⁵²⁴ Allen and Thompson, *A Narrative of the Niger Expedition*, vol. 2, 119-120.

⁵²⁵ Clarke, *Sierra Leone*, 102-03.

the future encouraged surgeons to focus upon children and, as will be examined below, reproductive health. Vaccination was considered an important medical duty as it would protect Africans from what was judged to be one of the greatest medical threats. The interest in children was displayed by Dr. R.A.K. Oldfield, a medical practitioner who served during the 1832 Niger Expedition, when he urged fellow practitioners to focus their attention exclusively on children:

I think we should consider Africa as an immense nursery, her sons as children, and ourselves as their teachers; leaving the adult population, combine all our energies in raising the character of the rising generation.⁵²⁶

In 1837, when visiting the village of Hastings, Clarke and an unnamed individual, attempted to vaccinate upwards of sixty children.⁵²⁷ They did not offer vaccination to adults. This focus on children made sense. Healthy children would become healthy adults who in turn had a better chance of producing healthy offspring. British physicians believed that they could positively contribute to the improvement of Africa. Nonetheless, as will be demonstrated, the failure to procure vaccine and African resistance to vaccination inhibited the impact British medical practitioners had on African health.

The medical practitioners would not accept the plurality of African medicine and that recourse to a variety of practitioners was for Africans a normal part of the healing process. Anita Jacobson-Widding and David Westerlund have pointed out that Africans had a long tradition of visiting a variety of healers:

⁵²⁶ Laird and Oldfield, *Narrative of An Expedition*, vol. 2, 394.
⁵²⁷ Clarke, *Sierra Leone*, 85-86.

Long before African patients came into contact with biomedical theories and practices, introduced during the colonial era, they used to travel long distances to consult different healers, often belonging to various kinds of cultural traditions.⁵²⁸

More galling for British practitioners was that liberated Africans would consult dressers while ignoring or avoiding their own services. British authorities believed that liberated Africans placed “too much confidence in dressers.”⁵²⁹ Practitioners saw dressers as a bridge to their African patients not as stand-alone healers. For British medical practitioners, dressers were only supposed to deal with minor complaints and to send all those with more substantial problems to Kissy Hospital. Practitioners were disappointed and complained profusely that dressers often did not forward cases to them.

Robert Clarke, who worked at Kissy Hospital for some eighteen years, believed that liberated Africans themselves were primarily to blame, not dressers, for delaying in seeking out European medical aid. Clarke stated that ninety percent of patients:

Arrive in the last stage of exhaustion; many from the villages even expire on their way. It is a fact, well known to all conversant with the African character, that they are averse to having recourse to European methods of treatment, until they have tried all the native remedies with which they are acquainted; consequently their diseases have, previous to coming under the Surgeon's notice, assumed a serious and often chronic character.⁵³⁰

Clarke directly linked avoidance to mortality. By placing the blame on Africans and not British practitioners or the medical system, Clarke created a convenient

⁵²⁸ Jacobson-Widding and Westerlund, “General Introduction,” 11.

⁵²⁹ N.A., CO 267/209 fo.93: Report submitted by B.C.C. Pine, Sierra Leone, 12 November 1848.

⁵³⁰ Clarke, *Sierra Leone*, 84.

scapegoat for the high mortality rates experienced at Kissy Hospital (a theme examined below). He intimated that it was not his fault or that of Western medicine but that of patients who delayed in presenting themselves at Kissy. For Clarke, avoidance was a product of African backwardness and this is why he supported public lectures aimed at “removing those deep rooted prejudices which now prevent the African from seeking medical assistance.”⁵³¹ Africans, before becoming proper patients, had to be convinced of the benefits of European medicine. At the time of writing in 1841, Clarke believed Europeans had yet to achieve this important task.⁵³²

Liberated Africans, who were stated to prefer dressers to European physicians, had little incentive to seek out British aid or to travel to Kissy Hospital. British practitioners thought this avoidance to be the principal deterrent to health in the colony,⁵³³ but, despite frequent complaints, were powerless to stop it. Repeatedly the record shows that British medical practitioners would have rather posted a European practitioner to specific villages but lacked the resources to do so. For instance, in 1832 Dr. Tebbs informed the governor that the colony was so short on physicians that dressers were being sent to attend to cases better handled by physicians.⁵³⁴ Despite the utility of dressers, and their important role in filling in the ‘gaps’ in the medical department, dressers were depicted as accomplices who encouraged or at least neglected to instruct liberated Africans to

⁵³¹ Clarke, *Sierra Leone*, 103.

⁵³² Clarke, *Sierra Leone*, 102-103.

⁵³³ Clarke, *Sierra Leone*, 84 ; 103.

⁵³⁴ N.A., CO 87/6: Tebbs to Rendall, Bathurst, 15 December 1832.

seek out European care. Nowhere in the surviving literature did British medical practitioners consider that dressers did indeed advise liberated Africans to seek further aid and that they had refused, leaving the dressers to do their best for these patients. While British medical practitioners were critical of the dressers' medical skills it may be that at least some African patients were happy with the care they received in the villages and thus had no desire or need to travel to Kissy. British medical practitioners were highly sensitive to perceived African rejection of European medicine. It may be that this sensitivity encouraged them to perceive avoidance. It may explain why practitioners, at least in print, never considered that avoidance may have been the product of logistics. Some villages, such as Kent, were more than twenty-five miles from Kissy Hospital and this must have discouraged some patients from travel. For the young and the elderly this would have been a considerable distance to travel while ill. Given some of the distances, it seems logical that Africans waited until their ailments were serious and they had exhausted all local options before travel. European medicine was often the last option for Africans but for many this may have been because of the difficulty of travel and not a reflection on their opinions on European hospital-based medicine. While a multitude of factors may explain why liberated Africans avoided or delayed in entering care at Kissy Hospital, it is important to note that British medical practitioners largely blamed avoidance on African ignorance and dressers.

Richard Price has drawn attention to the fragility of empire, emphasizing “the ways in which imperial hegemony was constantly compromised.”⁵³⁵ The British medical system in West Africa is an example of such compromise and serves as a reminder that colonial rule was constantly negotiated. Dressers acted as a medium between British medical practitioners and their African patients. Practitioners thought this system far from ideal and even dangerous; however, dressers provided a vital link to African patients. Dressers did encourage liberated Africans to accept ‘European’ care but in ways in which reportedly appealed to Africans. Dressers’ popularity may be because they accepted, in a way in which British medical practitioners never did, a multi-perspective approach to health and healing. Frederick Cooper has stated that it is these sorts of relationships that make it misleading to view European/African relations through the sole lens of colonizer/colonized.⁵³⁶ The reality, as colonial officials and medical practitioners found out was that medical care was constantly negotiated and that compromise was required.

The struggle to convince liberated Africans to submit to vaccination is illustrative of the difficulties of spreading European medicine to African subjects. The refusal of liberated Africans to submit to vaccination frustrated medical authorities, especially considering how difficult it was to get and then maintain a vaccine in Africa. Authorities took the threat of smallpox seriously. For example, William Fergusson recommended that Africans who contracted

⁵³⁵ Price, “One Big Thing,” 612.

⁵³⁶ Cooper, “Conflict and Connections,” 1517.

smallpox not only be quarantined but as a safety measure have their clothes and homes destroyed.⁵³⁷ British medical practitioners were aware of the threat that smallpox posed to unvaccinated Africans and fretted over how to achieve vaccination. Clarke wrote of liberated Africans distrust of vaccination, asserting that they preferred their own methods of treatment. This consisted of lubricating the body with palm or nut oil, and placing the patient next to a fire to produce a healing sweat. Clarke cautioned that this “improper treatment” could not possibly arrest the progress of smallpox which when not properly treated frequently attacked the eyes causing blindness.⁵³⁸ T. R. H. Thompson, a member of the ill-fated 1841 Niger Expedition, asked his readership not to judge Africans too harshly for refusing vaccination:

we must not forget the bitter animosity entertained by enlightened men of the day in our own country, against one of the greatest medical discoveries ever promulgated to the world. Upwards of half a century has passed away, and the prejudice against vaccination has not altogether disappeared with time.⁵³⁹

Vaccination became all the more important after 1832 when plans were developed to transport liberated Africans to the West Indies to supplement those colonies’ freed workforces. Repeatedly officials underestimated liberated Africans’ resistance to vaccination. In 1848, for instance, Governor Norman William MacDonald explained that the last time officials “tried to vaccinate before embarkation every liberated African left the ship and no matter what the doctor

⁵³⁷ N.A., CO 267/94: Report Submitted by William Fergusson 1 January 1828.

⁵³⁸ Clarke, *Sierra Leone*, 86.

⁵³⁹ Allen and Thompson, *A Narrative of the Niger Expedition*, vol. 2, 119-120.

said they would not get back on.”⁵⁴⁰ MacDonald reasoned that coercion was necessary. He justified this by stating: “Because the Africans are ignorant of the dangers of smallpox it is up to the more enlightened British government to judge whether vaccination is necessary.”⁵⁴¹ As MacDonald explained, it was best to vaccinate liberated Africans at sea where their power to resist was greatly diminished. Smallpox was too important, according to MacDonald, to be left to liberated Africans.

Liberated Africans’ avoidance of smallpox vaccination was of little real importance since the vaccine was hardly ever at hand. MacDonald, who supported coercion, admitted that “the colony very rarely possess any effective vaccine matter.”⁵⁴² Blaming Africans for the state of health in British West Africa was common, but as previously demonstrated, and confirmed by MacDonald, structural problems, in this case shipping a ‘healthy’ vaccine to Sierra Leone, inhibited efforts much more than avoidance. The theme of liberated African avoidance was overplayed. The medical system was already overstretched, and if liberated Africans had solicited care in the ways in which British medical practitioners wished them to do so, the system could not have coped. While a convenient scapegoat, avoidance could not explain the lack of practitioners, supplies, or organization.

⁵⁴⁰ N.A., CO 267/203 fo.10: MacDonald to Grey, Sierra Leone, 27 January 1848.

⁵⁴¹ N.A., CO 267/203 fo.10: MacDonald to Grey, Sierra Leone, 27 January 1848.

⁵⁴² N.A., CO 267/203 fo.10: MacDonald to Grey, Sierra Leone, 27 January 1848.

Native Africans were renowned and routinely praised for their willingness and desire to be treated by European physicians. While in the Gulf of Guinea, William Daniell remarked that:

Natives of every rank express the greatest confidence in his [a medical practitioner's] skill, and the efficacy of those remedial measures exhibited for their benefit; and should such unfortunately fail of affording the desired relief, the case is considered hopeless.⁵⁴³

T.R.H. Thompson buttressed Daniell's claims, stating that: "The Africans have the most sacred confidence in the powers of medicine," and that: "Medical practitioners are nowhere more respected [than in Africa]."⁵⁴⁴ He stated:

When I first proposed [smallpox] vaccination... many of the African mothers listened with doubt, and eventually ran away with their children... great numbers staid and submitted their children to the operation, when its simplicity and after benefits were clearly explained to them.⁵⁴⁵

James Ormiston McWilliam also of the 1841 Niger Expedition, stated that he had witnessed "few people in England submit so quietly and willingly to medical or surgical treatment as the Africans do."⁵⁴⁶ He told of one African boy who had cataract of the right eye,

which I had no sooner offered to remove, than he sat down and submitted without murmur to the operation of depression: he was astonished at being able to count his fingers with an eye which had previously been of no use, and after it was bandaged up he walked coolly into the canoe, as if nothing happened.⁵⁴⁷

Daniell cautioned medical practitioners that they must be careful for whenever,

⁵⁴³ Daniell, *Native Diseases of the Gulf of Guinea*, 61.

⁵⁴⁴ Allen and Thompson, *A Narrative of the Niger Expedition*, vol. 2, 119-120.

⁵⁴⁵ Allen and Thompson, *A Narrative of the Niger Expedition*, vol. 2, 119-120.

⁵⁴⁶ McWilliam, *Medical History of the Expedition to the Niger*, 246.

⁵⁴⁷ McWilliam, *Medical History of the Expedition to the Niger*, 246.

the surgeon of any vessel is known to be somewhat liberal in the distribution of his medicine, innumerable invalids flock on board, and, without hesitation supplicate his attention to their real or imaginary complaints.⁵⁴⁸

Daniell did not report the same difficulties of communication as noted by other practitioners, remarking that Africans “urge their [medical] claims so cogently.”⁵⁴⁹ For him the difficulty lay in exposing those who had constructed “imaginary complaints.”⁵⁵⁰ The popularity of European medicine was underlined by the “great numbers” who concocted “imaginary complaints” just to visit a European doctor.⁵⁵¹ This contrasts to liberated Africans who reportedly resisted and avoided European care.

Medical practitioners responsible for the health care needs of liberated Africans had a different perspective. All the above mentioned positive statements were made by British practitioners who possessed no formal responsibility for the care of the Africans who descended upon them. The medical staff in Sierra Leone had mandated responsibilities within a very imperfect system. At present, it is not clear where government surgeons with mandated responsibilities in the Gold Coast or the Gambia fell within this spectrum of opinions. It should also be noted that in the above examples treatment took place outside of a hospital whereas state-managed treatment privileged the hospital experience. Interestingly, native Africans, renowned for their respect of European medicine, did not travel to the

⁵⁴⁸ Daniell, *Native Diseases of the Gulf of Guinea*, 62.
⁵⁴⁹ Daniell, *Native Diseases of the Gulf of Guinea*, 62.
⁵⁵⁰ Daniell, *Native Diseases of the Gulf of Guinea*, 62.
⁵⁵¹ Daniell, *Native Diseases of the Gulf of Guinea*, 62.

colony for medical care.⁵⁵² Whether this was due to Africans not knowing about the free care available or whether they were simply unwilling or unable to travel to the colony and submit themselves to the hospital system is unknown.

Kissy Hospital and the Approach to Disease

Clarke, who served at Kissy Hospital for some eighteen years, provided the most in-depth account of the hospital. He published the returns for Kissy Hospital for the years of 1838, 1839, 1840-1841,⁵⁵³ and in his "Prevailing Diseases" included returns for 1845-1853.⁵⁵⁴ Unfortunately, it is impossible to determine exactly what classification of patients were under treatment; however, Clarke did state that the vast majority of hospital patients were liberated Africans or their direct descendants.⁵⁵⁵ These returns reveal the general trend of a decreasing number of patients combined with a lower mortality rate. An unusually large arrival of liberated Africans as in 1847 periodically interrupted this trend. There appears to have been a correlation between the number of recently liberated Africans sent to the hospital and a high hospital mortality. In the years 1838, 1839, 1841, 1845, and 1847, when a larger proportion of recently liberated Africans were treated at the hospital the mortality figures were high. In 1846 and from 1849 to 1853 when the number of admissions from those recently liberated were low, so too was the hospital mortality. This reinforces an argument for the difficulty in treating liberated Africans. The medical system could not

⁵⁵² Clarke, *Sierra Leone*, 102-103.

⁵⁵³ Clarke, *Sierra Leone*, 79-83.

⁵⁵⁴ Clarke, "Prevailing Diseases," 80.

⁵⁵⁵ Clarke, "Prevailing Diseases," 65.

cope with the large numbers and patients so thoroughly reduced.⁵⁵⁶ For the years under investigation, hospital mortality was 455 per thousand. In the years when more than 300 recently liberated Africans were sent to the hospital, mortality was 494.9 per thousand; nearly half of all patients treated. This suggests that the system struggled to cope with high numbers of recently liberated.

Table 4.1 Mortality Rate Per Thousand for All Patients Treated in Kissy Hospital 1838, 1839, 1840-1841, and 1845-1853⁵⁵⁷

Year	Treated	Died	Mortality per 1000
1838	2744	1509	549.9
1839	2773	1635	589.6
1841	1437	541	376.5
1845	1829	839	458.7
1846	514	110	214
1847	3124	1730	553.8
1849	941	270	286.9
1850	795	151	189.9
1851	744	197	264.8
1852	517	117	226.3
1853	433	113	260.9
Total	15851	7212	455

Kissy Hospital administered to both endemic and epidemic diseases as well as acute and chronic ailments. The division between these categories was not always clear as ulcers and other common afflictions could be an acute ailment for some patients and a chronic problem for others. Also there was considerable debate whether certain diseases such as dysentery should be classified as endemic

⁵⁵⁶ Clarke, "Prevailing Diseases," 65.

⁵⁵⁷ The data for years 1838, 1839, and 1841 are derived from Clarke, *Sierra Leone*, 79-83. The data for the years 1845-1848 and 1849-1853 can be found in Clarke, "Prevailing Diseases," 80.

or epidemic.⁵⁵⁸ This makes it inaccurate and misleading to try to sort the returns into rigid categories. Instead, what is provided below is an analysis of the diseases most frequently diagnosed and treated at the hospital as recorded by the attending physician. This is then contrasted with Clarke's fascination with venereal disease, a problem of little importance at the hospital. As will be shown, British medical practitioners were more interested in examining in print the reproductive health of the colony and smallpox vaccination than diseases that, while common, they considered to be less threatening to the future health of British West Africa.

Table 4.2 Number of Deaths for select Diseases in Kissy Hospital for the period 31 December 1840 to 31 December 1841⁵⁵⁹

	Stomach Complaints	Dropsy	Ulcers	VD	Fevers	Mania	All Others	Total
Treated	344	244	306	27	58	31	948	1437
Died	169	159	61	9	25	9	110	541
Mortality	491.3	651.6	199.3	333.3	431	290.3	116	376.5

Table 4.3 Number of Deaths for select Diseases in Kissy Hospital for the period 1 April 1853 to 31 March 1854⁵⁶⁰

	Stomach Complaints	Dropsy	Ulcers	VD	Fevers	Mania	All Others	Total
Treated	10	4	84	21	10	95	209	433
Died	5	2	14	3	0	30	59	113
Mortality	500	500	166.7	142.9	0	315.8	282.3	260.9

⁵⁵⁸ Clarke, "Prevailing Diseases," 66.

⁵⁵⁹ Clarke, *Sierra Leone*, 80-83.

⁵⁶⁰ Clarke, "Prevailing Diseases," 80.

The tables illustrate the declining number of African patients. By the 1850s the number of liberated Africans had diminished and this is represented in the hospital records. In all categories, excluding mania, there is a marked decrease in the numbers of cases. Stomach complaints which British medical practitioners had associated with the slave trade experienced a radical drop by the 1850s.⁵⁶¹ Historian Megan Vaughan has explained how mental illness became a central focus of medicine in British West Africa in the second half of the century.⁵⁶² This explains the large increase in patients diagnosed with mania.

In his published accounts of the colony, Clarke virtually ignored the diseases which he administered to most frequently at the hospital. Indeed, stomach complaints, dropsy, and ulcers which accounted for nearly half (48.3%) of all cases treated at Kissy Hospital received little attention in his writings. He blamed the prevalence of stomach complaints on the horrors of the slave trade.⁵⁶³ The returns of 1853-1854 reinforce this point as the small number of those liberated reduced the number of stomach complaints from 344 in 1841 to just 10 in 1853-1854. Clarke wrote very little about ulcers, the most common complaint in 1841, except to emphasize the importance of "proper care." He did not record what constituted proper care but warned that if neglected ulcers could become serious and even life threatening.⁵⁶⁴ Clarke stated that ulcers were mostly occasioned by slight injuries: such as scratches; insect bites, and bee stings and as

⁵⁶¹ Clarke, "Prevailing Diseases," 66.

⁵⁶² Vaughan, *Curing their Ills*, 100-125.

⁵⁶³ Clarke, "Prevailing Diseases," 66.

⁵⁶⁴ Clarke, *Sierra Leone*, 102.

such were very common among African inhabitants.⁵⁶⁵ He believed that the prevalence of ulcers could also be blamed on the African method of tying ligatures and soaking the affected area in water, which he believed inhibited healing.⁵⁶⁶ Even dropsy, which produced a mortality of 651.6, engendered little comment. Clarke noted in his 1853-54 account that tapping the affected area was not an effective treatment and in forty-eight cases where this method was tried only two patients recovered.⁵⁶⁷ Since Clarke chose not to emphasize his daily labours, the valuable and hard earned experience he acquired at Kissy Hospital remained obscured from readers. This both minimized its value to the next generation of practitioners in West Africa and limited any opportunity in Britain for comparative studies.

In 1841, twenty-seven cases of venereal disease were attended to at Kissy Hospital. Nine of these patients died, although two of these deaths were the result of bowel complaints contracted during the hospital stay.⁵⁶⁸ The mortality per thousand was 259.3. In 1851, twenty-one cases of venereal disease were recorded. Three patients died producing a mortality of 142.9 per thousand. Clarke, who rarely went into much detail when discussing individual complaints, explained in detail the threat that venereal disease posed to the future health of the colony. Clarke provided detailed descriptions of the deformities which afflicted Africans sexual organs. For example, he pointed out that African males were

⁵⁶⁵ Clarke, "Prevailing Diseases," 66.

⁵⁶⁶ Clarke, "Prevailing Diseases," 66.

⁵⁶⁷ Clarke, "Prevailing Diseases," 67.

⁵⁶⁸ Clarke, *Sierra Leone*, 81.

prone to “enlargements of the scrotum, forming a tumour of such dimensions as to reach to the knees, and even below them, are not uncommon.”⁵⁶⁹ He explained that male impotence was common and that Africans which called the complaint “broke back” constantly asked for remedies to restore their virile powers, or, as they apparently termed it “to strengthen their back.”⁵⁷⁰ Clarke emphasized that venereal disease and reproductive health were a concern to Africans but never explained why so few cases were attended to in the hospital. Kissy Hospital played a small role in the management of venereal disease, and if treated by British medical practitioners, the complaints must have been addressed elsewhere.

Clarke was not alone in his concern, for William Daniell also highlighted the serious problems caused by venereal disease:

Syphilis is perhaps the most frequent and fatal of those maladies to which the male inhabitants are liable, and predominates more among them than among the females. Many are cut off very early in life from the want of the necessary remedial applications, and it is not uncommon to meet with cases which have continued during nearly two-thirds of the patient's existence. The worst forms of syphilitic disease which have come under my notice, have been the foul and malignant phagedenic ulcers that indiscriminately attack both sexes. Gonorrhea virulenta, nodes, cutaneous eruptions, and, indeed, all the sequelae of syphilis in multiform varieties, are extremely prevalent, and not unfrequently resist the most energetic and judicious treatment of the European surgeon.⁵⁷¹

Clarke echoed these sentiments stating, that the infection rates among men were so high that: “In few of the males are the genital [still] intact.”⁵⁷² Although

⁵⁶⁹ Clarke, “Prevailing Diseases,” 68.

⁵⁷⁰ Clarke, “Prevailing Diseases,” 69.

⁵⁷¹ Daniell, *Native Diseases of the Gulf of Guinea*, 43-44.

⁵⁷² Clarke, “Prevailing Diseases,” 68.

considered more prevalent amongst African males, surgeons noted the threat that venereal disease posed to African women. Clarke explained the prevalence of gonorrhea among African women, asserting that: "Gleety discharges, the sequence of repeated attacks of gonorrhea... are constantly brought to the surgeon's notice."⁵⁷³ Daniell cautioned that venereal disease contributed to lower birth rates.⁵⁷⁴ British medical practitioners were not alone in their concerns about venereal disease and population for as John Janzen has demonstrated African medicine in the nineteenth century began to reflect growing concerns over the loss of population caused by the "appearance of venereal disease" and the slave trade.⁵⁷⁵ British medical practitioners believed that sexual complaints were a barrier to reproduction and the long-term health of the colony. Presumably this emphasis also reflects a belief that readers would be more interested in health issues that threatened the future productivity of British West Africa than diseases that, while common, were not perceived to endanger British plans in Africa.

Medical practitioners' interest in the future of Africa was reflected in their focus upon female reproduction. Daniell added medical credence to the long held notion that puberty occurred much earlier in Africans, stating that it usually happened around the age of eleven or twelve but sometimes much earlier.⁵⁷⁶ This should have provided women with a long reproductive period and the chance at providing more offspring. Puberty was an often examined issue and a key point

⁵⁷³ Clarke, "Prevailing Diseases," 69.

⁵⁷⁴ Daniell, *Native Diseases of the Gulf of Guinea*, 43.

⁵⁷⁵ Janzen, "Precolonial Western Equatorial African Therapeutics," 202.

⁵⁷⁶ Daniell, *Native Diseases of the Gulf of Guinea*, 98.

in the monogenist/polygenist debates where those seeking to prove separate creations argued that Africans, just like animals, reached an age of maturity at a much younger age.⁵⁷⁷ Daniell believed that African women often perished from the lack of “timely assistance” while in labour.⁵⁷⁸ Deaths were preventable but only if Africans would willingly submit to British care and if there were enough surgeons so that the British could involve themselves in the birthing experiences of Africans. As it stood, Daniell and others were merely interested observers who had no real involvement in the birthing practices of Africans.

European medical practitioners lacked a definitive cure for venereal disease. Clarke believed the best way to combat venereal disease was through the “liberal” application of palm wine and noted that a decoction of cola leaves, something he had yet to try, was known to be beneficial.⁵⁷⁹ Clarke observed that venereal disease often deformed the female anatomy and required the removal of the nymphae and the clitoris.⁵⁸⁰ Clarke explained to his readers that European therapeutics could not offer a perfect cure as venereal disease “frequently baffles the ordinary treatment, and a troublesome gleet often remains.”⁵⁸¹ Despite the limits of their own abilities, surgeons blamed much of the prevalence of venereal disease on African healers whose treatment they believed only served to injure patients. Winterbottom, for instance, observed that African practitioners had a false sense of confidence when confronted with venereal disease: “The African

⁵⁷⁷ Long, *The History of Jamaica*, vol. 2, 335.

⁵⁷⁸ Daniel, *Native Diseases of the Gulf of Guinea*, 98.

⁵⁷⁹ Clarke, *Sierra Leone*, 98-99.

⁵⁸⁰ Clarke, “Prevailing Diseases,” 68-69.

⁵⁸¹ Clarke, *Sierra Leone*, 98-99.

physicians boast that they are able to cure this disease in all its forms, and in every stage, for which purpose they employ a variety of remedies, chiefly sudorifics or violent purges.”⁵⁸² African practitioners, according to Clarke, only exacerbated the problem and that for the good of Africa this “barbarous treatment” needed to be replaced by European medicine.⁵⁸³ It is interesting that while aware of the limits of his own ability, Clarke called for the replacement of African healing techniques with European methods. This demonstrates the mindset of practitioners when it came to European medicine. Even when European therapeutics produced no demonstrative improvements surgeons believed their remedies to be superior. European assessment of African remedies was never unbiased and learning African healing techniques did not compromise their belief in the superiority of their own healing system.

British medical practitioners acknowledged the reluctance of liberated Africans to submit to European treatment and reported that the choice of whether to undergo a European course of treatment largely rested with these potential patients. The medical system struggled as African patients who chose to enter the system were, according to British medical practitioners, often too sick to save. According to British medical practitioners, European medicine, for many African patients remained a last resort. In print, physicians ignored diseases such as dysentery that were the most relevant to their patients. Instead, they focused upon smallpox and venereal disease, two afflictions which had little representation in

⁵⁸² Winterbottom, *An Account of Native Africans*, vol. 2, 32.

⁵⁸³ Clarke, “Prevailing Diseases,” 68.

the records of Kissy Hospital. One reason smallpox garnered so much attention was that medical practitioners, unlike with dysentery, were not powerless to stop smallpox.⁵⁸⁴ Vaccination, though not always successful, could reinforce European bio-medical power. For British commentators, the ability to vaccinate proved the superiority of European medicine by offering protection to Africans against a dangerous scourge. Why focus on dysentery which highlighted the futility of British efforts when a focus on smallpox reinforced and called for an extension of British medicine? Venereal disease, while it elicited so much discussion and had according to these authors a near total infection rate,⁵⁸⁵ appears to have remained almost totally outside the limited hospital system. Is it possible that British medical practitioners and dressers chose not to refer African patients suffering from venereal disease to Kissy Hospital? Or did Africans resist entering a hospital when afflicted with venereal disease? Was treatment provided outside the hospital system, possibly in the villages themselves? Unfortunately, more is not known about the medical discussions and decisions made by British medical practitioners and liberated Africans which defined medicine in British West Africa. Nonetheless, both parties had a hand in directing care and by doing so shared in the making of Kissy Hospital.

⁵⁸⁴ David Arnold had stated that smallpox gained increasing attention in the nineteenth century as it was regarded as a "preventable disease." See: Arnold, "Smallpox and Colonial Medicine," 45.

⁵⁸⁵ Clarke, "Prevailing Diseases, 68-69.

African Practitioners and Therapeutics

African and European practitioners had fundamentally different ideas on the origins of disease. Most Africans did not look to the miasmatic or environmental theories as an explanation for disease, but rather to social and supernatural factors. Africans believed that disease was caused by moral transgressions or as a direct result of an evil person or spirit. In 1979, physician turned historian R.L. Cheverton explained the centrality of divination which operated as both an instrument of diagnosis and informed the type of treatment needed.⁵⁸⁶ British medical practitioners responded to this difference by deriding African beliefs while asserting that a combination of science and experience, not a belief in and appeal to the supernatural, should guide a physician's hand. British medical practitioners had no sympathy for the notion that witchcraft caused illness and that the application of charms and amulets had therapeutic value.⁵⁸⁷ They expressed frustration that Africans "cannot believe, or at least will not try, to understand how natural causes create diseases."⁵⁸⁸ British practitioners chose to emphasize difference. They ignored the fact that the African belief in moral transgressions resembled the European notion that intemperance left a person susceptible to disease. Winterbottom asserted that the system of medicine that currently existed in Africa was the highest level of achievement that could be reached without accepting European medical knowledge.⁵⁸⁹ British medical

⁵⁸⁶ Cheverton, "A History of Community Medicine," 6.

⁵⁸⁷ Winterbottom, *An Account of Native Africans* vol. 1, 235-36; 251.

⁵⁸⁸ Hutchinson, *Impressions of Western Africa*, 150-151.

⁵⁸⁹ Winterbottom, *An Account of Native Africans*, vol. 1, 251-52.

practitioners, at least in print, never considered that what they believed to be traditional medicine was no more ‘traditional’ than the medicine practiced in London. The British exploited the trope of traditional medicine to their own advantage.⁵⁹⁰ Traditional medicine was, in some situations, depicted as worthy of British emulation, while at other times, traditional African curatives were mentioned to emphasize the lack of progress made by Africans. In the eyes of European commentators, a great inertia defined African medicine, for as long as Africans remained ignorant of scientific advances they could not hope to further improve their therapeutics.⁵⁹¹ According to British physicians it fell to Europeans to enlighten Africans.

Whether a medical system can be framed as being ‘traditional’ continues to be explored by historians. The term ‘traditional’ carries negative connotations suggesting that African medicine was static and unable to progress. In the past, scholars commonly depicted African medicine as “closed,” unable to change or adapt to new situations. For instance celebrated scholar Robin Horton in his influential essay “African Traditional Thought and Western Science,” wrote of the, “closed” nature of “African traditional thought” contrasting African medicine with the supposedly “open character of Western Science.”⁵⁹² Horton has rightly

⁵⁹⁰ Whitfield and Ibhawoh, “Colonial Africanist Historiography,” 589; Leroy Vail, ed. *The Creation of Tribalism in Southern Africa* (London: Currey, 1989).

⁵⁹¹ The idea that African societies were closed or stagnant is discussed in John and Jean Comaroff, *Of Revelation and Revolution*, vol. 1, 17-19.

⁵⁹² Robin Horton, as quoted in David Westerlund, “Pluralism and Change. A Comparative and Historical Approach to African Disease Etiologies,” in *Culture, Experience and Pluralism, Essays on African Ideas of Illness and Healing*, ed. Anita Jacobson-Widding and David Westerlund (Uppsala: Almqvist & Wiksell, 1989), 178.

drawn criticism for such an approach. Steven Feierman has argued that the duality of open and closed systems is far too simplistic and that no medical system is truly open or closed.⁵⁹³ John Janzen and Gloria Waite have traced the growth and evolving nature of African therapeutics before colonial rule.⁵⁹⁴ These evaluations demonstrate the ever-evolving nature of African therapeutics challenging any attempt to depict African medicine as static. While the term traditional does carry negative connotations, we should not lose sight of the fact that British practitioners believed African medicine to be static. Biomedicine was equated with progress. This duality was not restricted to medicine, as the ‘traditional’ African was contrasted with the dynamic and improving European culture.

British medical practitioners categorized African practitioners as quacks who used medicine to reinforce their own power and prestige. According to these accounts, it was the practitioners and not the patients who were to blame for the backwardness of African medicine. Patients were at times chided for ignorance, but in most accounts were depicted as unknowing and innocent victims who fell under the spell of African medicine. Winterbottom argued that the “superstitious dread of witchcraft” had such an effect over Africans that it should be “considered as a mental disease.”⁵⁹⁵ William Daniell also disliked the power that traditional

⁵⁹³ Westerlund, “Pluralism and Change,” 169.

⁵⁹⁴ John Janzen, “Precolonial Western Equatorial African Therapeutics,” 195-211; Gloria Waite, “Public Health in Precolonial East-Central Africa,” in *The Social Basis of Health and Healing in Africa*, ed. Steven Feierman and John Janzen. Berkeley: University of California Press, 1992), 212-234.

⁵⁹⁵ Winterbottom, *An Account of Native Africans*, vol. 1, 262.

African healers held over their patients “superstition exercises her delusive sway; charms, amulets, with other fetish remedies, are employed *ad libitum* by designing priests, whose useless mummeries” he believed caused more harm than good.⁵⁹⁶ McWilliam believed that African practitioners deceived their followers by promoting charms and amulets as a form of healing:

The practice of medicine throughout Africa, although in the lowest state of degradation, and clouded with superstitious bigotry, obtains for its professors emolument, respect, and even veneration. In the Nufi, Eggarra, and Kakanda countries, the Mallam, chiefly from Rabba and Sokatoo, travel about teaching Mahomendanism, and practicing the healing art. Charms, consisting of scraps from the Koran, are resorted to in all cases of great difficulty.⁵⁹⁷

Robert Clarke complained that African practitioners were a danger to their patients, because they prepared and administered herbal remedies without reference to the season, the patients, their condition, age, or sex. He asserted that due to this negligence “many lives are yearly sacrificed.”⁵⁹⁸ Thomas Hutchinson, a physician who traveled to the Bights of Biafra in 1854, disagreed with Clarke’s assertions praising African practitioners for their careful moderation, informing his readers that African healers rarely caused harm. Indeed, Hutchinson believed that much could be learned from their close adherence to the *similia similibus curantur* system.⁵⁹⁹ *Similia similibus curantur* (like heals like) was the main tenet of homeopathy; a system of medicine that attempts to heal patients with heavily diluted remedies and places emphasizes on never injuring a patient. Junior

⁵⁹⁶ Daniell, *Native Diseases of the Gulf of Guinea*, 44.

⁵⁹⁷ McWilliam, *Medical History of the Expedition to the Niger*, 245.

⁵⁹⁸ Clarke, “Prevailing Diseases,” 74.

⁵⁹⁹ Hutchinson, *Impressions of Western Africa*, 154.

surgeon R. A. K. Oldfield explained the dangers associated with African's faith in charms and healing amulets. In one instance he claimed to have witnessed an African woman who had so much faith in the power of her charms that she assented to have her leg hacked with an axe. Oldfield informed his reader that her misguided trust in the power of amulets cost this poor women her leg.⁶⁰⁰

Physicians emphasized the threat that African therapeutics posed to Africans and the future of Africa, arguing that only European practitioners and therapeutics could improve Africa and the African.

British practitioners were thus placed in a difficult position. They 'knew' that the medicine offered by dressers and African practitioners was substandard and even dangerous but due to the dearth of British medical practitioners could not attend to all their medical responsibilities. This mirrors the present-day situation where numerous African governments recognize herbal traditions as an important part of their heritage, but still desire to replace popular healers with biomedicine. However, if they were to prosecute and close down popular healers and patients were forced to go to government hospitals and dispensaries the system could not cope.⁶⁰¹ Thus, while popular healing remains illegal in much of Africa, governments are forced to turn a blind eye because of the lack of resources.

⁶⁰⁰ Laird and Oldfield, *Narrative of An Expedition*, vol. 2, 11.

⁶⁰¹ Steven Feierman and John Janzen, "Introduction," in *The Social Basis of Health and Healing in Africa*, ed. Steven Feierman and John Janzen (Berkeley: University of California Press, 1992), 16-17.

Few commentators not associated with the medical profession took note of African medicine, but those who did offered a more positive view of African practitioners. G.A. Robertson, who published an account of his travel in West Africa in 1819, stated that:

In truth many cases which have been considered by medical Europeans as hopelessly incurable, have yielded to the humble knowledge of the native old women, who have made themselves familiarly acquainted with the virtue of herbaceous decoctions, and other curative means. The Africans seem much better acquainted with the powers of vegetable acids, than European practitioners, and frequently produce extraordinary effects in cases of putrid fevers.⁶⁰²

Robertson also noted that health would be significantly improved if a higher quality of practitioners were attracted to Africa, for in his estimation most European medical practitioners were inexperienced or inadequately educated.⁶⁰³ William Whitaker Shreeve lavished praise upon the skill of African healers.⁶⁰⁴ As will be discussed later, Shreeve's faith in African medicine prompted him, when he fell ill, to search out an African practitioner. Robert MacBrair called Africans "bad physicians" because of what he judged to be their limited knowledge; however, his account demonstrates the various abilities of African practitioners. Although he chided African practitioners for "seeming only to know the use of some sudorifics, bitters, and purgatives" he granted that "they are pretty good at

⁶⁰² G. A. Robertson, *Notes on Africa: Particularly those parts which are situated between Cape Verde and the River Congo; Containing Sketches of the Geographical Situations – the Manners Customs – the Trade, Commerce, and Manufactures – and the Government and Policy of Civilization: With Hints for the Melioration of the Whole African Population* (London: Sherwood, Neely and Jones, 1819), 21.

⁶⁰³ Robertson, *Notes on Africa*, 21.

⁶⁰⁴ Shreeve, *Sierra Leone*, 77-78.

reducing dislocations and binding up fractures.”⁶⁰⁵ MacBrair also conceded that although the African methods of bleeding and especially cupping were in his estimation rather simple, they succeed in reducing local inflammation.⁶⁰⁶ On the whole, those few commentators not associated with medicine who discussed African practitioners were impressed by or at least saw some utility in African therapeutics.

European medical practitioners criticized African healers for their lack of a scientific basis, but they recognized the value of various African remedies and were willing to employ these cures in conjunction with a European course of treatment. This is in sharp contrast to the second half of the century where British medical practitioners, more confident in their own therapeutic practices, began to ignore local remedies.⁶⁰⁷ Necessity dictated that British medical practitioners employed African remedies. Indeed, Winterbottom complained that: “The high price of Peruvian bark” and “the uncertainty of obtaining a constant and regular supply of it” combined with “the schemes of interested men to enhance its value and lower its quality, render it an object of importance for us to increase, if possible, the number of substitutes.”⁶⁰⁸ Daniell concurred with this assessment and, through his frequent interaction with native healers, found adequate

⁶⁰⁵ R. M. MacBrair, *The Africans at home being a popular description of Africa and the Africans condensed from the accounts of African travelers from the time of Mungo Park to the present day* 2nd, ed. (London: Longman, 1864), 78-79.

⁶⁰⁶ MacBrair, *The Africans at Home*, 78-79.

⁶⁰⁷ Crozier, *Practising Colonial Medicine*, 93.

⁶⁰⁸ Thomas Winterbottom, as quoted in *West African Sketches*, 19.

substitutes for quinine.⁶⁰⁹ Daniell also learned of an alleged cure for fever.

Instead of trying to cool the fever patient, healers of the Bights held the sufferer above a fire while slowly dripping water onto the fire to produce a steady steam that would aid in producing a healthy sweat. Daniell, much impressed by this approach, attempted this treatment to his satisfaction:

I have no hesitation in asserting that not only myself, but many others, who have experienced its efficacy by the speedy restoration to health, can vouch for its superiority over the ordinary practice of venesection, saline purgatives and large doses of calomel.⁶¹⁰

Clarke, so impressed with the healing properties of the bark of the Bellanda tree, shipped the bark back to England and in one notable trial carried out at the infirmary at Newcastle, displayed “with complete success” its value in combating intermittent (malarial) fever.⁶¹¹ C. A. Gordon, surgeon to the tenth Regiment of Foot stationed at Cape Coast Castle in 1857, took a keen interest in native cures and found much to praise about African practitioners’ moderation and especially their approach to fever. Gordon in one memorable passage explained the therapeutic benefits of lime sponging as a palliative for fever:

In treating febrile attacks, great attention is paid to the state of the skin, the surface being sponged [with lime juice] every morning... It is impossible for those who have not experienced, in their own persons, to understand the grateful sensation and benefit derived from this occasional sponging, with diluted lime juice, during the heat of fever, and it is no reflection upon our science to say, that when on the Gold Coast, I have frequently observed more relief, as well as comfort to the patient, to arise

⁶⁰⁹ Daniell, *Native Diseases of the Gulf of Guinea*, 128-129.

⁶¹⁰ Daniell, *Native Diseases of the Gulf of Guinea*, 120.

⁶¹¹ Collier and MacCarthy, *West African Sketches*, 19.

from being thus occasionally sponged by an old Fantee woman, than from all the remedies prescribed by the regularly educated professional man.⁶¹²

Interestingly, Gordon, who later served in Bengal, claimed to have had much success in applying this remedy while in India.⁶¹³ Gordon also placed great faith in the healing properties of African cooking, particularly nourishing broths:

In the preparation of nourishing broths, the Fantees are second to none,... and I feel certain, from personal experience, that not only does the sick and debilitated native frequently owe his recovery to this good fare, but that many an European owes his life to being well supported by this excellent compound of fowls and eggs or fish, with rice and cassada root, administered probably in opposition to the strict injunction of the white doctor, particularly of the salivating and bleeding school.⁶¹⁴

Henry Tedlie, who was part of a three man mission sent to the Ashanti in 1817, paid close attention to African therapeutics, recording the medical properties of thirty-seven different plants employed by native healers. Tedlie carried out his research while suffering from a severe bout of dysentery which claimed his life. His work was later published by his friend and fellow delegate to the Ashanti Thomas Edward Bowdich.⁶¹⁵ British physicians took an interest in African healing techniques and for the most part, when investigated, found them to be useful additions to European techniques. British practitioners were uncomfortable with the employment of charms and amulets but recognized the value of numerous traditional palliatives. It was not the remedies that engendered such

⁶¹² Gordon, "Some Observations on Medicine and Surgery," 532.

⁶¹³ Gordon, "Some Observations on Medicine and Surgery," 532.

⁶¹⁴ Gordon, "Some Observations on Medicine and Surgery," 532.

⁶¹⁵ Tedlie's account of African health and healing can be found in: T. Edward Bowdich, *Mission from Cape Coast to Ashantee* (London, 1873), 282-292. First published in London, 1824.

violent reactions from British medical practitioners but the lack of ‘science,’ the use of charms, and one suspects that African practitioners remained the first choice of African patients. Nonetheless, British medical practitioners adopted African methods and desired to incorporate them into a secular European medicine buttressed by theories of causation rooted in European medical theory.

European patients did seek out African healers. For example, William Whitaker Shreeve, who found no satisfaction with European medicine, looked towards African healers for a cure:

I was for a considerable time suffering under an acute disease of the bones, which baffled all the medical and surgical talent of the Colony; my agony was intense, and I was so reduced that one might have supposed that pain had wasted away my flesh for the special purpose of rendering the seat of disease visible. My case having been pronounced incurable in the Colony, I proceeded in a cutter to the Island of Matacong, in order to consult (as a forlorn hope) the Doctress Yimba.⁶¹⁶

Fortunately, Shreeve noted in detail the treatment he received from an African healer, who, after providing a “scientific” examination, pronounced his affliction to be rheumatism.⁶¹⁷ Shreeve’s lengthy description of his treatment emphasized the personal and attentive nature of African healing:

Her first operation was to squeeze the affected joints with all her strength, then the limbs, and tottled up the whole by pummelling my body, with the greatest local impartiality, until the cure seemed worse than the disease. She then left me, and proceeded to her dispensary, the “bush,” to cull certain medical leaves, which she pounded into a pulp, and layered over me from head to foot; this universal poultice was allowed to remain until

⁶¹⁶ Shreeve, *Sierra Leone*, 77.

⁶¹⁷ Shreeve, *Sierra Leone*, 77.

quite dry and hard, and as it fell off was replaced by fresh. This application was continued for two months, with repeated washings and drink from a decoction of wood to purify the blood. Her attention was so unremitting, that she became my nurse, and, with her two adopted children, slept in an adjoining apartment, that she might attend to my nightly wants....⁶¹⁸

After three months of treatment, Shreeve reported that he returned to his duties in perfect health. Shreeve paid twenty bars of cloth, the equivalent of about forty shillings for what he called “a perfect cure.”⁶¹⁹ He concluded his ordeal with rheumatism by stating that he “left Yimba and Matacong unexpectedly, in a canoe, instead of a coffin, and once more was ‘back to busy life again....’”⁶²⁰ Shreeve’s account suggests that in Africa, British practitioners had to compete with African therapeutic methods and healers for patients both black and white.

These sorts of medical interactions challenge the diffusionist model of knowledge expansion as advocated by Daniel Headrick and others who see knowledge predominantly moving from the West to the East.⁶²¹ Headrick, so confident in the impact of Western technology, stated: “Western industrial technology has transformed the world more than any leader, religion, revolution, or war.”⁶²² In this model, new ideas, particularly Western industrial technology, developed in the West, acted as ‘tools of empire’ that overwhelmed and displaced

⁶¹⁸ Shreeve, *Sierra Leone*, 77.

⁶¹⁹ Shreeve, *Sierra Leone*, 77.

⁶²⁰ Shreeve, *Sierra Leone*, 78.

⁶²¹ Headrick explains how European technology facilitated European imperialism, *Tools of Empire*, *passim*. Pages 58-82 deal exclusively with West Africa. For ideologies of Western dominance see Adas, *Machines as the Measures of Men*, *passim*.

⁶²² Headrick, *Tools of Empire*, 4.

‘traditional’ practices.⁶²³ The diffusionist model relegates the periphery to a largely insignificant and static place that requires outside ideas to achieve change. The experience of C. A. Gordon and other practitioners challenge this model, showing that information flowed in many directions.⁶²⁴ New knowledge was not exclusively transferred in linear patterns to and from centre and periphery but could take more unpredictable routes through the empire. Alan Lester employs the concept of imperial networks to explain the connection between metropole and periphery. For Lester, these networks tied the empire and periphery together and were mutually reinforcing. Indeed, networks helped to create an imperial world that could be viewed as a seamless whole.⁶²⁵ His emphasis on the creation of ideas and the interaction between the metropole and British colonies adds to the understanding of relationships within an empire. While information engendered in both the metropole and the periphery flowed in multiple directions it is important to realize that barriers to transmission did exist.

Mark Harrison in a study of Dr Helenus Scott, a British physician in India who championed nitric acid as a tropical remedy, explained the importance of networks - medical, patronage, and professional - in ensuring that ideas from the periphery received full consideration in the metropole.⁶²⁶ For Harrison, without strong connections important information gained in the colonies could be

⁶²³ Headrick, *Tools of Empire*, 4.

⁶²⁴ Gordon, “Some Observations on Medicine and Surgery,” 532.

⁶²⁵ Lester, *Imperial Networks*, *passim*.

⁶²⁶ The importance of patronage system in disseminating knowledge is explored in Laidlaw, *Colonial Connections*, *passim*.

ignored.⁶²⁷ On the whole, medical techniques learned in Africa had little impact upon the practice of medicine at home and in the empire. While some practitioners, such as Clarke and Gordon brought new techniques home and to new foreign postings the medical knowledge gained in Africa was largely ignored. Africa did serve as a testing ground for already known cures and played an important role in confirming the value of quinine.

Conclusions

Medical practitioners depicted themselves as important agents of change, risking their lives to help rehabilitate West Africa after years of depopulation caused by the slave trade. For a variety of reasons, the British colonial administration and its medical practitioners failed to implement a fully functional system of medicine that significantly improved the health of Africans. This failure became well known as important officials, including Lieutenant Governor George Rendell of the Gambia, complained in 1829 that one of the main reasons liberated Africans proved so unproductive was their poor health.⁶²⁸ By emphasizing the future, medical practitioners drew attention away from the realities of European medicine in early nineteenth century Africa. Europeans could dream of a healthy and productive Africa but during the first half of the century accomplishments were limited. Instead, the system of medicine that developed in Africa was defined by compromise and shortages. The British

⁶²⁷ Mark Harrison, "Medical experimentation in British India: the case of Dr Helenus Scott" in *The Development of Modern Medicine in Non-Western Countries*, ed. Hormoz Ebrahimnejad (London: Routledge, 2009), 23-41.

⁶²⁸ National Archives, CO 87/2 F 22: George Rendall to Robert William Hay, Bathurst, 28 September 1829.

adapted to the situation as best they could by utilizing African agents and adopting African healing techniques and important substitutes for European medicines.

British medical practitioners felt that they should have played a larger role in the health of liberated Africans. Medical practitioners lamented that liberated Africans avoided care, but the constantly stretched medical system could not have dealt with a general population seeking out European care. Liberated Africans were contrasted with native Africans, who did solicit care. No medical practitioner considered, at least in print, that the difference between the observed reactions of native and liberated Africans to European medicine did not lie in the Africans themselves but in how they viewed the hospital. It may be that liberated Africans disliked the idea of leaving their new communities, and having to travel while ill to Kissy Hospital and it is these issues, not biomedicine as a whole, that encouraged liberated Africans to avoid care. The medical system was very limited and British medical practitioners were, according to their own accounts, largely unsuccessful in convincing Africans of the benefits of European medicine.

Chapter Five

Health and the Armed Forces: African and European Health in the West African Squadron

The themes of health, illness, and treatment for Africans who served the British navy and army are important ones. This chapter primarily evaluates the health of African and European sailors who served in the British Navy in West Africa up to 1861. The area of focus is the West African station, a three-thousand mile expanse that reached from Cape Verde in the north to Cape Frio in the south. It examines morbidity and mortality rates and how British naval surgeons' tended to the health concerns of African personnel. A major question is whether naval surgeons provided African and European personnel suffering from similar ailments with the same forms of treatment. Answering this question will provide insight into the degree to which medicine in British West Africa may have been racialized.

Currently, historians know exceptionally little about the health experiences of African and European sailors who served in the British Navy in West Africa during the nineteenth century. Parliamentary reports and published first-hand accounts from naval surgeons, especially Alexander Bryson and Morris Pritchett, make it clear that service in the West African Station proved to be extremely dangerous for 'unacclimatized' European bodies. These sources illuminate

European sailors' fears of the region's fevers.⁶²⁹ Scholarly interest in the West African Station has been confined to the politics and processes of slave trade suppression and, if these studies do mention health, they echo the opinions of the likes of Bryson and Pritchett without development or context.⁶³⁰ The scholarship pertaining to the health of Africans on board European vessels begins and ends with the enslaved, for while historians have examined the health of Africans jammed into slave ships, they have ignored the health experiences of the free Africans who took employment on board British vessels.⁶³¹ This chapter will correct this deficiency through a comparison of the health of African and European sailors serving on the West African Station. Comparison will allow for an examination of British naval medicine in Africa, in order to provide insight into the degree to which, if any, naval medicine was racialized in the early nineteenth-century. This information will expose how Britons perceived, understood, and in a practical sense dealt with the African body.

In 1807, after years of debate, the British Parliament outlawed the Atlantic slave trade. Although the degrees to which humanitarianism, economic self-interest, and political expediency influenced this decision are widely debated, the

⁶²⁹ For example: British Parliamentary Papers, *Select Committee on West Coast of Africa, Report*, 1842 (551-II), appendix 423-430; Bryson, *Diseases of the African Station*; Pritchett, *Some Account of the African Remittent Fever*.

⁶³⁰ Studies that examine the practice of slave trade suppression include: Mathieson, *British Slavery and Its Abolition* and *Great Britain and the Slave Trade*; Lloyd, *The Navy and the Slave Trade*; Temperley, *British Antislavery*; LeVeen, *British Slave Trade Suppression Policies*; W.E.F. Ward, *The Royal Navy and the Slavers*; Kielstra, *Slave Trade Suppression in Britain and France*.

⁶³¹ There are a number of publications that focus upon the topic of slave mortality at sea. These include: Cohn, "Maritime Mortality," 159-234; Riley, "Mortality on Long-Distance Voyages," 651-6; Klein et al., "Maritime Mortality," 159-191 and Herbert Klein, *The Atlantic Slave Trade* (Cambridge: Cambridge University Press, 1999).

fact remains that in 1807 the British government had pledged itself to the prevention of this ‘notorious trade.’⁶³² The abolition of the British slave trade engendered a sixty-year campaign in which the British government wrestled with the realities of ending a lucrative and multinational trade. For sailors of the Royal Navy, this meant risking their lives in the dangerous and often fruitless work of policing the fever-stricken West African coasts in an attempt to block the transportation of enslaved Africans. In 1808, the West African Station was patrolled by only two naval vessels; however, over time the British dedicated more and more resources to the Station and by 1847 it had some thirty vessels in regular service.⁶³³ It is not normally recognized that this arduous and unpleasant work was carried out by not only Europeans but also by African personnel, hired to engage in work considered too dangerous to the health of Europeans,⁶³⁴ and to fill gaps in the ships’ complements caused by death and disease. The West African Station was judged to have the worst mortality and morbidity rates of the entire nineteenth-century British Navy.⁶³⁵ African and Europeans served on the same ships, and received medical care from the same personnel. Hence this station serves as an ideal location for an in-depth comparison of the health

⁶³² Influential works include: Clarkson, *The Abolition of the African Slave Trade*; Coupland, *The British Anti-Slavery Movement*; Williams, *Slavery and Capitalism*; Roger Anstey, *The Atlantic Slave Trade*; David Brian Davis, *The Problem of Slavery in the Age of Revolution, 1770-1823* (Ithaca: Cornell University Press, 1975); Seymour Drescher, *Econocide: British Slavery in the Era of Abolition* (Pittsburgh: University of Pittsburgh Press, 1977); Drescher, *Capitalism and Anti-Slavery*; David Eltis, *Economic Growth and the Ending of the Atlantic Slave Trade* (Oxford: Oxford University Press, 1987); Eltis, “Europeans and the Rise and Fall of African Slavery,” 1399-1423.

⁶³³ Lloyd, *Medicine and the Navy*, vol. 4, 61; 282.

⁶³⁴ National Archives, ADM 101/132: C. Keenan, Medical Journal of HMS *Ranger*, 1 January 1861 to 31 December 1861.

⁶³⁵ Bryson, *Diseases of the African Station*, 177.

experiences and health care of African and European personnel over the four decades from 1825 (the date of the first surviving medical records) to 1861.

This investigation is divided into four parts. The first describes the sources used, explains the methodology, clarifies terms and descriptors, and provides other contextual information. It includes the categories of naval personnel and their duties, and the medical landscape and options available to ships' surgeons. The second section establishes the mortality rates of European and African sailors employed in the West African Station. This data is compared to the West African military returns prepared by Major Alexander Tulloch and later analyzed by Philip Curtin.⁶³⁶ The comparison contributes to the wider historiography on naval and military health, for few studies have compared the health experiences of soldiers to those of sailors in the same foreign posting. The second section investigates the role of tropical fevers in producing a high European mortality rate, while describing the steps taken by surgeons to reduce this threat. The third section establishes the morbidity rates of African and European sailors. It explores whether Africans and Europeans suffered from different ailments, and how long it took for African and European bodies to recover from illness or injury and return to duty. The final section compares the treatment methods employed by European surgeons, on African and Europeans.

⁶³⁶ Alexander Tulloch, *Statistical Reports on the Sickness, Mortality, & Invaliding, Among the Troops in Western Africa, St. Helena, The Cape of Good Hope, and Mauritius* (London, 1840). The two best examples of Curtin's use of these statistics are found in the companion articles, Curtin, "The White Man's Grave," and Curtin, "The End of the 'White Man's Grave'?"

This provides the first, and best, analysis of the degree to which naval medicine may have been racialized in the first half of the nineteenth century.

Sources, Methodology, and Categories of Personnel

The primary data employed in this analysis is derived from medical journals of eight Royal Navy ships whose dates of service ranged from 1831 to 1861. These comprise all such records for the West African Station between 1800 and 1861 extant in the National Archives. Medical journals provide each patient's name, age, and 'quality.' Contained within medical journals are sick lists. These provide information on health complaints, and the dates when a patient was placed on, and discharged from care. The reason for the discharge is also provided: sent to hospital for further care; returned to duty; invalided home; or dead. Ships' logs present information on the size of the ship's complement, location of vessel, and important events (such as going ashore or engagement with slavers). Muster records provide a physical description of each member of a ship's complement and information about age and experience. The total number of morbidity cases in this data set is 1,961. It is possible to determine comparative morbidity and mortality rates of European and African sailors, the susceptibility of Europeans and Africans to different diseases (in so far as these were labeled by the imprecise knowledge of the time), and the duration of treatment. The extant ship records in the British National Archives also contain some medical journals that provide insight into the treatment of African and European patients. These accounts are buttressed by quarterly and annual reports

from a military hospital in Sierra Leone that, on occasion, treated Royal Navy personnel. On the whole the medical journals from both ships' surgeons and military surgeons who came into contact with Royal Navy personnel are valuable, but surgeons in their extant reports tended to emphasize the sensational, spilling little ink over everyday health complaints. Since African mortality proved so low and Africans for the most part avoided the fevers that often afflicted Europeans, Africans do not feature prominently in these medical summaries. Nonetheless, the limited descriptions of African patients and their interaction with European surgeons, do provide the opportunity to examine and compare the treatment methods received by both European and African sailors.

The ships' records that survived did so for particular reasons. Thus, the cases that they cover should be thought of as suggestive of treatment regimens rather than representative. Two of the eight surviving medical journals, for HMS *Aetna* (1837-38) and HMSS *Trident* (1858-59), probably survived because both these ships experienced outbreaks of yellow fever. Yellow fever terrorized the West African Fleet, and naval officials and medical authorities were anxious to study outbreaks in hopes of learning more about the epidemiology of this disease.⁶³⁷ The medical journals of HMS *Arrogant* (1860-61) and HMSS *Wilberforce* (1840-42) appear to have survived because of their vessels'

⁶³⁷ William Coleman, *Yellow Fever and the North: The Methods of Epidemiology* (Wisconsin: University of Wisconsin Press, 1987); James Ormiston McWilliam, *Dr. McWilliam's remarks on Dr. King's "Report on the fever at Boa Vista"* (London, 1848); Bryson, *Diseases of the African Station*; Gilbert King, *The fever at Boa Vista in 1845-6 unconnected with the visit of the "Éclair"* (London, 1852); Sir William Pym, *Observations upon Bulma, Vomito-Negro, or Yellow Fever, with a review of "A report upon the disease of the African coast, by Sir William Burnett and Dr. Bryson"* (London: Henry Renshaw, 1848).

involvement in important naval activities. HMS *Arrogant* was involved in the famous attack on Porto Novo, believed to be one of the last bastions of West African slavery.⁶³⁸ During this action numerous members of the ship's complement were injured and the medical journal abounds with cases of gunshot wounds.⁶³⁹ HMSS *Wilberforce* also was expected to play a major role in anti-slavery, serving as part of the 1841 Niger Expedition, commissioned to transverse the Niger and encourage Christianity and 'legitimate' trade in the heart of Africa.⁶⁴⁰ The voyage was endangered from the very beginning as sickness, especially fevers, caused 85.1% of all Europeans on board to be placed on the sick list. The high mortality rate of 265 per thousand serves as a grim reminder of the European vulnerability to the West African disease environment in the first half of nineteenth century.⁶⁴¹ For the other four medical journals there is no discernable reason why they survived; these ships were not involved in notable naval activities. Most of the medical records for the Royal Navy during the first half of the nineteenth century are not extant, and the West African Squadron is not unusual in this respect. Extensive culling took place, possibly at different times and not necessarily for identical reasons. The surviving documentation is considered in this study to be strongly suggestive of health and health care trends

⁶³⁸ Lloyd, *The Navy and Slave Trade*, 160-161.

⁶³⁹ National Archives, ADM 101/130: Medical Journal of HMS *Arrogant*, 30 August 1860 to 31 August 1861.

⁶⁴⁰ Temperley, *White Dreams, Black Africa*.

⁶⁴¹ The morbidity rate of 85.1% is calculated from: National Archives, ADM 101/127/3: Medical Journal of HMSS *Wilberforce*, 14 November 1840 to 14 September 1842. The mortality rates is extracted from the British Parliamentary Papers, *Papers relative to Expedition to River Niger*, 1843 [472], 54.

during the decades of the 1830s, 40s, and 50s, and of significant value for an examination of European and African naval health experiences for the period overall.

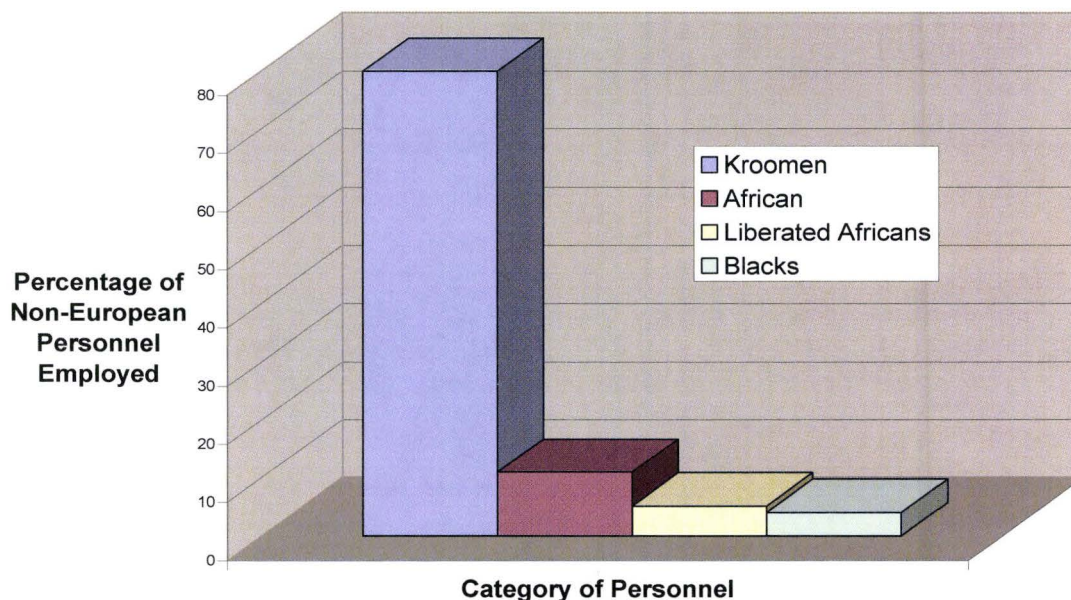
Four categories were employed to describe and to differentiate the African work force on the West African Station. These four categories were: Kroomen; liberated Africans (both boys and men); Africans; and Blacks. The first and most numerous of hired Africans were Kroomen (or Krumen), a people who originated in what is today eastern Liberia and actively sought employment upon European vessels as qualified seaman. Liberated African was a term employed by the British to describe any African who had been rescued from a slaver and ‘repatriated’ to Africa. African was a term used by the Admiralty to describe any African serving in the station who was neither a Kroomen nor a liberated African. Blacks referred to sailors of African descent, who had been born, or at the time of recruitment, were living, outside of Africa. Blacks were only employed on one ship under study, HMSS *Wilberforce*.

This study uses these four categories in the analysis of African health experiences. To these four categories I have added that of European. Europeans are distinguished from Africans in the medical journals, for under quality European sailors had their rank or occupational status recorded while African sailors had only their classification (i.e. Kroomen or liberated African) specified. European is used as a general description for Europeans and those of European descent. For the purposes of this investigation it was not necessary to inquire into

the origins of the European personnel, but, as a general observation, the substantial majority had been born within England, Wales, Scotland, and Ireland. The term African is used in two ways: the Admiralty classification (always clearly specified below); and by this author as the standard way of describing all Africans, regardless of designation, who appear in this thesis. 'Blacks' are not included by this author in the general category of 'African' as they were not born in nor did they reside in Africa.

Europeans comprised 79% of all ship board personnel on the eight ships: Africans and Blacks made up the remaining 21%. The numbers of shipboard personnel are: European 1001; Africans 265; Blacks 11 (see Appendix 1.1). The 220 hired Kroomen comprised 80% of all non-Europeans. African was the next most common designation with 31 hired, comprising 10.9% of all hired Africans and Blacks. There were fourteen liberated Africans in the records of the ships surveyed (5.1% of hired Africans and Blacks). Only two of these sailors were adults; the other twelve were recorded as being liberated African boys. Eleven Blacks served upon HMSS Wilberforce; they comprised 4% of all non-European personnel on board the ships surveyed.

**Graph 1.1 Distribution of Non-European Personnel
Hired for Service, 1831-1861⁶⁴²**



The Royal Navy was particular in the Africans it employed and, as the numbers demonstrate, preferred Kroomen to all others. Kroomen originated in what is today eastern Liberia and, according to nineteenth-century commentators, lived along the coast between Cape Mount and Cape Palmas.⁶⁴³ Kroomen were well aware that the British believed them to be expert seafarers and eagerly propagated the myth that they alone among the African peoples were ‘naturally’

⁶⁴² National Archives, ADM 101/81/2: Medical Journal of HMS *Aetna*, 4 October 1837 to 13 November 1838; N.A., ADM 101/130, Medical Journal of HMS *Arrogant*; National Archives, ADM 101/88/3: Medical Journal of HMS *Atholl*, 2 September 1831 to 21 February 1832; N.A., ADM 101/132: Medical Journal of HMS *Ranger*; National Archives, ADM 101/116/4: Medical Journal of HMS *Rapid*, 2 January 1846 to 2 January 1847; National Archives, ADM 101/120/1: Medical Journal of the HMS *Scout*, 25 November 1837 to 12 June 1838; National Archives, ADM 101/129: Medical Journal of HMSS *Trident*, 28 June 1858 to 17 July 1859; N.A., ADM 101/127/3: Medical Journal of HMSS *Wilberforce*.

⁶⁴³ Collier and MacCarthy, *West African Sketches*, 85.

suited for seafaring.⁶⁴⁴ Kroomen were also popular with the Navy because they did little to resist British culture or customs and were willing, for the most part, to assume British cultural norms.⁶⁴⁵ This willingness to adopt European habits extended to adopting 'English' names. Kroomen selected or accepted outrageous and whimsical names including; "Prince of Wales" and "Bottle of Beer."⁶⁴⁶ Kroomen who served upon a Royal Navy vessel placed themselves under the authority of a single Headman.⁶⁴⁷ The Headman had authority over all his Kroomen, acting as a mediator between British officers and his Kroo. In return, the Headman took a portion of each Krooman's salary.⁶⁴⁸ The British accepted this effective chain-of-command as superior to the haphazard recruitment and instruction of a variety of unattached individuals not under the supervision and authority of a single African leader.⁶⁴⁹

Kroomen were transient labour. They came to Sierra Leone without their wives or children and had no interest in permanently settling in the colony, working (the British thought) only until their material needs were covered.⁶⁵⁰ Moving back and forth from home and Sierra Leone was the norm, with more

⁶⁴⁴ Diana Frost, "Diasporan West African Communities: The Kru in Freetown & Liverpool," in *Review of African Political Economy* 29, No. 92 (June, 2002): 288-289.

⁶⁴⁵ One significant exception to the willingness of Kroomen to assimilate was their disregard and disinterest in Christianity: George Brooks, *The Kru Mariner in the Nineteenth-Century* (Bloomington: Indiana University Press, 1971), 7; National Archives, CO 267/160 fo.51: Richard Doherty to John Russell, Earl Russell, Sierra Leone, 7 Oct 1840.

⁶⁴⁶ Prince of Wales served on HMSS *Wilberforce* and HMS *Rapid*. The name Bottle of Beer appeared in the records of HMSS *Wilberforce*, HMS *Rapid*, HMSS *Trident*, and HMS *Aetna*.

⁶⁴⁷ Brooks, *The Kru Mariner*, 9.

⁶⁴⁸ Brooks, *The Kru Mariner*, 9-10.

⁶⁴⁹ British Parliamentary Papers, *West Coast of Africa*, 1842 (551) (551-II), 239.

⁶⁵⁰ Coke, *Narrative of a Mission*, 45.

experienced Kroomen setting themselves up as Headmen.⁶⁵¹ The transient nature of Kroomen made them ideal employees for the Royal Navy who were provided with a steady stream of labour that wanted employment while asking for little other benefits.

Numerous British commentators praised Kroomen as the most reliable, loyal, and intelligent of all Africans. For example, after having examined the skulls of thirty or more Kroomen, Dr. Graham Miller, an assistant surgeon on the surveying vessel HMS *Alma* for the years 1830 and 1831, came to the conclusion that Kroomen have “considerable mental endowments” and were “morally and intellectually superior to the natives.”⁶⁵² According to the physician James Boyle, Kroomen were not only intellectually superior, but due to their hardy and powerful physiques, were also the healthiest of all West Africans.⁶⁵³ Britons believed Kroos to be a fiercely independent people, who successfully resisted being enslaved while ardently refusing to enslave others.⁶⁵⁴ According to Esu Biyi:

No Kru man or women, is known to have been a slave. Any slave, owned by them, whether purchased or kidnapped, on being initiated into the customs of the tribe and tattooed, was thenceforward free and could not be sold.⁶⁵⁵

⁶⁵¹ Coke, *Narrative of a Mission*, 45.

⁶⁵² National Archives, ADM 105/92: Dr. Graham Miller, Journal of HMS *Alma*, December 1830 to July 1831.

⁶⁵³ Boyle, *A Practical Medico-Historical Account*, 34-35.

⁶⁵⁴ Elizabeth Helen Melville, *A Residence at Sierra Leone* (London: John Murray, 1849), 276.

⁶⁵⁵ Esu Biyi, “The Kru and Related Peoples, West Africa. Part 1,” in *Journal of the Royal African Society*, 29, No. 113 (Oct, 1929): 71.

Kroomen were cast as African allies willing to fight against the evils of slavery. On surveying the perceptions of a variety of Britons towards Kroomen, it is clear that Kroomen were the ideal Africans, perceived to be physically strong and fiercely independent; yet they were submissive enough to follow the directions of the British and their Headman. On the whole, it is clear that Kroomen served both the practical and even psychological needs of the British, and thus, it is not surprising that they were the preferred local labour force for the Navy.

Muster records reveal that most of the African personnel was hired in Freetown. Kroomen looking for hire would leave their families, travel to Freetown and wait to be hired.⁶⁵⁶ Kroomen carried British-issued identification cards which recorded their employment histories.⁶⁵⁷ Most other Africans were also primarily hired out of Freetown, but less is known about the processes through which they joined the ships. It appears that many were well known to the British. What is clear is the centrality of Freetown in supplying the extra labour necessary to sustain the West African Station. The Freetown labour market attracted sailors and this kept down the costs of recruitment.

Once African personnel were hired for naval duty, they were expected to engage in a variety of low status jobs. Kroomen were viewed as an auxiliary labour force responsible for engaging in the most labour-intensive jobs, including going ashore to acquire fresh water and cutting fire wood.⁶⁵⁸ Kroomen, thus,

⁶⁵⁶ Brooks, *The Kru Mariner*, 9.

⁶⁵⁷ Brooks, *The Kru Mariner*, 11.

⁶⁵⁸ Brooks, *The Kru Mariner*, 14; N.A., ADM 101/132; C. Keenan, Medical Journal of HMS *Ranger*.

comprised a versatile labour force employed on ship and shore. Kroomen, for the most part, had no stated status, quality, or rank on board ship except that of being a Kroomen. There were exceptions to this, for example, Prince of Wales who, while serving on HMS *Scout* in 1837, held the position of general room cook. The Admiralty also used those classified as ‘Africans’ as a utilitarian labour force; however, the scant evidence suggests that these Africans did have more defined roles as members of the ships’ crews.

One of the most common jobs for hired ‘Africans’ was that of ship’s steward. The steward was responsible for the preparation of and cleaning up after meals. After the advent of the steam-powered ship, Africans often served as stokers, responsible for stoking the coal fires. This was a labour intensive, low status, extremely uncomfortable and sometimes dangerous position. For the ships examined the overwhelming majority of Admiralty designated Africans and Kroomen occupied the lowest employment classifications. However, some did have opportunities for advancement. Jake Campbell, who served on HMSS *Trident* in 1859, was able to capitalize on the illness of the ship’s engineering staff and was promoted to the rank of engineer. This implies knowledge of the workings of European steam ships. On the whole, ‘Africans’ were more likely to be listed as members of the ships’ complement than Kroomen. When Europeans became too ill to fill their duties, it was not Kroomen who were assigned to take over their posts but those classed as Africans. This suggests that the British perceived the employment responsibilities and capabilities of Kroomen and

Africans differently. It may also suggest that Kroomen were seen more collectively, that is as members of a team serving under a Headman, whereas Africans entered the ship's books as individuals and, thus, may have been selected for skills which were seen as better placed for advancement. Language skills may also have been a factor. Despite Britons' praise of Kroomen's intelligence,⁶⁵⁹ they were reserved for the more menial and labour intensive tasks, whereas when opportunities for advancement were opened up by death or incapacity, other Africans were more likely to be promoted than their Kroo counterparts.

Naval surgeons had three official means of dealing with incapacitated personnel. They could discharge the patient to a hospital for further care, they could declare the patient invalided, and arrange transport home, or they could complete treatment on board. Surgeons on the West African Station rarely ordered a patient to hospital for further care. Apart from the sailors quarantined from the HMSS *Trident*, at Ascension Hospital in June 1859, only 3% of all sick Europeans and 1.4% of hired Africans were discharged to a hospital for further care. The reason for this is hard to determine, but it was probably a product of surgeons' belief in their own abilities and also the result of simple logistics. Ships were often far away from a hospital and, consequently, no matter whether the surgeon thought the patient warranted hospital care, this form of treatment was not always immediately available. Only one hospital, on Ascension Island far to

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N.A., ADM 105/92: Miller, Journal of HMS *Alma*; Boyle, *A Practical Medico-Historical Account*, 34-35.

the south of Sierra Leone was of much value to the Navy. Ascension Island, located 1600 km off the coast of Africa, was the major supply depot and sanatorium for the sailors of the West African Station. In addition, the Royal Navy occasionally utilized the colonial Kissy Hospital located in Freetown and the army's Garrison Hospital in the Gambia. Although these two hospitals were willing to accept and treat patients for the Royal Navy, they were not set up for this sort of care. The logistical difficulty of discharging a patient to hospital for further care is reflected in the records, for it was common to have someone on the sick list for over two months before being discharged to a hospital. For example, Thomas Strong and John Wright after sustaining gunshot wounds on 21 February 1861 remained on the sick list for 119 days until 20 June 1861 when HMS *Arrogant* finally docked near a hospital.⁶⁶⁰

The practice of invaliding home was pursued even less than discharging patients to a hospital. Only around 1% of all European morbidity cases resulted in the patient being invalided, while not a single hired African was invalided. Few hospital records exist and it is impossible to know how often these institutions ordered home naval patients who had previously been placed in their care. However, the infrequent use of hospitalization meant that the numbers could not have been substantial. Naval surgeons on the West African Station primarily handled the medical needs of their crews on board. This was true for the great majority of European, and virtually all African, labour.

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N.A., ADM 101/130, Medical Journal of HMS *Arrogant*.

Mortality

The Royal Navy's reliance upon African labour was partly a consequence of the disease environment. For, in the first half of the nineteenth century, the West African Station proved more deadly than any of the Navy's other foreign stations.⁶⁶¹ Those who survived long enough to formulate an opinion of the climate agreed with Dr. Bryson, who called service in the West African Station "the most disagreeable, arduous and unhealthy service that falls to the lot of British officers and seaman."⁶⁶² Bryson was well equipped to make an assessment; he served for nine years as a surgeon in West Africa and published the standard analysis of the 'healthiness' of the Station. This work, *Report on the Climate and Principal Disease of the African Station*, examined the mortality rates of sailors serving in the British Navy over a twenty-year period beginning in 1825. Bryson demonstrated that the West African Station was by far the most deadly station and that it earned this reputation by a considerable margin. Its mortality rate per thousand from disease was 54.4 per thousand or three times that of the West Indian Station, which possessed an average mortality rate of 18.1 per thousand.⁶⁶³ Bryson calculated the mortality per thousand from all causes (diseases and accidents) in the West African Station to be 64.9.⁶⁶⁴ The reason that the West African environment proved so hostile to European bodies was the high incidence of endemic and epidemic fevers, for which most of the naval work force

⁶⁶¹ Bryson, *Diseases of the African Station*, 177.

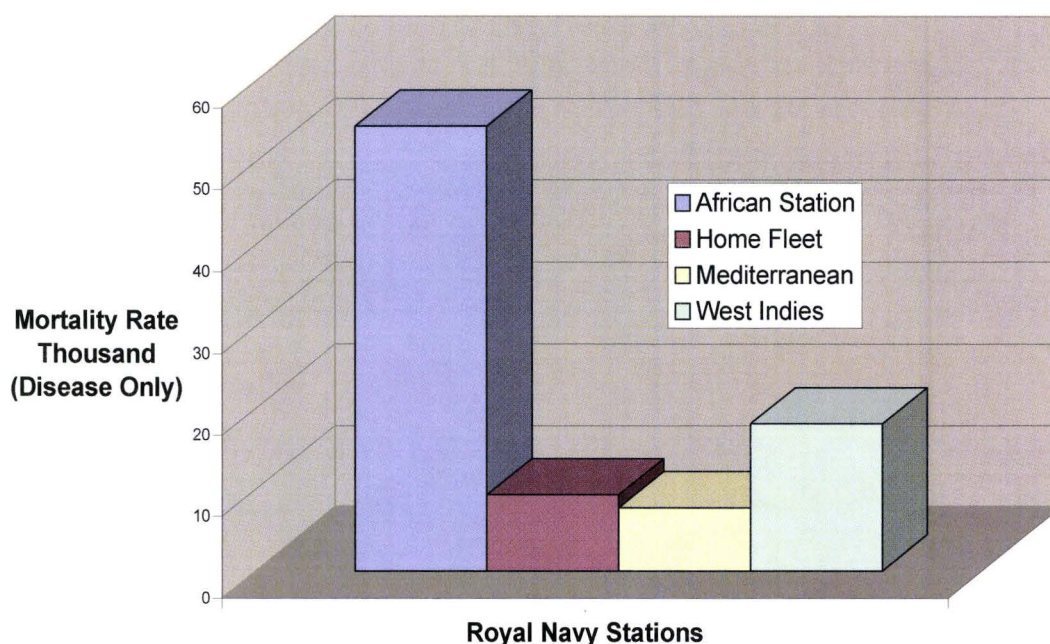
⁶⁶² Bryson, *Diseases of the African Station*, 166.

⁶⁶³ Bryson, *Diseases of the African Station*, 177.

⁶⁶⁴ Bryson, *Diseases of the African Station*, 177.

had little or no resistance. The existence of endemic malaria and epidemic yellow fever, in particular, combined to make the West Africa Station the most deadly posting in the whole of the Royal Navy.

Graph 1.2 Average Rate of Royal Navy Mortality from Disease on Select Stations, 1825-1845⁶⁶⁵



Bryson's statistics covered the period 1825-1845. Records extant for the eight ships studied for the period 1831-1861 reveal an overall mortality rate of 43.9 per thousand for the whole ships' complements, and 56 per thousand for Europeans.⁶⁶⁶ This lower mortality than the 64.9 per thousand calculated by Bryson is perhaps explicable because in the 1840s naval surgeons abandoned

⁶⁶⁵ Bryson, *Diseases of the African Station*, 177.

⁶⁶⁶ Calculated from the sources identified in Graph 1.1. Mortality per thousand is calculated by taking the number of deceased members of a ship's crew dividing this number by the total number of men and then multiplying by a thousand. Average mortality is calculated in the same way except those deceased are divided by the total mean force for a given period.

bleeding as their primary method of treatment and began to adopt instead quinine as both a preventative and specific for fever.⁶⁶⁷ These changes appear to have had a positive effect on the mortality rate. The application of quinine significantly reduced the mortality from malaria,⁶⁶⁸ while surgeons were no longer needlessly weakening their patients by bleeding, thus, giving them a better chance of recovery. Given that this was the deadliest station, an average yearly loss of less than five out of each hundred lives for the eight ships surveyed appears to be rather low when one considers how deadly the West African environment was for European soldiers. For the period 1819-1836, the mortality rate amongst European troops in Sierra Leone was 483 per thousand.⁶⁶⁹ Although a comparison for the same years and exact locales is not possible, the European mortality on board HMS *Atholl* (1831-32), HMS *Aetna* (1837-38) and HMS *Scout* (1837-38) can provide an interesting comparison. Despite the fact that the HMS *Aetna* had experienced an outbreak of yellow fever, the three ships had a combined average mortality of 65.3 per thousand,⁶⁷⁰ approximately one eighth the mortality rate experienced by soldiers (and almost identical for the twenty-year average up to 1845 produced by Bryson). There was a significant difference between sailing the West African coast and serving out one's duty in West Africa.

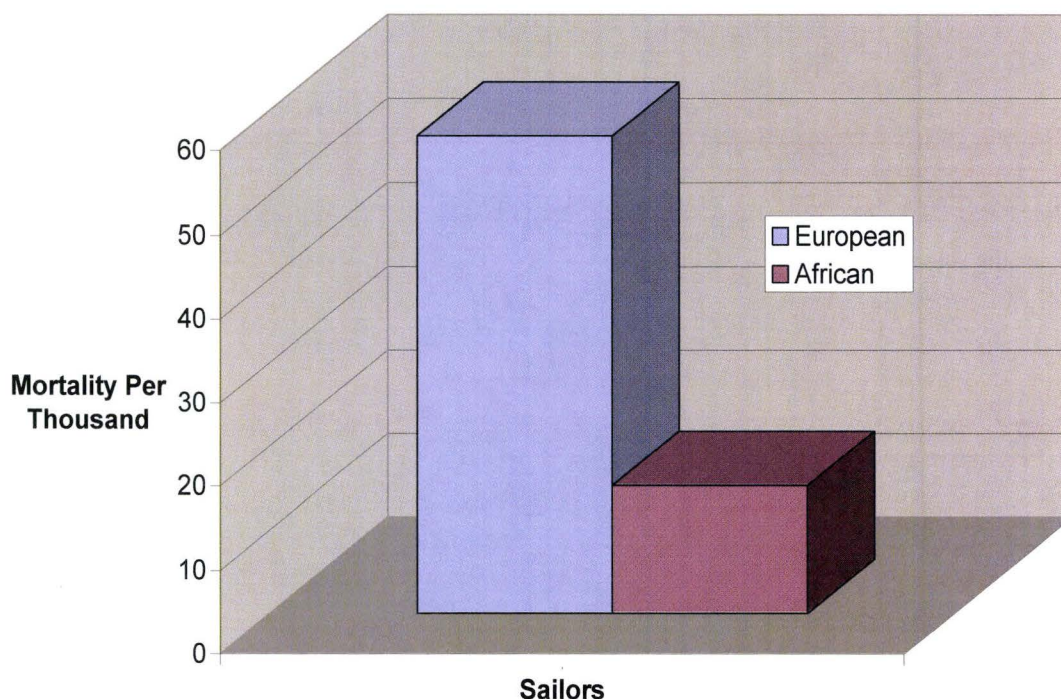
⁶⁶⁷ Curtin, "The White Man's Grave," 106-110.

⁶⁶⁸ Curtin, "End of the 'White Man's Grave'?", 74.

⁶⁶⁹ Curtin, *Death by Migration*, Table 1.1, 7-8.

⁶⁷⁰ Calculated from: N.A., ADM 101/88/3: Medical Journal of HMS *Atholl*; N.A., ADM 101/81/2: Medical Journal of HMS *Aetna*; N.A., ADM 101/120/1: Medical Journal of the HMS *Scout*.

Graph 1.3 Mortality Rate of Naval Personnel Per Thousand for the Eight Ships Surveyed, 1831-1861.⁶⁷¹



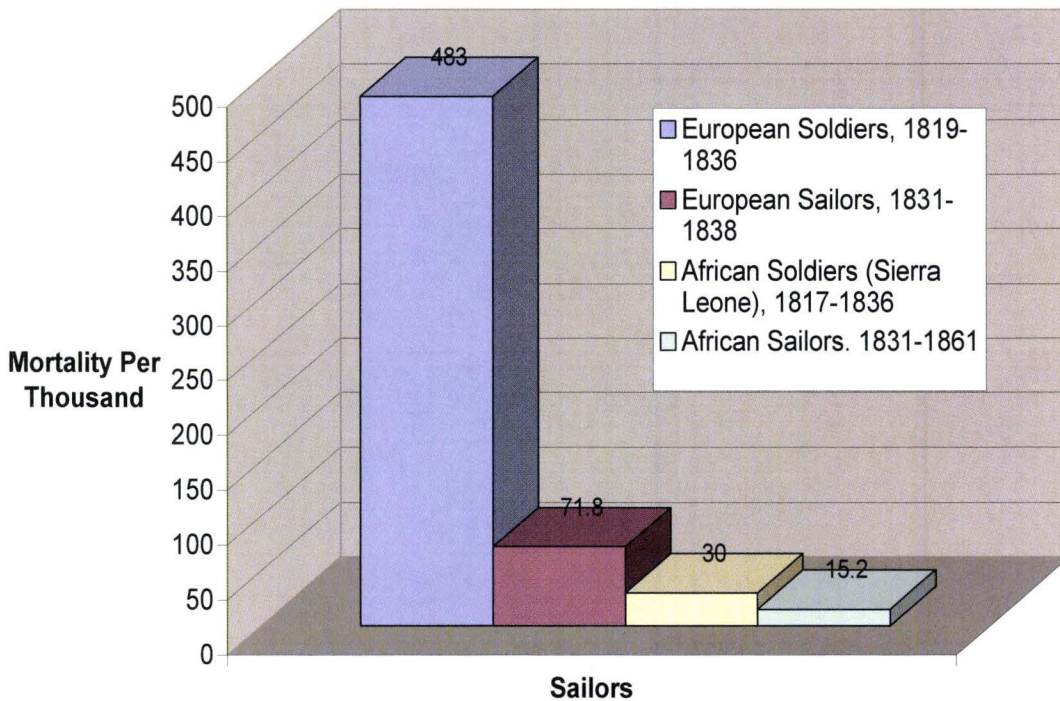
Mortality amongst Africans serving on the naval patrols of West Africa was very low. On the eight ships under examination, Africans accounted for 21% of the labour force but only 6.6% of the deaths. The causes of the four deaths involved were recorded as an abscess, pericarditis, heart clot and apoplexy.⁶⁷² This low mortality demonstrates the utility of these hired Africans. Europeans comprised 79% of all personnel, and accounted for 93.4% of the total mortality. This provides insight into the importance of African labour in sustaining the West

⁶⁷¹ Calculated from the sources listed in Graph 1.1.

⁶⁷² Pericarditis is inflammation of the membrane that surrounds the heart. This membrane, known as the Pericardium is responsible for protecting the heart and inflammation of this thin layer of tissue can cause major complications including heart attack. Apoplexy was used to describe uncontrolled bleeding of the internal organs including the brain. It was often also used as a synonym for a stroke.

African Station, although to date the labours of Africans in suppressing the slave trade has been virtually ignored.

Graph 1.4 African and European Naval and Military Mortality⁶⁷³



The mortality rate for Africans serving in the British Navy can be compared with the mortality rates for African soldiers serving in West Africa. For the years 1817-1836, African soldiers serving in Sierra Leone died at a rate of 30 per thousand,⁶⁷⁴ compared to African sailors who between 1831 and 1861 died at a rate of 15.2 per thousand. For a direct comparison using the three ships that served in the 1830s [HMS *Atholl* (1831-32), HMS *Aetna* (1837-38) and HMS

⁶⁷³ Curtin, "African Health at Home and Abroad," 371-72; Curtin, "End of the 'White Man's Grave'?", 65. Also calculated from sources listed in Graph 1.1.

⁶⁷⁴ Curtin, "African Health at Home and Abroad," 371-372.

Scout (1837-38)] not a single African of the seventy-eight who served on these vessels died. Whether African or European, it was less deadly to be a sailor in the West African Station than to serve as a soldier in West Africa. The reason can be explained in part by two sets of diseases: smallpox, which gravely affected Africans, and the “fevers” which attacked European soldiers and sailors. One reason European sailors did not suffer the same high mortality rate as European soldiers was that sailors spent much of their time either at sea or moored miles off the coast.⁶⁷⁵ At this distance, crews would have been located outside the reaches of mosquitoes and thus, for much of the time, sailors were significantly safer than European soldiers in West Africa. This distance gave sailors a much better chance of surviving the West African ‘climate.’ Smallpox proved a constant threat to West Africans. Despite the efforts of British colonial, medical, and military officers, smallpox caused the highest level of mortality amongst African soldiers serving in Sierra Leone.⁶⁷⁶ Despite its deadliness on land, not a single case of smallpox was found in the records of the eight ships surveyed. This outcome may well have been the result of compulsory naval vaccination. That smallpox proved so deadly on land compared to at sea helps explain why African soldiers suffered twice the mortality rate as African sailors serving in West Africa.

In “The End of the ‘White Man’s Grave’?,” Curtin proposed that during the 1870s British West Africa experienced a mortality revolution when the mortality rate of European soldiers posted in West Africa fell substantially on

⁶⁷⁵ Curtin, “End of the ‘White Man’s Grave’?,” 74.

⁶⁷⁶ Curtin, “African Health at Home and Abroad,” 373.

account of the introduction of quinine, which greatly reduced malaria's fatal impact.⁶⁷⁷ The Royal Navy had also experienced a mortality revolution. Its revolution occurred much earlier – around mid-century – and the decline in mortality was much more rapid. Indeed, for the years 1854-1858 the total mortality for European sailors serving in the West African Station had dropped dramatically to 15.5 per thousand.⁶⁷⁸ This was a significant decline for according to the figures compiled by Bryson the mortality rate for the years 1840-1845 for all personnel had been 45.1 per thousand.⁶⁷⁹ Only in the early twentieth century did the British Army reduce its mortality rate for service in West Africa to a level experienced by the Navy in the 1850s.⁶⁸⁰ By keeping a distance from the coast, limiting shore time,⁶⁸¹ hiring Africans to engage in labour considered too dangerous for European bodies, including “wooding and watering”⁶⁸² and by adopting quinine the Navy successfully experienced a mortality rate that the Army could only match after both the application of the germ theory and the verification of the mosquito as the vector in the transmission of malaria and yellow fever.⁶⁸³

⁶⁷⁷ Curtin, “The End of the ‘White Man’s Grave’?,” 74.”

⁶⁷⁸ British Parliamentary Papers 1857-58, vol. LXI and 1861, vol. LXIV extracted from Lloyd, *The Navy and the Slave Trade*, 289.

⁶⁷⁹ Bryson, *Diseases of the African Station*, 177.

⁶⁸⁰ Curtin, “The End of the ‘White Man’s Grave’?,” 72.

⁶⁸¹ Curtin, “The End of the ‘White Man’s Grave’?,” 74.

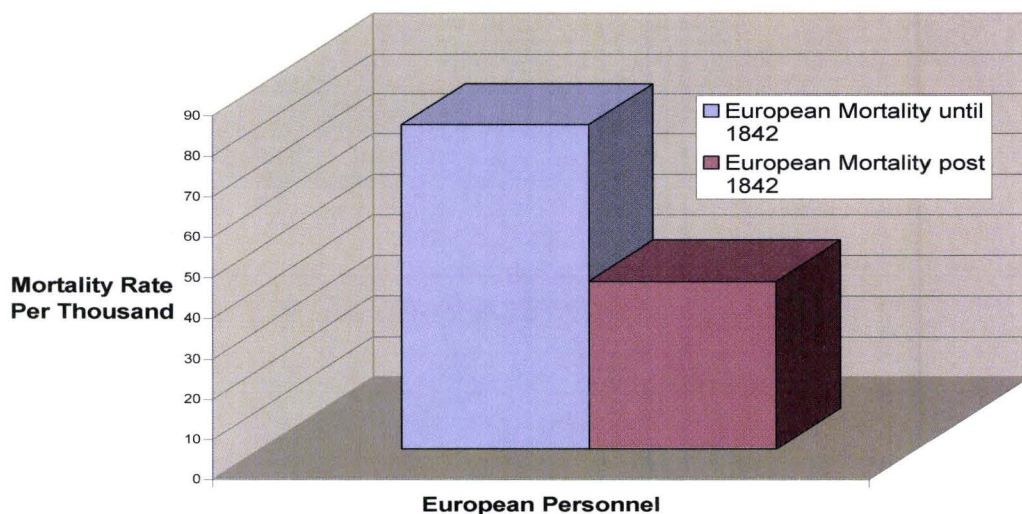
⁶⁸² C. Keenan, N.A., ADM 101/132: Medical Journal of HMS *Ranger*.

⁶⁸³ For a straight-forward analysis of the germ theory and the process of its discovery see, John Waller, *The Discovery of the Germ* (United Kingdom: Icon Books, 2002). For the perception and application of germ theory in the nineteenth century see: W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge: Cambridge University Press, 1994). For the discovery of the vector in the transmission of yellow fever, Francois Delaporte, *The History of Yellow fever: An Essay on the Birth of Tropical Medicine* (Cambridge, Mass: MIT Press, 1991). For malaria see: Gordon Harrison, *Mosquitoes, Malaria, and Man: A Story of the Hostilities since 1880* (New York: Dutton, 1978).

The differing patterns of mortality for soldiers as compared to sailors provide another perspective on the hazards of West Africa for European labour.

The mortality rates aboard the eight ships examined strongly suggest that the Royal Navy in West Africa experienced a ‘mortality revolution’ around mid-century. If the eight ships surveyed are divided into two groups, one comprising the four ships up to and including the Niger Expedition of 1841-42 and the other group the four ships 1846-61, the evidence is striking. For the first set, the mortality rate was 80.2 per thousand, whereas for the second it was 41.5 per thousand. This drop confirms Curtin’s assertion that by the mid 1840s, largely due to the use of quinine, the Navy experienced a dramatic reduction in the mortality of (European) seaman on the West African Station.⁶⁸⁴

Graph 1.5 European Mortality Per Thousand onboard the Eight Ships examined in West African Station; Before and After 1842⁶⁸⁵

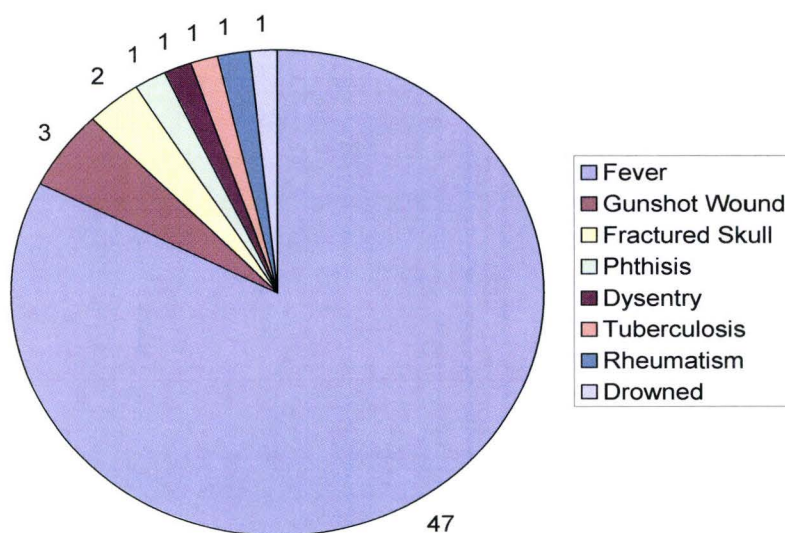


⁶⁸⁴ Curtin, “The End of the ‘White Man’s Grave’?”, 74.

⁶⁸⁵ Calculated from sources listed in Graph 1.1.

‘Fever’ proved to be by far the most likely disease category to claim a European sailor’s life. Excluding three cases of gunshot wounds,⁶⁸⁶ two occurrences of fractured skulls⁶⁸⁷ and one drowning,⁶⁸⁸ fever accounted for forty-seven out of the fifty-one fatalities attributed to disease (92.4%).⁶⁸⁹ ‘Fever’ proved deadly in only one out of every ten cases, but without tropical fevers, the death rate for European sailors would have dropped from fifty-six to ten per thousand.

Graph 1.6 Attributions for European Naval Mortality for Eight Ships, 1831-1861⁶⁹⁰



⁶⁸⁶ N.A., ADM 101/130: Medical Journal of HMS *Arrogant*.

⁶⁸⁷ N.A., ADM 101/127/3: Medical Journal of HMS *Arrogant*; Medical Journal of the HMS *Wilberforce*.

⁶⁸⁸ N. A., ADM 101/127/3: Medical Journal of HMSS *Wilberforce*.

⁶⁸⁹ Physical Trauma is defined as any fracture, contusion, wound or broken bone that required medical assistance.

⁶⁹⁰ Calculated from sources listed in Graph 1.1.

Medical opinion throughout the early nineteenth century differed regarding the etiology of fevers. Fever was routinely regarded as a disease, not merely a symptom. Some medical practitioners were content with the vagueness of the term fever others devised systems for understanding and differentiating types of fevers. The physician William Cullen created a system for understanding fevers in which he divided all fevers into two overarching categories: intermittent and continued.⁶⁹¹ In continued fevers the symptoms were constant, while in cases classified as intermittent the symptoms abate and return making it difficult to judge when a patient had recovered. Cullen further divided the continued fevers into well-used classifications, including typhus, synochus, and so forth.⁶⁹² Despite these attempts at classification, physicians understood that a fever that appeared simple one day could exhibit signs of a deadly intermittent fever the next.⁶⁹³ There was confusion over classification. Should malarial fever always be described as a continued fever or if it abated only to reappear would it be an intermittent fever? This confusion allowed surgeons to employ dozens of accepted fever classifications when assessing and categorizing fever. Medical reports from the anti-slaving vessel HMSS *Trident* are illustrative this point. Its surgeon, Mackay Ogilvie, who contracted fever and was discharged from duty in 1859, recorded all cases of fever that occurred as *febris*. However, James Farnaley, who replaced him and was responsible for drafting the surgeon's

⁶⁹¹ William Cullen, *First Lines of the Practice of Physic*, 2 vols. (Edinburgh: Longman and co., 1816), vol. 1: 50-51. First published in London in 1777.

⁶⁹² Cullen, *Practice of Physic*, 51.

⁶⁹³ Bynum, *Science and Practice*, 22.

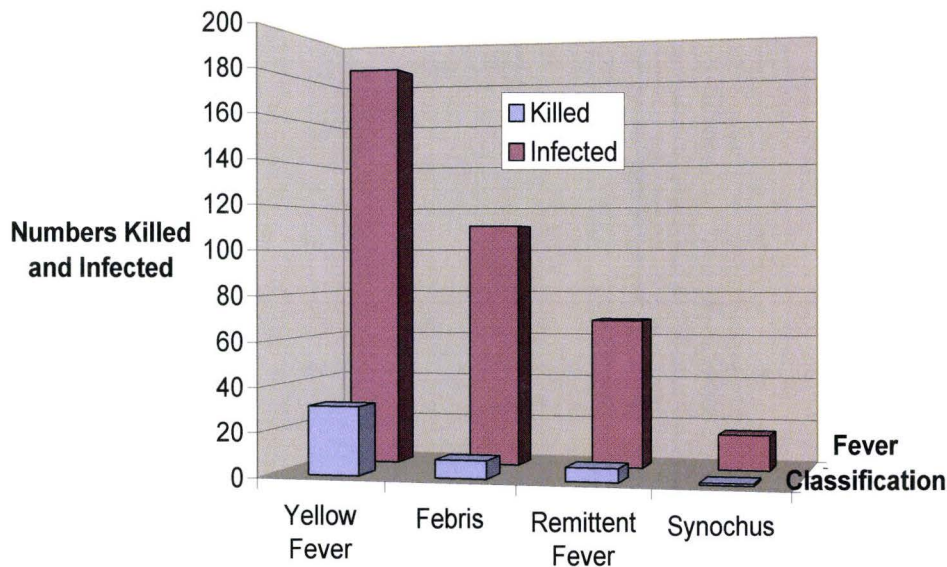
general remarks, classified this fever as yellow fever.⁶⁹⁴ There is good reason to doubt Ogilvie's diagnosis, for he was one of the first on the vessel to contract the 'fever,' and as such was not afforded the opportunity to witness the disease's progression.⁶⁹⁵ Precise conclusions about the classification of any disease must be treated cautiously since they depended entirely on physicians' personal judgment in an age of diagnostic confusion.

For the eight daily sick lists under examinations surgeons employed nine different fever classifications: ague, ephemera, febricula, *febris*/fever, intermittent fever, remittent fever, prexia, synochus; yellow fever. Of these four proved deadly, killing a total of forty-six European sailors. Yellow fever killed thirty-one. In percentage terms, it killed 16.4% of all Europeans on the sick lists who were identified as having the disease. Eight Europeans were killed by what was recorded simply as fever or *febris*. These eight amounted to 7.2% of the men who contracted fever. Six deaths were attributed to remittent fever and that accounted for 7.0% of all such cases. One death was blamed on synochus. In total 10.3% of all diagnosed cases of fever resulted in death, and fevers accounted for 92.4% of European mortality on board the eight vessels.

⁶⁹⁴ N.A., National Archives, ADM 101/129: James Farnaley, Medical Journal of the HMSS *Trident*, 10 September 1858 to 11 November 1859.

⁶⁹⁵ The Admiralty accepted Farnaley's diagnosis, and this study accepts that judgment.

**Graph 1.7 European Fever Morbidity and Mortality onboard the
Eight ships examined: Navy 1831-1861⁶⁹⁶**



It is normally difficult, and often impossible, to follow incapacitated sailors from a ship's sick list to a shore hospital. For example, no records exist for the sailors of HMSS *Trident* discharged to Ascension Island Hospital after having contracted yellow fever in the summer of 1859. The daily sick list shows that from the beginning of the epidemic on 11 June 1859 until 25 July 1859 thirteen Kroomen and sixty-seven Europeans contracted fever. Four Kroomen and fifty-five Europeans were removed to the hospital. Since these specific Hospital records are not extant, it is unknown what percentage of those sent to the Hospital survived. The difficulty in following patients from the daily sick list to a

⁶⁹⁶ Calculated from the sources listed in Graph 1.1.

shore hospital is significant; however the overall impact upon statistical analysis is mediated by the fact that so few patients, (approximately 6% for the ships' complements, were sent to a hospital). The limitation only really manifests itself with cases of yellow fever; other diseases and ailments rarely resulted in hospital care. Despite this difficulty it is possible to calculate a mortality rate for yellow fever by simply excluding patients sent to a shore hospital and focusing only on those patients who either recovered and returned to duty on board ship or died. The mortality for these European men was 36.2%.

An examination of the mortality experiences of both European and African sailors allows for two important conclusions. First, regardless of nativity, service was significantly less deadly aboard a ship than in the Army. For Africans it was about two times more deadly to serve as a soldier in West Africa than as a sailor. For Europeans it was almost seven times more deadly.⁶⁹⁷ Second, European sailors and soldiers suffered a much higher mortality rate - nearly five times higher for sailors and sixteen times higher for soldiers - than their hired African counterparts. It made sense, therefore, that British officials endeavoured to replace European soldiers and sailors with Africans. In 1829, British authorities, baffled and frustrated by the high mortality rates amongst soldiers serving in West Africa, replaced most of the remaining European troops (high ranking officers excepted) with "coloured" soldiers from the West India

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Curtin, *Death by Migration*, 7-8; Bryson, *Diseases of the African Station*, 177.

Regiments.⁶⁹⁸ British officials recognized the dangers associated with service in West Africa and altered their military plans either to protect the lives of European soldiers or to optimize military effectiveness. Some officials worried about the loyalty of these soldiers,⁶⁹⁹ but the British acknowledged that “coloured” troops had immunities to the environment not afforded to European soldiers. Race was an important part of British military plans in West Africa. At sea, for numerous logistical reasons, the British officials could not simply replace all European naval personnel. Instead the Royal Navy tried to minimize mortality within a skilled workforce by hiring Africans, especially Kroomen, to do the labour considered the most injurious to European life. In general, this was effective: most European and most African sailors survived.

Morbidity

There was a noticeable difference in the morbidity rates of European and African personnel serving in the West African Station. Morbidity is defined for the purposes of this investigation by being placed on the ship’s sick list. Both European and African personnel may have been ill or unwell long before being placed on the list, or their injury or illness was not severe enough to gain notice from the ship’s surgeon (or judged not severe enough to be placed on the sick list) and thus the ailments were not recorded in the daily sick lists. It is also true that the determination of incapacitation possessed cultural features, and that it varied according to the schedule and crises of a vessel’s responsibilities. Despite these

⁶⁹⁸ Curtin, “White Man’s Grave,” 70.

⁶⁹⁹ Fyfe, *Sierra Leone*, 118.

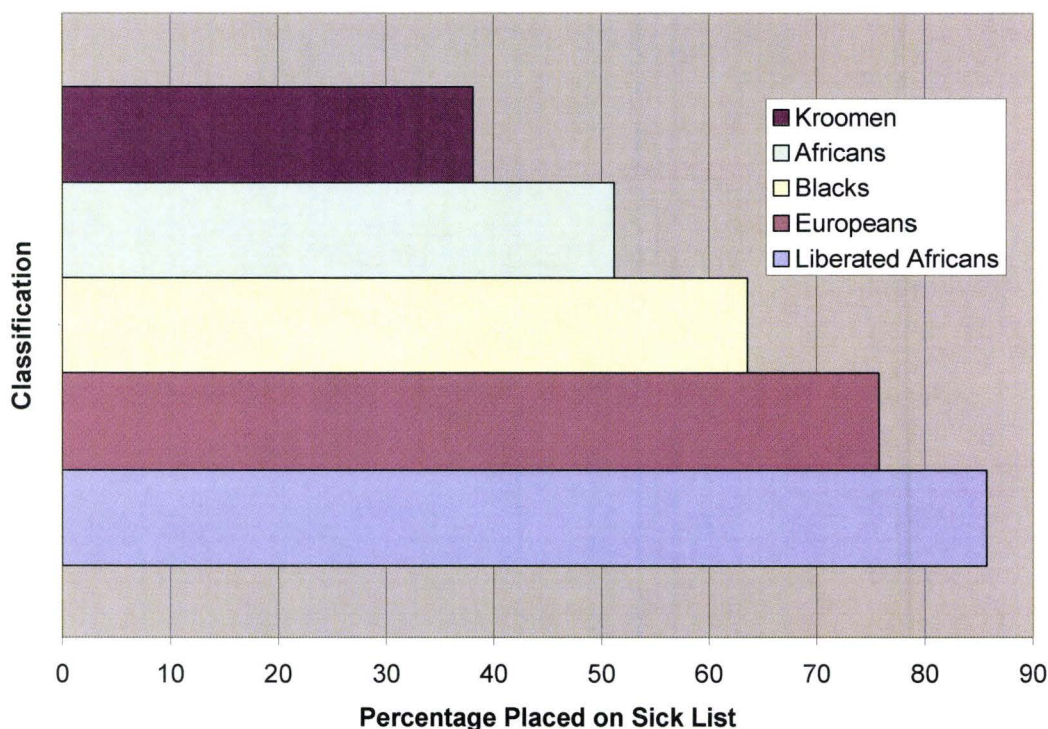
limitations, morbidity rates as calculated from the sick lists remain the best statistical measure of health for the nineteenth-century Royal Navy.

An examination of morbidity demonstrates how regularly naval personnel were unable to attend their duty while affording the opportunity to examine which of the Admiralty's classification of personnel were most likely to be placed on, and which groups were most likely to avoid being put on, the sick list. On average, three out of four European sailors who worked on the eight ships surveyed entered medical care on the sick list. Even the surgeon of HMS *Scout*, which experienced the lowest level of morbidity for ships surveyed, placed half of all sailors on the sick list.⁷⁰⁰ Africans on board British vessels experienced lower morbidity rates, with approximately four out of ten hired Africans being placed on the sick list. The range of morbidity for hired Africans extended from a low of 29.1% to a high of 57.1%, depending upon the vessel. The morbidity rate of European personnel ranged from 50.7 to 86.1%. Europeans comprised 79% of all sailors on the eight ships examined; however, they accounted for 89.5% of all recorded morbidity. Hired Africans constitute 21% of personnel, but accounted for only 10.5% of the total morbidity.

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N.A., ADM 101/120/1: Medical Journal of the HMS *Scout*.

Graph 1.8 Classifications of Naval Personnel Placed on the Daily Sick Lists, 1831-1861⁷⁰¹



Liberated Africans, whether boys or men, were the most likely of all sailors, European or African, to become ill. Of the fourteen individuals identified as liberated Africans, twelve entered the sick list with one dying. If statistically viable this would equal morbidity rate of 857.1 per thousand and a mortality rate of 71.4 per thousand. The likely reason is extensive pre-service ill health. Once slavers were condemned by the Mixed Commission for the Suppression of the Transatlantic Slave Trade at Sierra Leone, the court that adjudicated whether a vessel was involved in the slave trade, liberated Africans immediately became the

⁷⁰¹ Calculated from the sources listed in Graph 1.1.

responsibility of the colonial government.⁷⁰² Liberated Africans would then be subjected to a quick medical exam to determine who was in need of medical care and who could be put to work. This precaution should have ensured that liberated Africans were ready for employment. However, in an attempt to minimize costs, colonial governors and officials responsible for liberated Africans, put Africans to work as soon as possible.⁷⁰³ Liberated Africans were in demand with the Army and other employers. The Army's hiring policy was so aggressive that they enlisted liberated Africans still in poor health. Army surgeons complained of this practice and the poor condition in which the liberated Africans arrived for service.⁷⁰⁴ It is possible that some liberated Africans taken into service by the Navy had not fully recovered their health following liberation. The case of six liberated African boys recruited for work on HMS *Aetna* in 1837 is illustrative. These six boys all entered service together on 1 December and by 4 December four had been placed on the sick list with pre-service cases of yaws. Within the week, another liberated African boy joined them, having come down with

⁷⁰² For the role of the mixed commissions see: Bethell, "Mixed Commissions," 79-93.

⁷⁰³ Charles Turner, Governor of Sierra Leone expressed the need to employ liberated Africans, for according to him they had too long "been supported in idleness by the government." In this letter to Earl Bathurst he congratulates himself on reducing the number of liberated Africans being supported by the government by one-half, National Archives, CO 267/71 fo.24: Charles Turner to Henry Bathurst, Earl Bathurst, Sierra Leone, 25 January 1826.

⁷⁰⁴ Although no evidence of this practice exists for the Navy, Army surgeons complained that they were being sent ill Africans who had recently been liberated from the hold of a slaver. For examples of these complaints see the quarterly and yearly reports for the years 1844-50 contained in National Archives, WO 344/168. According to Dixon Denham the military was so anxious to recruit liberated Africans that immediately upon being liberated the military would give them a quick health inspection and try to get them to sign up for military duty without the "poor creatures" understanding what they were agreeing to. When Denham became governor in May of 1828 he put an end to this policy, National Archives, CO 267/94: Dixon Denham to William Huskisson, Sierra Leone, 14 May 1828.

fever.⁷⁰⁵ That five of the six liberated African boys had fallen sick within a week of joining HMS *Aetna* strongly suggests that these particular employees were not in good health when they entered service. Given the relative low morbidity of all other African groups onboard British ships, and the fact that nearly every liberated African on the sick lists became ill within days of beginning their service, it is reasonable to assume that liberated Africans were regularly hired out in less than ideal health. It should be noted that twelve of the fourteen liberated Africans under study were children. Their young age may have made them prone to illness or more likely to be placed under care.

Seven of eleven Blacks born or domiciled in the West Indies, Canada, the United States and England brought to Africa on board HMSS *Wilberforce* to serve in the Niger Expedition were placed on the sick list. This proportion (63.6%) is high, in fact the highest except for Europeans and liberated Africans on all the ships examined. On the same voyage, 6 of 11 (54.5%) of Kroomen fell ill and 14 of 24 (58.3%) of other Africans. Forty of the HMSS *Wilberforce*'s forty-seven European sailors were placed on the sick list resulting in a morbidity per thousand of 85.1%. The ship's hiring pattern was unique; on none of the other seven vessels were Blacks who had been born outside of Africa employed, nor did any of the other ships rely so heavily on Africans of all backgrounds.

The major service problem with the Blacks born outside of Africa was not simply their high morbidity rate but the fact that once they found themselves

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N.A., ADM 101/81/2: Medical Journal of HMS *Aetna*.

on the sick list they frequently ended up on the list time and time again. The experiences of William Jackson illustrate this point. Born in Jamaica, the twenty-two year old appeared on the sick list five times in the span of only six months having suffered catarrh twice, fever twice, and colic once for a total incapacitation of forty-four days.⁷⁰⁶ It was this frequent reoccurrence of disease amongst Blacks born or domiciled across the Atlantic that prompted Morris Pritchett, one of the surgeons on the Niger Expedition, to conclude that since “many of the blacks and mulattos we had onboard having become accustom [ed] to colder climates of the North, they were probably at least as liable to be attacked with disease as Europeans.”⁷⁰⁷ He points out that: “It was among the men of colour in fact, that the first cases of the disease [fever] occurred.”⁷⁰⁸ Blacks, according to Pritchett, were not only a liability as unhealthy employees but a hazard for placing all sailors at risk of infection. Although other hired Africans were also placed on the sick list multiple times over the duration of the expedition, 29 January 1840 until 23 August 1842, not a single one of the eleven Kroomen was placed on the sick list more than once. This difference in health was noticed and likely reinforced the value of the Kroomen in the eyes of those who hired them. In the end, the Admiralty seemed to have learned a lesson from HMSS *Wilberforce* and the Niger Expedition. After 1841 it appears that the Admiralty returned to hiring predominantly Kroomen; after the Niger Expedition, never again, on the four

⁷⁰⁶ N.A., ADM 101/127/3: Medical Journal of the HMS *Wilberforce*.

⁷⁰⁷ Pritchett, *Some Account of African Fever*, 2.

⁷⁰⁸ Pritchett, *Some Account of African Fever*, 2.

ships surveyed after 1842, were Africans preferred over Kroomen, nor were Blacks born or domiciled outside of Africa hired for service within these four ships.

As stated above, Africans comprised 21% of all sailors surveyed, but were only responsible for 10.5% of total morbidity. This difference in morbidity, combined with Africans', much lower mortality rates, made Africans essential to British naval activities on the coasts of West Africa. African personnel were not only far less likely to die, but also seem to have better avoided incapacitation. This is all the more impressive when one considers that Africans were expected to do work considered too dangerous for Europeans.⁷⁰⁹ While European sailors generally avoided shore duty and thus, the dangers of "marsh miasma", Africans were sent to the shore to gather wood and water.⁷¹⁰ Despite this, Africans were deemed to be much healthier than Europeans. Over three quarters of Europeans employed on the ships of the West African Station contracted an illness sufficiently severe to place them on the sick lists; for Africans, of all classifications, the figure was 42.3% (see Appendix 1.1).

When Africans became ill they required similar recovery times as European personnel. On average, Europeans and Africans who were placed on the sick list remained there for twelve days. When Europeans and Africans became ill, they just were as likely to get sick again. On average, both Europeans and Africans placed on the sick list once were likely to be placed on the list once

⁷⁰⁹ N. A., ADM 101/129: James Farnaley, Medical Journal of HMSS *Trident*.

⁷¹⁰ N. A., ADM 101/129: James Farnaley, Medical Journal of HMSS *Trident*.

more before the end of their term of service. Once Africans became ill, their experiences, in terms of the number of days sick and the likeliness of becoming ill again, paralleled that of European sailors. Where Africans differed, and why they were so valuable, was their ability to avoid incapacitation in the first place.

Europeans believed that the weather, and more specifically particular seasons, had an effect on health in a specific climate.⁷¹¹ Surgeons paid considerable attention to weather; many diligently recorded meteorological information for examination back home.⁷¹² Medical practitioners asserted that the West African climate had two seasons: a wet season ranging from May to November and a dry season lasting from December until April.⁷¹³ Medical authorities generally believed that the wet season was by far the most deadly for both Europeans and Africans.⁷¹⁴ Robert Clarke believed that it was not the height of the rainy season in August that proved the most dangerous but the beginning and end of each rainy season.⁷¹⁵ An analysis of European morbidity by month for the eight ships surveyed confirms this assertion, with the months of May, at the beginning of the rainy season, and December, during the transition from rainy to the dry season, producing the highest levels of recorded sickness.⁷¹⁶ African

⁷¹¹ For example, Pritchett, *Some Account of African Fever*, 108.

⁷¹² McWilliam, *Medical History of the Expedition to the Niger*, 269-284; William Allen, *A Cruise in West African Waters*, 503-506.

⁷¹³ Although some commentators were aware that the seasons began and ended at different times depending on location most generalized and stated that the above months represented the beginning and termination of the two seasons.

⁷¹⁴ National Archives, CO 267/50: Dr Stormonth to Sir Charles MacCarthy, Sierra Leone, 23 January 1820.

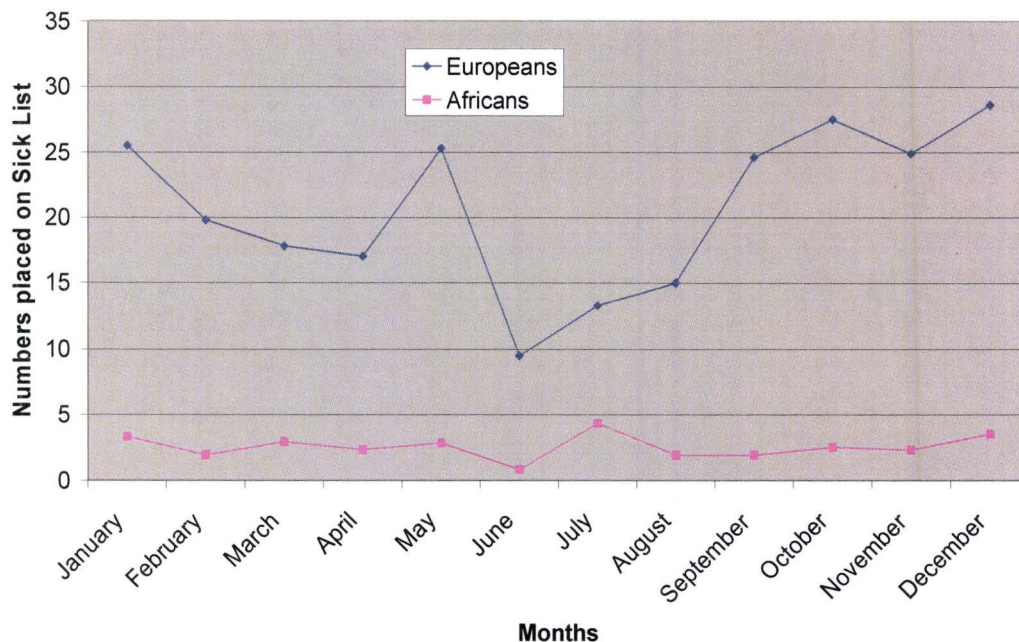
⁷¹⁵ Robert Clarke, "Remarks on the Diseases of the Gold Coast," in 108.

⁷¹⁶ Morbidity per month was calculated by adding up all the incidences of sickness for each month for the eight ships and then dividing each individual month by the total number of times

morbidity on board the eight vessels followed a similar pattern; however, instead of their morbidity increasing in May the increase occurred in July. This pattern contradicts Clarke and Pritchett. Moreover, the seasonality of morbidity among Africans differed from that for Europeans. The most striking aspect of an examination of morbidity by month is the episodic nature of European health compared to the relative stability of African health. European morbidity could fluctuate wildly; for example, between May and June, morbidity for Africans remained relatively steady regardless of the season. This difference could be attributed to European susceptibility to mosquito-vector diseases; during a malaria or yellow fever epidemic the morbidity rates for a given month would markedly increase. In the absence of epidemic fever, for example in June, the European morbidity rates remained low. The reasons for the lack of reported 'fevers' in June is unknown.

this month featured in the eight daily sick lists. For example, for January there were two hundred and thirty individual incidences of disease involving Europeans over eight separate Januarys. Thus two hundred and thirty was divided by eight to produce an average morbidity of 25.5 per month.

**Graph 1.9 Incidence of Reported Disease per month
for European and African Sailors⁷¹⁷**



For the eight ships under consideration, fever was responsible for nearly a quarter of all European morbidity (24.1%) and a third of the total number of days spent by Europeans on the sick list.⁷¹⁸ Fever required one of the longest recovery periods, taking on average 16.6 days for a patient to be released from the sick list. Africans did not escape fever; it accounted for 11.8% of their total morbidity. On average Africans who contracted fever spent 10.4 days on the sick list. Despite these numbers, some surgeons maintained that Africans had a natural resistance to

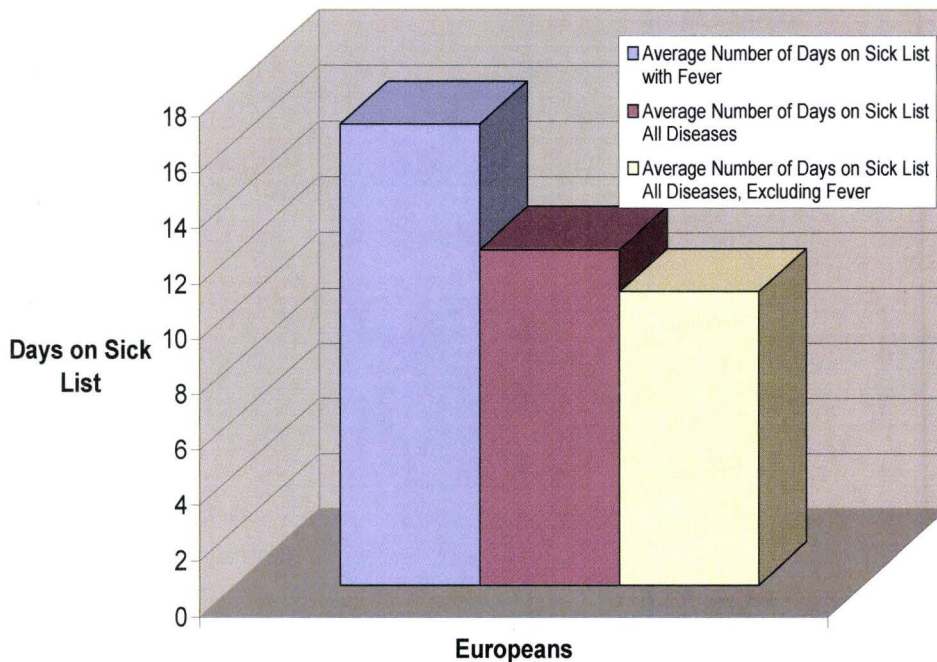
⁷¹⁷ Calculated from the sources listed in Graph 1.1.

⁷¹⁸ All calculations involving the number of days spent on the sick exclude the data from HMSS *Trident* during its time in quarantine from 28 June to 25 July. The reason for this is that European fever patients were likely only to spend a day on the sick list before being transferred to the hospital and their inclusion would severely skew results for calculations involving the total days spent on the sick list.

fever.⁷¹⁹ Fever was a health problem for employed Africans, but it never proved deadly nor when contracted did the affliction lead to a hospital stay. The shorter stay on the sick list may have reflected an expectation by the ship's officers that Africans could quickly get back to active duty. It would be misleading to attribute the higher morbidity rates amongst Europeans exclusively to fever. Even if fever is temporarily removed from the analysis, the pattern of morbidity does not change. Certainly the *mortality rate* of Europeans drops dramatically from fifty-six per thousand to ten per thousand, when fever is excluded from the calculation, while the total average days spent on the sick list for all diseases drops from 12.1 days to 10.6. However, the frequency of European morbidity would not be affected. If fever was removed from the analysis, Europeans (who comprised 79% of all personnel) would still have accounted for 87% of total morbidity and 88% of the total days spent on the sick list. A possible reason for these findings is that although fever most markedly divided European and African mortality, in almost all categories of disease it was Europeans and not Africans who were most likely to be placed on the sick list. The exceptionality of fever needs to be noted and its influence on the European statistics shown; however, regardless of how deadly some fevers were, Europeans were more likely overall to become ill – or at least to enter the sick list – than their African counterparts.

⁷¹⁹ Clarke, *Sierra Leone*, 86; Lind, *Diseases Incidental to Europeans in Hot Climates*, 224-25.

Graph 1.10 Average Number of Days on Sick List for European Personnel⁷²⁰



The analysis of morbidity presents an opportunity to examine, in addition to fever, a few ailments at a closer level in order to acquire further insight into the health experiences of African and European sailors. The sick lists show that, with the exception of fever, diseases that occurred infrequently required some of the longest recovery times. Bubo, a swelling of lymph nodes in either the groin or armpits used to identify plague or plague-like symptoms,⁷²¹ is an ideal example of this, for when contracted, Bubo led to a long stay on the sick list. It must be said that the fact that the lists produced only nine cases means that they are suggestive rather than statistically significant. The six Europeans who contracted the disease

⁷²⁰ Calculated from the sources listed in Graph 1.1.

⁷²¹ Although most often reserved for plague Bubo was used to describe a variety of other ailments including gonorrhea, tuberculosis, and syphilis.

had an average stay on the sick list of 16.7 days, while the two afflicted Kroomen spent an average of 18.5 days on the sick list. One African boy (Admiralty classification) diagnosed with Bubo spent five weeks under treatment.⁷²²

Parasitical infections provide another example. Parasites were rarely diagnosed, averaging only a single case per ship; those who contracted them, regardless of race, spent on average upwards of four weeks in care. The most striking example of an uncommon disease causing a long convalescence is phthisis or, as likely what it later became known as tuberculosis. Of the eleven cases contracted by Europeans, the average stay on the sick list was 47.4 days. One patient was discharged to hospital for further care,⁷²³ and three others invalided home.⁷²⁴ There was a single diagnosed case of phthisis among Africans: a Kroomen spent twenty-two days on the sick list.⁷²⁵

Venereal disease, an acknowledged problem for the British Army and Navy in the nineteenth century, had relatively little impact on the eight ships surveyed. It sent twenty-seven Europeans and six Africans to the sick bay. While the incidence of venereal disease was, for the British Navy, low, those who were incapacitated by a venereal disease spent weeks recovering. The recovery time for the twenty-seven Europeans who contracted some form of venereal disease was, on average, 21.2 days. Four of these Europeans were then sent to a shore hospital for further treatment while another was invalided. For Africans

⁷²² N.A., ADM 101/120/1: Medical Journal of HMS *Scout*.

⁷²³ N.A., ADM 101/129: Medical Journal of HMSS *Trident*.

⁷²⁴ Two of these cases occurred upon the HMS *Arrogant* in 1861 and the final case happened on HMS *Atholl* 1831.

⁷²⁵ N.A., ADM 101/127/3: Medical Journal of the HMS *Wilberforce*.

incapacitated by venereal disease, the average recovery time was also around three weeks. Venereal disease appeared intermittently, and usually on ships after they had docked at certain locations. HMS *Arrogant* suffered a limited outbreak of syphilis after the ship had visited St. Helena in January 1861.⁷²⁶ Ship's surgeon Hart Ginlette blamed St. Helena's populace for spreading syphilis. Ginlette stated that although most Europeans had contracted a mild form, others suffered from "secondary symptoms."⁷²⁷ Ginlette reported that the two Kroomen who had contracted syphilis did not experience any secondary complications.⁷²⁸ Once incapacitated by syphilis, European sailors often required a long convalescence as the disease evolved into other stages. It is noteworthy that in an era of heightened sensitivity venereal disease remained a small and manageable problem for the eight ships surveyed.

Perhaps due to the strenuous demands of their employment, Africans were somewhat more likely than Europeans to wind up on the sick list because of trauma, such as a sprain, fracture, wound or contusion, than from any individual disease. Trauma placed twenty-one Kroomen, six Africans and one liberated African boy on the sick lists. In total, 15.3% of all medical cases involving Africans were the result of injuries. Europeans of course were not exempt from the "rigours of the sea," with 12.5% of all medical cases involving Europeans

⁷²⁶ N.A., ADM 101/130: Medical Journal of HMS *Arrogant*.

⁷²⁷ N.A., ADM 101/130: Hart Ginlette, Medical Journal of HMS *Arrogant*.

⁷²⁸ N.A., ADM 101/130: Hart Ginlette, Medical Journal of HMS *Arrogant*.

attributed to a physical trauma. The small numbers of African injuries makes comparisons unsafe.

The source of injuries to Africans ranged from a gunshot wound,⁷²⁹ to burns acquired while stoking.⁷³⁰ Severity varied from treatable contusions that required rest and recovery, to skull fractures that resulted in immediate death. In total, two hundred and ten Europeans were placed on the sick list due to physical trauma, with thirteen cases referred to a hospital, while a further six ended in death. Three of these deaths resulted from gunshot wounds,⁷³¹ two from a fractured skull⁷³² and one from a sailor drowning.⁷³³ None of these fatalities appeared on the sick lists for more than a day. Their deaths likely followed shortly after being placed in the surgeon's care. Not a single African died or was placed in hospital care after sustaining a physical trauma. Given that Africans and Europeans suffered from similar physical injuries (although severity cannot be ascertained) it is noteworthy that not a single African died or was sent to the hospital because of physical injury. The explanation for this may lie in the general perception that Africans were blessed with a durable constitution and thus would recover quickly from physical trauma.⁷³⁴ Although Europeans and Africans suffered from high rates of physical trauma, only injured Europeans and not Africans were afforded hospital treatment.

⁷²⁹ N.A., ADM 101/130: Medical Journal of HMS *Arrogant*.

⁷³⁰ N.A., ADM 101/132: Medical Journal of HMS *Ranger*.

⁷³¹ N.A., ADM 101/130: Medical Journal of HMS *Arrogant*.

⁷³² N.A., ADM 101/127/3: Medical Journal of the HMS *Wilberforce*.

⁷³³ N.A., ADM 101/127/3: Medical Journal of the HMS *Wilberforce*.

⁷³⁴ Pritchett, *Some Account of African Remittent Fever*, 2.

Two of the most common ailments on board the eight ships surveyed were catarrh and abdominal complaints. Catarrh, a catch-all diagnosis that refers to a host of possible ailments that produce a discharge from any mucous membrane was responsible for 7.7% of European cases, and 11.8% of recorded cases involving Africans. Catarrh never proved deadly, although in one case a European patient was sent to a hospital. Europeans diagnosed with catarrh spent on average 7.6 days on the sick list compared to 9.6 days for their African counterparts. Naval surgeons' somewhat greater reliance on catarrh as an explanation for African disease may suggest that surgeons had difficulty in diagnosing African complaints and, instead of achieving precise diagnosis, relied on a term which covered a variety of ailments with similar symptoms. Problems of communication will be dealt with in detail below, when examining the difficulties European surgeons encountered in treating African personnel.

Abdominal complaints, dysentery, diarrhea, and general stomach pain routinely afflicted European sailors. Given the quality of the naval diet and the propensity of European sailors to drink large quantities of palm wine, to which their stomachs were unaccustomed, it is no surprise that they often suffered from bowel complaints.⁷³⁵ Indeed, 12.3% of all European complaints consisted of diagnosed bowel problems. Although the incidence of stomach complaints was high, the severity of these complaints was, for the most part, low. Europeans on

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In the late eighteenth and early nineteenth century prominent naval surgeons turned their attention to the both the dangers and therapeutic properties of different forms of alcohol. See for example, Sir Gilbert Blane, "Observations on the Disease of Seaman," in *The Health of Seaman* (London: Navy Records Society, 1965); Thomas Trotter, *An Essay, Medical, Philosophical, and Chemical, on Drunkenness, and Its Effect on the Human Body*, 2nd ed. (London: Longman, 1804).

average spent 5.7 days on the sick list. Bowel complaints accounted for 5.6% of all African ailments while stays on the sick list averaged 9.3 days. The reason why fewer Africans were diagnosed with bowel complaints is unknown though it may have to do with their familiarity with the cuisine and sparse diet.⁷³⁶ It is difficult to know why Europeans suffering from bowel complaints recovered their health faster than their African counterparts. It appears that age played no factor, as the distribution was equal among all ages and classes of sailors. The most obvious area of difference was that when diagnosed with dysentery Europeans recovered nearly six days faster than African personnel. Again, the reason for this is unknown but may be due to the fact that the threshold for placing Europeans on the sick list was lower than that for Africans. Thus Europeans with more mild cases of dysentery (which may have really been a bad case of diarrhea) were placed onto the sick list while an African in a similar condition was not brought to official notice or considered incapacitated.

The examination of morbidity strongly suggests that African personnel were much less likely to be placed on the sick list than their European counterparts. Africans were familiar with the climate, less likely to be incapacitated by malaria or yellow fever, and believed to be more durable. These factors ensured that Africans were less likely to be placed on the sick lists than Europeans. It meant that Africans and Europeans had different responses to the health risks associated with serving in the West African Station. In all likelihood

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Kenneth Kiple, *The Caribbean Slave: A Biological History* (Cambridge: Cambridge University Press, 1984), 23-28.

the somewhat better ability of African labourers to endure or avoid illness helped sustain the British presence on the West African coast.

Did European surgeons treat African and European sailors suffering from the same ailments in identical ways? And if not, what was the basis for differentiated treatment? It is possible to offer tentative answers because once placed on the daily sick list, both African and European personnel received medical treatment from the same personnel. The details were recorded in the medical records.

The entries for fever are often the most detailed accounts, and their frequency provides enough examples to venture conclusions. European physicians and surgeons were nearly unanimous in their belief that Europeans were more likely to contract fever and that, while an attack of fever for a European could be life threatening, fever had only a mild affect on Africans. Despite this common belief, Morris Pritchett of HMSS *Wilberforce* treated Africans and Europeans suffering from yellow fever identically. He believed the best treatment for yellow fever, regardless of race, was to apply a soothing lotion to cool the skin, to open the bowels and to blister the temples.⁷³⁷ Replacement surgeon James Farnaley of HMSS *Trident* also treated European and African patients diagnosed identically so far as the records allow us to tell. His treatment consisted of quinine, wine, and a nutritious diet employed alongside a purgative

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N.A., ADM 101/127/3: Medical Journal of the HMS *Wilberforce*.

of calomel and Jalap.⁷³⁸ Pritchett and Farnaley's chosen treatments buttress Curtin's assertion that, although bleeding as a cure for fever may have been on the decline by mid-century, that other forms of heroic medicine, especially purging, continued to be practiced in conjunction with the relatively new use of quinine.⁷³⁹

When confronted with yellow fever Farnaley and Pritchett employed the same treatment methods regardless of race; however, it is not accurate to say that the entire treatment process was identical, as naval surgeons delayed in sending African personnel diagnosed with fever to the hospital. The likely explanation behind this lack of urgency is that naval surgeons generally agreed that in Kroomen "as well as all of the race" fever could only take a very mild form and, thus, there was no need for urgency.⁷⁴⁰ This assertion appeared to be well founded. Numerous Europeans died from fever on the eight ships surveyed, but fever did not kill a single African. When HMSS *Trident* was in quarantine off Ascension, Farnaley exercised a policy of immediately discharging into hospital any European who showed "signs of fever" for further care.⁷⁴¹ This same policy was not extended to Kroomen who contracted fever. They stayed on board and many were only sent to the hospital after spending upwards of two weeks on the sick list.⁷⁴² The only reason that Farnaley likely ordered these sick Kroomen to the hospital was that the whole crew needed to leave the ship as it was about to return to England. It is possible that Farnaley delayed in sending Kroomen who

⁷³⁸ N.A., ADM 101/129: Medical Journal of HMSS *Trident*.

⁷³⁹ Curtin, "The White Man's Grave," 108.

⁷⁴⁰ N.A., ADM 101/129: James Farnaley, Medical Journal of HMSS *Trident*.

⁷⁴¹ N.A., ADM 101/129: James Farnaley, Medical Journal of HMSS *Trident*.

⁷⁴² N.A., ADM 101/129: Medical Journal of HMSS *Trident*.

contracted fever to the hospital because he believed that Africans suffered from only the mildest forms of fever. Farnaley or the hospital authorities may also have been concerned about hospital space or segregation and desired to reserve the limited space for Europeans. African personnel may have resisted the idea of being sent to a hospital. This possibility could have explained in part why so few Africans were ordered to a shore hospital. It is likely that injured or sick Kroomen would not have relished the idea of being separated from their companions and sent, for example, to Ascension Island Hospital.

Another reason why Farnaley may have delayed in sending Africans to the hospital was that during the course of a fever epidemic it was the responsibility of Kroomen to care for sick Europeans and as such he may have been unwilling to part with this resource. In the case of HMSS *Trident*, once all sailors were removed to shore, it was Kroomen, and not European personnel, who were given the responsibility of caring for the sick in a makeshift hospital erected on the shore.⁷⁴³ Farnaley was not happy with their performance and stated: "More intelligent nurses would certainly be desirable."⁷⁴⁴ He explained that the use of Kroomen was a necessity as "the Europeans had a very great objection to going near the sick."⁷⁴⁵ Although in this period, European Royal Navy sailors commonly served as emergency nurses, Farnaley accepted their fear of contagion as a reason for resisting out this duty. The idea that Africans were resistant to

⁷⁴³ N. A., ADM 101/129: James Farnaley, Medical Journal of HMSS *Trident*.

⁷⁴⁴ N. A., ADM 101/129: James Farnaley, Medical Journal of HMSS *Trident*.

⁷⁴⁵ N. A., ADM 101/129: James Farnaley, Medical Journal of HMSS *Trident*.

fever was near universal and did much to direct the tasks assigned to Africans who served on board British vessels.

Farnaley's criticism of Kroomen's nursing abilities was not universal. R. Henderson Brown, surgeon to HMS *Scout* in 1838, praised the Admiralty for allowing him to hire a Krooman to serve as his medical assistant and was so satisfied with his assistant's ministrations that he called for the practice to be extended to every naval vessel serving in the West African Station.⁷⁴⁶ This ship, HMS *Scout*, with 113 Europeans and 29 Africans on board at that time, in fact experienced the lowest morbidity rate of the eight vessels (48.2% compared to the average for the eight of 68.3%). For the *Scout*, the principal causes of illness were stomach complaints, particularly diarrhea and colic. Fever was not a concern. While the exact reasons for the lower morbidity on the *Scout* are unknown, surgeon R. Henderson Brown believed that his Krooman deserved some of the credit for the good health of the crew.

On occasion, when the need was pressing or out of convenience, African and European sailors would be discharged to a military - not a naval - hospital for further care. Within the military hospital, European and African seaman were at times given quite different treatments for similar complaints. The treatment of John Ogden, a European marine from HMS *Growler* in 1845, and an unnamed Kroomen from HMS *Penelope* in 1845 suggest that this was the case. Staff surgeon W. Johnston of the First West Indies Regiment gave John Ogden,

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N.A., ADM 101/120/1: R. Henderson Brown, Medical Journal of HMS *Scout*.

identified as having remittent fever, a “sample of calomel” followed three hours later by a solution of sulphate of magnesia in peppermint water, while his body was sponged with lime juice and water.⁷⁴⁷ Instead of the soothing treatment of lime juice and water, the Kroomen, also diagnosed by Johnson with remittent fever, was “bled immediately on admission to the extent of twenty ounces” and, according to Johnston, due to the severity of this treatment “fainted.”⁷⁴⁸ After three hours, a sample of calomel and jalop purge was administered. A blister was also applied to the Krooman’s “affected” side and a mercurial injection was administered to his groin.⁷⁴⁹ Thus, two naval personnel, diagnosed and treated for presumably the same disease, by the same surgeon, at the same time and location, received substantially different treatments.

This apparently racialized approach to the treatment of African and European patients was not unusual. When Arthur Hayden, a liberated African and a new recruit to the Second West Indian Regiment, and Richard Months, a European of HMS *Waterworld*, were admitted to Dr. Johnston’s care in 1845, both suffering from fever, Hayden was bled whereas Months, instead of the lancet, was “lathered with lime juice and water to produce perspiration.”⁷⁵⁰ What led Dr. Johnston to treat these four patients, admitted within months of each other, in such significantly different ways? Since one of the European patients died and

⁷⁴⁷ National Archives, WO 334/168: W. Johnston, Quarterly Summary Report on Disease, West Coast of Africa, 1 July to 30 September 1844, 44.

⁷⁴⁸ N.A., WO 334/168: W. Johnston, Quarterly Summary, 1 July to 30 September 1844, 54.

⁷⁴⁹ N.A., WO 334/168: W. Johnston, Quarterly Summary, 1 July to 30 September 1844, 54-55.

⁷⁵⁰ N.A., WO 334/168: W. Johnston, Quarterly Summary, 1 July to 30 September 1844, 58-61.

both Africans were able to resume their duties, it seems unlikely that the Africans received more extreme forms of treatment because their cases were considered more life threatening. This differentiated treatment may have been the result of the perception of Africans as possessing stronger constitutions than Europeans thus, requiring harsher, more aggressive, treatments. This was not out of line with contemporary European medical beliefs, as those who appeared to be the most healthy were often afforded “stronger” doses and treatments than those who were classified as weaker.⁷⁵¹

The different treatments according to European and African patients extended to other ailments. When European sailor William Wills injured his big toe after accidentally shooting himself in the foot in 1861, assistant surgeon Keenan of HMS *Ranger* washed the wound and wrapped the injured toe. According to Keenan this mode of treatment “was peculiar [worthy of notice] only in its simplicity.”⁷⁵² Impressed by the ease of treatment, Keenan credited his patient’s temperate habits and otherwise excellent health.⁷⁵³ A Kroomen by the name of Jack Smart was also sent to Keenan to have his toe examined, for he was reported to be in the habit of applying a very tight ligature to his right little toe and had worn the toe raw. The frustrated surgeon stated that the patient had applied the ligature “without being able to assign [to me] any reason for doing

⁷⁵¹ Wendy Churchill, “Female Complaints: The Medical Diagnosis and Treatment of British Women, 1590-1740” (Ph.D. diss., McMaster University, 2005), 148.

⁷⁵² N.A., ADM 101/132: C. Keenan, Medical Journal of HMS *Ranger*.

⁷⁵³ N.A., ADM 101/132: C. Keenan, Medical Journal of HMS *Ranger*.

so.”⁷⁵⁴ Instead of instructing Smart to stop applying the ligature and dressing the injured toe as he had done with Wills, Keenan believed the best remedy was amputation. After amputation the healing process was “rather slow owing to the cartilaginous state of the ends of the flaps” which resulted in another surgery to promote “further healing.”⁷⁵⁵ It is noteworthy that after having so much success with wrapping a severely damaged toe that this surgeon, instead of trying to treat Smart’s toe, ordered immediate amputation. Keenan may have feared gangrene, but if so, did not state this in his medical journal.

There were some racialized differences in the treatment of Europeans and Africans, but not all variations were due to racial ideas of physiology or constitution. A language barrier sometimes made it difficult for surgeons to treat Africans. Hart Ginlette, surgeon to the Commodore’s ship HMS *Arrogant*, complained in 1861 of that barrier.⁷⁵⁶ Effective medicine requires an exchange of information and without this diagnosis could be difficult. In one instance diagnosis was so difficult that Ginlette listed three diseases as the possible source of one Krooman’s discomfort: pericarditis, pleuritis, and bronchitis. Instead of treating a specific ailment, Ginlette acted more generally “due to the difficulty of communication with the patient the treatment was adopted to the most prominent symptoms.”⁷⁵⁷ Given the lack of an accurate diagnosis, Ginlette relied upon blisters, brandy, and the use of turpentine enemas but none of these treatments

⁷⁵⁴ N.A., ADM 101/132: C. Keenan, Medical Journal of HMS *Ranger*.

⁷⁵⁵ N.A., ADM 101/132: C. Keenan, Medical Journal of HMS *Ranger*.

⁷⁵⁶ N.A., ADM 101/130: Hart Ginlette, Medical Journal of HMS *Arrogant*.

⁷⁵⁷ N.A., ADM 101/130: Hart Ginlette, Medical Journal of HMS *Arrogant*.

arrested the progress of the disease.⁷⁵⁸ The inability of Ginlette to reach a diagnosis may have contributed to the death of this Krooman after ten days of treatment. Ginlette found treating Kroomen to be frustrating and believed Africans to be rather unintelligent and their approach to medicine backwards.

Ginlette's attitude is evident in the following case when he attempted to cure a Kroomen of guinea worm. In this case, one John Nimrod was found to be suffering from a small swelling above the left ankle. When opened with a lancet, the surgeon saw no pus but instead the head of a small white worm which he said caused much excitement in the Krooman who joyfully exclaimed: "I got him last year at Accra." The surgeon then took a piece of cocoa nut fiber, wrapped it around the worm and began to draw the worm out slowly.⁷⁵⁹ Taking out a worm was a delicate process that could take many days; it was important not to break the worm as it would only continue to grow inside. Although the surgeon had instructed the Krooman not to "meddle with the worm," the patient ignored this advice and applied "a whole host of Kroo remedies" including onions and palm oil to the wound.⁷⁶⁰ Eventually when almost eighteen inches of the worm had been withdrawn, the patient, while employing his own remedies, accidentally broke the worm, forcing the surgeon to start the tedious process afresh. This second attempt was successful and after a total of thirty days the patient was deemed completely recovered.⁷⁶¹ This episode reveals that Kroomen at times

⁷⁵⁸ N.A., ADM 101/130: Hart Ginlette, Medical Journal of HMS *Arrogant*.

⁷⁵⁹ N.A., ADM 101/130: Hart Ginlette, Medical Journal of HMS *Arrogant*.

⁷⁶⁰ N.A., ADM 101/130: Hart Ginlette, Medical Journal of HMS *Arrogant*.

⁷⁶¹ N.A., ADM 101/130: Hart Ginlette, Medical Journal of HMS *Arrogant*.

resisted or at least attempted to complement European treatment on board ship. Kroomen may have had more faith in traditional healing methods than the westernized medicine prescribed by European surgeons. The nature of the documentation makes it difficult to measure the scope of resistance to, or modification of, European medicine, but, if present, may have manifested itself in not reporting or trying to hide ailments from naval surgeons. Avoidance could be one reason for the lower morbidity rates recorded for the hired Africans. Of course, the Royal Navy also possessed a history of its European personnel attempting to avoid painful, unpleasant, or embarrassing medical treatments. For this workforce, medical care was both a right, and a requirement. Medical officers attempted to encompass Africans within the ship's medical system, although the surviving records are not sufficiently rich to touch upon the topics of sanitary hygiene, sick diets, and the like. Similarly, both self-help and group co-operative help rarely appear in the documentation, for either Africans or Europeans. Resistance to treatment was not uniquely African, but avoidance may have been more achievable.

Not all European surgeons had difficulty in treating Kroomen nor were they always opposed to the application of traditional African forms of healing. When a Kroomen accidentally got jammed between the capstan's "bars and bits," in 1849 the surgeon to HMS *Albatross* ordered that the frightened Krooman needed rest and should be left undisturbed. Instead of obeying the surgeon's orders, a fellow Krooman was observed "jumping on the man's hurt back" and

“kneading him with his feet as if he were on the steps of a treadmill.”⁷⁶² The next day the Kroomen declared himself better and ready to return to his duties. When the surgeon was told that the Krooman directly disobeyed his orders in employing “kroo remedies,” he was astounded that such treatment worked and was pleased that despite not adhering to his mode of treatment that his patient had recovered.⁷⁶³ Interestingly, in the British Navy, failure to follow prescribed courses of treatment often led to punishment of European sailors. This episode suggests that a degree of latitude not granted to European personnel may have been afforded to injured or sick Africans. Dr. Lawson, a military surgeon, was so impressed with the efficacy of traditional healing methods that in cases of remittent fever rather than utilizing cold water to cool the patient, as many European surgeons and physicians prescribed, he relied upon the native cures of warm bathes to produce perspiration.⁷⁶⁴ Dr. Johnston also favoured this mode of treatment and even applied this traditional African cure to European fever patients but (oddly) continued to bleed his African patients.⁷⁶⁵ Whether Johnston was aware of this contradiction is unknown.

Conclusions

African labor helped sustain British slave-trade suppression actions in the West African Station. Africans had a significantly lower mortality rate and were

⁷⁶² National Archives, ADM 101/82/1: Medical Journal of HMS *Albatross*, 1849.

⁷⁶³ N.A., ADM 101/82/1: Medical Journal of HMS *Albatross*.

⁷⁶⁴ National Archives, WO 334 /168: Dr. Lawson, Annual Report on the Diseases which have Prevalled among the Troops at Sierra Leone, 1 April 1847 to 31 March 1848, 203.

⁷⁶⁵ N.A., WO 334/168: W. Johnston, Quarterly Summary, 1 July to 30 September 1844, 58-61.

far less likely to be incapacitated by disease. One of the reasons for this difference was the response to fevers, which had relatively little effect on African personnel while causing one third of the European morbidity and upwards of 90% of their deaths. During a yellow fever epidemic, Kroomen proved especially valuable as they not only kept the ship in service but were also responsible for caring for the sick. While, on average, three out of four Europeans appeared on the sick list, Africans were more likely to remain healthy and able to attend to their duties. However, once sick, Africans and Europeans appear to have had similar health experiences in terms of the number of days spent on the sick list and had a comparable risk of being placed on the sick list again. Where African employees differed, and why they were so valuable, was their ability to avoid sickness in the first place.

At times, Europeans and Africans received similar treatment but important differences existed. Hired Africans were almost never discharged to a hospital for further care. When suffering from fever their cases were rarely considered urgent. The very limited evidence suggests that Africans may have preferred their own treatments, and at times resisted European medicine. Some surgeons did not racialize their treatment and treated Africans and Europeans suffering from the same ailment in identical ways, but other surgeons, such as Dr. Johnston, gave Africans harsher and more extreme forms of treatment. Some physicians perceived African bodies to be very similar to or the same as European bodies and thus afforded all patients similar modes of treatment. Other surgeons perceived

the African body to be different and this led to a racialized form of medicine in which Africans and Europeans received substantially different treatments. The lack of a coherent doctrine of racialized medicine left naval surgeons to decide for themselves the validity of a racialized approach to health and healing.

Chapter Six

Conclusion

This study is an analysis of the health-related experiences and interactions between Britons and Africans in British West Africa during the first half of the nineteenth century. It examines the ways in which Europeans created and understood Africans and their bodies during a relatively neglected period for relevant scholarship, while exploring evidence for bi-directional medical knowledge and practice, African reactions to European medicine, and British management of African health care. A number of conclusions concerning the health and medical interactions of Britons and Africans, circa 1800-1860 have been reached. This chapter contextualizes these conclusions, while illuminating their relationship and contribution to the relevant historiography. It also suggests opportunities for future research. The first section summarizes the central arguments, while the second analyzes the importance of these findings and their relation to the relevant historiography. The third section advances new areas of research. The final section focuses upon the continuity in medical thinking and practice in British West Africa for the first half of the nineteenth century.

Arguments

Chapter two examined the theories of race that guided Britons' understanding of race and sub-Saharan Africa. It emphasized the ways in which medical practitioners depicted the African body. Historians have emphasized that during the early nineteenth century, and especially by the 1850s, racial ideas

had become fixed in hierarchical systems.⁷⁶⁶ While there occurred a noticeable ‘hardening’ of racist thought, no position monopolized the discourses in Britain up to 1850. This intellectual diversity helps to explain the multitude of reactions (medical and non-medical) to race and ‘the African body’ characteristic of this period.

Medicine played a minor role in the intellectual development of theories of race, but several fields loosely associated with medicine - biology, zoology, and ethnology determined the grounds upon which debates over race were conducted. Physicians themselves, in particular Thomas Masterman Winterbottom, James Cowles Prichard, and Robert Knox, played important roles in these debates; however, their arguments relied principally not upon their medical knowledge and evidence but upon logic and reasoning. Thus, while medical practitioners made significant contributions to understandings of race in Britain, health, medicine, and the body were largely left out of debates on race. Medicine had yet to develop as a source of authority characterizing races.

Chapter three investigated British Protestant missionaries for their interactions with African health. Neither the WMMS nor the CMS exhibited substantial interest in the health issues of West Africans, or advocated for development of a government-directed system of colonial medicine in British West Africa. Yet, missionaries, because of their roles as schoolteachers, their attendance at hospitals, and their focus upon ‘sickly’ liberated Africans, became

⁷⁶⁶ Curtin, *Image of Africa*, 143; Harrison, *Climates and Constitutions*, 16; 124; Stepan, *The Idea of Race in Science*, 3.

involved in the health of Africans. The vast majority of missionaries did not have medical training and their inexperience and, at times, their negligence reportedly had an adverse affect on African health. The thesis demonstrates that even in the hospital missionaries concentrated on the African soul and showed little interest in the dying body. However, missionaries employed their own poor health and that of liberated Africans to solicit home support for their actions. While not central to missionary activities, health drew attention to the mission. When needed, illness offered an explanation for failure.

Missionary societies emphasized the respect Africans gave European physicians, but they did not employ medicine to assist with converting Africans. Medical missionaries went to China and India during the early nineteenth century, but none traveled to West Africa. Missionary societies believed that Africans were open to and ready for conversion.⁷⁶⁷ Thus, there was no pressing need to enlist medicine. The British missionary concern for African humanity during the age of abolition did not consider the African physical health as the priority. African acceptance of Western medicine was viewed consistently as a marker of cultural conversion, not a goal or objective on its own.

Africans who became missionaries could employ health as a way to promote greater African involvement in African conversion. In the wake of the failed 1841 Niger Expedition, missionary societies faced the reality that the interior of Africa proved too inimical to European health for missions to rely

⁷⁶⁷ Coleman, *Nigeria: Background to Nationalism*, 93.

solely upon their own efforts. African missionaries Samuel Crowther and Charles Knight seized this opportunity. African missionaries had previously been expected to serve as assistants to European-led missions. Charles Knight challenged his subordinate position by arguing that the deadly climate necessitated African action and that successful conversion campaigns could only be carried out if Africans received ordination and had the same powers as European missionaries.⁷⁶⁸ Missionary societies, after the failure of the Niger Expedition, for the first time offered real advancement prospects to African missionaries. Africans employed the subject of health to push for more equitable inclusion within the mission.

Chapter four examined the interaction between British colonial medical practitioners and African patients and healers in West Africa, with particular attention to Sierra Leone. Ultimately, up to 1850, the British had not established a system capable of convincing or coercing Africans into care. Western medicine during this period became one option within an array of medical options available to African patients. The available evidence suggests that in practice because of the scarcity of overworked British medical practitioners, European medicine was the option usually reserved for the very sick and desperate. European medicine, however, was imposed upon liberated Africans immediately after disembarkation from slavers when their freedom of choice was very restricted. The system of dressers, junior assistants employed by the British, became another medical

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WMMS, box 281, no. 1899: Charles Knight, Sierra Leone. May 1847.

option, an expedient forced by the dispersal of freed slaves to special settlements and the concentration of European doctors – always and inadequate number – at Kissy Hospital and Freetown. There was concern at the time that the dressers especially in the villages operated more as a barrier than a bridge to British medical control. British medical practitioners and officials believed that African patients largely controlled their bodies interacting with European medicine on their own terms. The reality was that European medicine was for some villagers far away and that the shortages of practitioners, combined with the difficulty of travel when ill, may have made soliciting European care difficult. British medical practitioners ignored these realities blaming liberated African ‘avoidance’ upon Africans’ general lack of civilization and dressers who held back patients who they believed should have been sent to the Kissy Hospital.

The thesis demonstrated that the medical system was largely managed from the metropole. Governors and colonial surgeons were not afforded the ability to make policy decisions. The substantial management from afar meant that it was the Colonial Office and not the colonial surgeon who decided where surgeons would be stationed. Advice from the periphery was often ignored. Calls for more physicians and medical supplies, especially for smallpox vaccination, often went unheeded. This dynamic provides important insights into how the empire operated. Locally acquired expertise, such as that of Robert Clarke, could not form the foundation for effective action, in West Africa, at Westminster, or elsewhere in the empire.

While liberated Africans were reported to have preferred African healers and to have avoided European medicine, native Africans were depicted as eager patients who solicited care. The difference between these two groups can be explained, in part, by the ways in which care took place. Liberated Africans interacted with a resource poor colonial-run medical system that could provide hospital care as the primary mode of treatment. For native Africans, most interaction with European medicine took place outside of the hospital system in their own villages and through the attention of native dressers. Africans may not have been opposed to European medicine, but disliked and resisted hospital-based care and the journey necessary to acquire it.

British medical practitioners serving in Africa often characterized African practitioners as quacks who used healing as a way of gaining power and prestige. Patients, although criticized for their ignorance, were cast as victims of this backward medicine. Europeans emphasized the injustice done by these practitioners claimed that many lives are yearly sacrificed to African healing methods.⁷⁶⁹ They derided African practitioners for their belief that supernatural forces could cause disease and that amulets and charms could offer protection. British medical practitioners compared what they perceived to be a dynamic progressive European system of medicine based on scientific truths to a stagnant traditional medicine that had reached its full potential. They believed that only by importing European science-based medicine could medical practice in West

⁷⁶⁹ Clarke, "Prevailing Diseases," 74.

Africa advance. In their minds, they were part of a great good by supplanting a stagnant form of practice with a superior system of medicine capable of improving African health.

British medical practitioners were often critical of both African healers and their conceptual understanding of human health, but they acknowledged the usefulness of many of their cures. Native remedies, whether new to Europeans or substitutes for known European remedies, were incorporated into their therapeutics. Some of these treatments followed practitioners as they moved within the Empire, while others were brought back to the British Isles. Some African healers, primarily during periodic inland exploration, were taught the process of European smallpox vaccination. Medicine in British West Africa was bi-directional as medical practices flowed in both directions.

Chapter five examined the health experiences of European and African personnel serving at the Royal Navy's West African Station, 1825-1861. African personnel sustained much lower mortality rates and were far less likely than Europeans to be incapacitated by disease. The main difference was in the differential experience of fevers. While causing a third of European morbidity and nearly 90% of mortality, fever had relatively little effect upon African personnel. Africans were given tasks considered inimical to European health. During epidemics, Africans and not their European counterparts were expected to care for the sick. Although far less likely to be placed upon the sick list, once sick, Africans, on average, spent the same number of days on the list and were as

likely to experience a relapse. Evidence suggests that Africans preferred their own medicine. Surgeons noted that despite forbidding the employment of ‘traditional’ medicine, African patients attempted to heal themselves or relied upon treatment from other African personnel. Failure for European sailors to adhere to surgeons’ directives could result in physical punishment, but African sailors were, at least at times, given a degree of latitude. Some surgeons afforded Africans and Europeans identical treatment, while others provided Africans with harsher, more aggressive, forms of treatment. Racialized medicine was not as yet systemized, as each surgeon decided upon the validity of such an approach. The important variety of practice and understanding of Africans and their bodies was reflected in surgeons’ various approaches to and application of medicine in Africa. It is important to note that although in some instances Africans were treated differently than Europeans, they were perceived of and treated medically as fellow humans.

Historiography

The thesis contributes to our understanding of race and Africa by shifting focus away from the origins of British racism. Debates over causation, so prevalent in the historiography, while undoubtedly important, have narrowed understanding of the introduction of racism into British culture.⁷⁷⁰ This narrowing has obscured the ‘flux’ in this period and the unsettledness of

⁷⁷⁰ For instance, Stuart Gilman argued that racial fears can be traced to Edward Long, “Degeneracy and Race,” 30-32; Stepan asserts that James Cowles Prichard played a central role in delaying the onset of British racism, *The Idea of Race in Science*, 2.

characterizations of ‘the African body.’ Symptomatic of the narrowness has been the focus of historians on well-known authors who wrote and lived in the imperial centre. By doing so, scholars have largely ignored views articulated at the periphery. As demonstrated, British medical practitioners working in the empire engendered numerous opinions concerning Africans and their bodies. This thesis has demonstrated the variety of understandings of Africans and their bodies that existed in the first half of the nineteenth century.

An evaluation of the health of Royal Navy personnel serving in the West African Station, 1825-1861 demonstrated the importance of race as a marker of care. To date, studies of health and the Royal Navy have largely ignored race.⁷⁷¹ Race influenced experiences as Africans hired to engage in labour considered inimical to European health were much less likely, in comparison to European personnel, to be sent to a shore hospital and, during a fever epidemic, were preferred as nurses. Race may have influenced how the Royal Navy and its surgeons understood and treated African patients. While some African patients were afforded treatments similar to Europeans others received harsher more aggressive forms of healing. The different approaches to treating African patients provide insight into the relationship between health and medicine in the nineteenth-century Royal Navy. This adds a new perspective to what has been, to date, a Eurocentric field of study.

⁷⁷¹ For instance, Lloyd, “The West African Squadron,” 155-172.

A focus on medical missionaries has monopolized debates concerning missionaries and healing in the nineteenth century British world. The thesis has enlarged our knowledge about connections between medicine and conversion by examining the degree to which missionaries without medical training were involved in African health in the first half of the century. It was determined that medicine played almost no role in missionaries' approach to African conversion. This finding is in-line with the traditional approach which argued that health and healing was not a feature of missionary conversion efforts in the first half of the century.⁷⁷² The thesis questioned the revisionist position, articulated by Christoffer Grundmann. Grundmann argued that political weakness in Asia facilitated the penetration of medical missionary penetration into China and India.⁷⁷³ This cannot be the only reason for the focus on Asia, as Sierra Leone, the Gambia, and Gold Coast were all British colonies open to British missionaries. The reason Africa was overlooked as a place requiring medical missionaries appears to lie in the perception of Africans as being more open to conversion and, thus, not requiring medicine as an added tool of conversion. The deadliness of the African disease environment for Europeans may also have encouraged missionary societies to privilege healthier climes over Africa to protect their limited numbers of trained medical idealists.

⁷⁷² Williams, "Healing and Evangelicalism," 271-86; Fitzgerald, "Clinical Christianity," 94-95.

⁷⁷³ Grundmann, *Sent to Heal*, 162.

An emphasis on agency and a desire to work outside the colonizer/colonized paradigm has encouraged historians to examine the limitations of empire. Heading this approach is Richard Price who has shown the fragility of empire by highlighting the necessity of compromise.⁷⁷⁴ This thesis supports his argument. The medical system that developed in British West Africa was limited. At times, Sierra Leone would only have a single British practitioner capable of duty. The Gambia and the Gold Coast were allotted two practitioners each. These medical systems and their practitioners were invariably overwhelmed and forced to make concessions. In important aspects, the medical system that developed was not thrust upon Africans but was the result of compromise. The most important and criticized compromise was the employment of dressers, African medical attendants, who were viewed by British medical practitioners more as a barrier than a bridge to African patients. Western medicine was not transported to the periphery as an unaltered whole; it was strongly influenced by indigenous responses. In West Africa, 1800-50, this possessed some therapeutical, and many socio-cultural, features.⁷⁷⁵ The ability of Western medicine 'to penetrate' the 'African body' remained limited and compromise was at the forefront of African/British medical interactions in this period.

This thesis contributes to the question: "What is colonial about colonial medicine?"⁷⁷⁶ For the purpose of the following development of this question, in

⁷⁷⁴ Price, "One Big Thing," 612.

⁷⁷⁵ Arnold, "Medicine and Colonialism," 1410.

⁷⁷⁶ Ernst, "Beyond East and West," 508.

light of this thesis, the field of reference will be limited to British medicine in colonies where there were subjugated people (or peoples) - subjugated in whole or part, or in the process of undergoing subjugation.⁷⁷⁷ The rise of state interest and involvement in health care and health policy during the nineteenth and early twentieth centuries took place within polities which were strongly socially stratified. One way of interpreting Professor Porter's question is to ask another question: Were there essential differences between the British state's imposition of medicine upon the poor of Britain's industrial slums, and the imposition upon the subjugated peoples of a British colony? As David Arnold has observed, colonial medicine reflected the growing desire of "bourgeois societies" to categorize, discipline, and dissect the body. Because, both colonial and metropolitan medicine shared the same desire to order, it is "pointless" to deny the metropolitan origins and continued influence upon medicine in the colonies.⁷⁷⁸ Attitudes of Western bio-medicine to the impoverished lower-class British as well as the not-as-yet assimilated immigrants from Ireland, European Jewry, and elsewhere could be as judgmental as those expressed towards subjugated Black Africans. This investigation cannot for reasons of space and focus attempt a comparison between these two large and diverse cohorts as the objects of the British state's intentions and/or actions. Nonetheless, it is useful to emphasize, when addressing the question, "What is colonial about colonial medicine?", that

⁷⁷⁷ The questions of "What is colonial about colonial medicine?" in colonies without subjugated peoples, or within non-British colonial systems are worthy of study, but will not be dealt with here.

⁷⁷⁸ David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley: University of California Press, 1993), 9.

'colonial medicine' dealt with subjugated peoples, where 'subjugated' necessarily meant more than severe economic hardship (shared by many peoples of the nineteenth century) or the harsh attitudes of state medical personnel (similarly shared). Western bio-medicine in the nineteenth century confronted 'ignorance' and 'filth,' and benefited from economic, social, and political weaknesses among the targeted populations, in many places far removed from colonial locales. What then was 'colonial' about state medicine when it was experienced by subjugated peoples? This leads to the following set of overlapping questions and conclusions in respect to British West Africa, 1800-1860.

Was the population subjugated? In British West Africa, 1800-1860, the extent of state control was limited. While the state had a measure of influence over populations along the coast, the interior of all three colonies remained largely outside European direction. The state could influence specific individuals and it did have the power to coerce liberated Africans into apprenticeships and the armed forces.⁷⁷⁹ At times, British jurisdiction was near total. For instance, liberated Africans recently freed had little, or no, authority over their bodies. Those forced into apprenticeship or the army experienced subjugation. According to Christopher Fyfe, many liberated Africans who served as apprentices were “virtually domestic slaves, to masters and mistresses who treated them harshly, even cruelly.”⁷⁸⁰ Those placed into the King’s/Queen’s Yard were also under

⁷⁷⁹ Fyfe, *Sierra Leone*, 182-183; John Peterson, *Province of Freedom: A History of Sierra Leone* (London, Faber, 1969), 59-60.

⁷⁸⁰ Fyfe, *Sierra Leone*, 182-183.

state authority. They were often put to compulsory manual work before being re-settled in the villages. Outside of these examples, state jurisdiction was, for the most part, rather weak. While liberated Africans forced into temporary medical care or longer army service may be considered subjugated, those re-settled in the villages had much more autonomy and were not subjugated by the rudimentary state. While the villages were under the direction of a manager, his power was in practice muted.⁷⁸¹ Liberated Africans who did not agree with specific policies could leave the villages and establish new communities outside of British management.⁷⁸² Negotiation, not subjugation, governed the management of the villages and the lives of much of the liberated African population. This was also true for African populations in the Gambia and Gold Coast.

Did the subjugation or the actual act of establishing a colony – in the minds of the British state or of its medical providers – constitute a medical obligation? The British state felt a moral obligation to care for liberated Africans.⁷⁸³ Liberated Africans were considered victims of an evil trade (which the British had long participated and profited from) and thus were entitled to the help that the British could offer.⁷⁸⁴ There were of course other agendas: The state hoped to build a productive colony on the back of these, ideally healthy, workers.⁷⁸⁵ Medical practitioners were obligated to offer care. Despite the

⁷⁸¹ Christopher Fyfe, *A Short History of Sierra Leone* (London: Longmans, 1962), 61.

⁷⁸² Fyfe, *Sierra Leone*, 182-183.

⁷⁸³ Peterson states that “officials felt moral if not legal obligations towards the recaptives [liberated Africans].” Peterson, *Province of Freedom*, 48.

⁷⁸⁴ Fyfe, *Sierra Leone*, 115.

⁷⁸⁵ Peterson, *Province of Freedom*, 94 and 199.

rumblings of Surgeon James Boyle, medicine was to be provided to any petitioner in Sierra Leone, whether such person could pay for the services or not.⁷⁸⁶

Practitioners took their duties seriously, engaging in a variety of medical tasks in what was a stretched and over committed system. They judged their care to be beneficial and complained that potential patients avoided or waited too long before seeking out European care. On the whole, this ethical obligation went largely unchallenged as physicians and officials accepted the responsibility for caring for liberated Africans. It is important to note that these obligations arose, out of liberation not subjugation.

Did the state believe that a subjugated people had an obligation to submit to British medicine? And if so, did such an obligation lead to the imposition of a system of intrusive and coercive Western medicine? Medical practitioners subjected liberated Africans to a mandatory examination upon their removal from a slaver. This was to ensure both the health of liberated Africans, and to protect the health of the colony. Those carrying signs of deadly infectious disease would be isolated. Likewise, Africans who entered the army were obligated to undergo a medical inspection.⁷⁸⁷ Later when emigration to the West Indies became an issue, Governor Norman MacDonald asserted, in 1847, that liberated Africans, because of their known resistance to smallpox vaccination, should be compulsorily vaccinated at sea, where their power to resist or avoid was greatly diminished.⁷⁸⁸

⁷⁸⁶ N.A., CO 267/94: Boyle to Denham, Sierra Leone, 13 May 1828. See above, p. 166.

⁷⁸⁷ N.A., CO 267/94: Denham to Huskisson, Sierra Leone, 14 May 1828.

⁷⁸⁸ N.A., CO 267/203 fo.10: MacDonald to Grey, Sierra Leone, 27 January 1848. See above, pp. 184-185.

The medical system, as this example suggests, could be draconian, but in practice rarely had either the power or opportunity to force Western medicine on Africans overall. Given the limited examples of coercion, it would be difficult to characterize Western medicine in British West Africa up to 1860 as an intrusive system that coerced Africans into care. The medical system had elements of coercion and was not above taking advantage of weakness to assert its authority but actual events were rare. British medical practitioners certainly believed strongly that Africans should submit to European care but did not, despite their frequent complaints, argue that liberated Africans should be coerced.⁷⁸⁹ So far as can be determined, no one in this period framed acquiesce to Western health care as an obligation imposed upon subjects, with the exception of some contagious disease. Even here, the later very controversial topic of Africans and syphilis attracted medical attention, but no calls for mandatory treatment.

Is it sufficient in considering the relationship between medicine and colonialism to place the focus upon the power dynamic? Margaret Jones has questioned such an approach and instead of focusing on power, depicted medicine in the colonies as an extension of state medicine at home. She argued that there was little that was specifically colonial about medicine in the colonies (for her period and area) because the same practices and approaches were found in Britain.⁷⁹⁰ This is a useful approach, although it may minimize important regional

⁷⁸⁹ See above, pp. 176-177; 180-181.

⁷⁹⁰ Margaret Jones, "Infant and Maternal Health Services in Ceylon, 1900-1948: Imperialism or Welfare?" *Social History of Medicine* 15, no. 2 (August 2002): 288.

variety and tend to ignore unique problems of implementation, with resulting policy changes, in colonial settings. If power is the fundamental theme of 'colonial medicine,' then what can be said about British West Africa, 1800-1860? Yes, power was present, but nowhere in the evidence does British power (either state or medical) appear as the central determinant of historical events. State medicine in British West Africa, 1800-1860, was not part of the limited subjugation (or colonization) of peoples that took place. Indeed, while the British wanted healthy and productive workers to increase the profitability of its West African holdings, there is no evidence to suggest that medicine was perceived or indeed employed as a tool of the empire. On a practical level the medical system was simply too weak to take this course of action.

For scholars who examine British Africa in the second half of the century, the power of the medical system and its role in subjugation is a dominate theme.⁷⁹¹ As Marks has stated, it was the century *circa* 1850-1950 which witnessed, not coincidentally, the “heyday of European empires” and “the emergence of an effective and apparently all-conquering biomedicine, each the product of Europe’s technological revolution.”⁷⁹² For the first half of the century, evidence of such power, authority, or coercion remains scarce. The colonized/colonizer model which buttresses this later historiographical perspective ignores the important nuances of medicine in British West Africa.

⁷⁹¹ For example: Curtin, *Disease and Empire*; Curtin, “Medical Knowledge and Urban Planning,” 235-255; Vaughan, *Curing their Ills*.

⁷⁹² Marks, “What is Colonial about Colonial Medicine?,” 207-208.

For instance, Kroomen, employees who traveled from outside of areas of British influence to Sierra Leone in search of work, were neither colonized nor subjugated. Their obligation to submit to medical care on board the Royal Navy vessels arose out of this particular employment, not subjugation. However, as has been demonstrated, Kroomen did, even on the tight confines of a Royal Navy ship, sidestep medical ‘power’ by continuing to practice their own preferred medical treatments. For liberated Africans, it was their liberation which imposed an ethical duty of health care upon the state, not their subjugation. This requirement, in practice, was restricted to a few key occasions,⁷⁹³ when British power could not be challenged. Within the Church, converts were expected, but not forced, to restrict their medical care to European methods and practitioners. Coercion was likely present in the pastor-parishioner relationship. However, the British missionaries were so aware of the limitations in their ability to convert, it seems unlikely that they could, or did, coerce successfully as a norm. While the discourses of Western medical superiority were present, the state largely lacked the power to force British medicine upon Africans.

The thesis, therefore, has challenged some traditional thinking about colonial medicine. As Shula Marks observed pointedly in 1997, the historiography of colonial medicine possessed neither an agreed theoretical base, nor a coherent agenda.⁷⁹⁴ This study provides reason for the further development

⁷⁹³ For instance, when liberated Africans were freed from a slaver and before entering the army.

⁷⁹⁴ Marks, “What is Colonial about Colonial Medicine?,” 207.

of both. The two central themes identified by Marks in the literature – “how medicine served as an instrument of empire, as well as an imperializing cultural force itself” and “the impact of western medicine on indigenous healing practices, as well as on the indigenous experience of, and responses to, western medicine” – are well known, and deserve study.⁷⁹⁵ However, they are not the only themes, nor are they necessarily universal in either theory or practice. Colonialism and colonial medicine were not linear processes. An individual is not either colonized or not, but part of a larger process where in some situations their relative power and autonomy may be restricted. In other circumstances, their freedom of action could be relatively uninhibited. Medical power was continually mediated by circumstances. At times, these circumstances favoured state and medical control, at others, the individual. Bio-medical power as a key determinant in understanding colonialism possesses justification in many colonial periods and settings, but falls short as a means of describing the relationship between medicine, state, and population in the first half of the century in British West Africa. Also, if it is power which defines colonial medicine, how was medical power in a colonial setting different than the power which governed medical interactions in the metropole? Medical coercion was not always physical nor forced. British medical practitioners tried to convince liberated Africans of the benefits of European care. They believed that once African ‘ignorance’ had been removed that Africans would willingly submit to Western medicine. This is why

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Marks, “What is Colonial about Colonial Medicine?,” 207.

practitioners such as Robert Clarke hoped to educate Africans through free lectures that reveal the benefits of Western medicine.⁷⁹⁶ Power was largely absent, or at least muted, in this instance. These conclusions warrant a re-evaluation of what is colonial medicine. It is clear that the current model, with its close association with the later transcendent power of the British state and Western medicine, does not fit for British West Africa, 1800-1860.

The thesis has challenged the diffusionist model as suggested by Daniel Headrick and others who depict knowledge as moving from the West to the East.⁷⁹⁷ This model relegates the periphery to a largely insignificant and static place that required European ideas to achieve change. This approach plays upon earlier perceptions that African medicine and societies were stagnant and largely unable to change.⁷⁹⁸ Medicine in British West Africa was not stagnant nor did it require direction from outside to change. British medical practitioners developed or learned new healing techniques from African healers and would, at times, bring these remedies back to the imperial centre. Mark Harrison buttresses this assertion in his study of Helenus Scott which described the ways in which a new remedy for venereal disease developed in India influenced treatment in the metropole, if only briefly.⁷⁹⁹ New knowledge was not exclusively transferred in linear patterns to and from centre and periphery but could take a more circular pattern traveling within the empire. For instance, therapeutic innovations

⁷⁹⁶ For example: Clarke, *Sierra Leone*, 102-03.

⁷⁹⁷ Headrick, *Tools of Empire*, passim; Burrows, *A History of Medicine in South Africa*, 67-

68.
⁷⁹⁸ Winterbottom, *An Account of Native Africans*, vol. I, 251-52.

⁷⁹⁹ Harrison, "Medical experimentation in British India," 23-41.

developed in the West Indies were brought to Africa while C. A. Gordon took healing techniques learned in Africa to India.⁸⁰⁰ According to Alan Lester, imperial networks tied the empire and periphery together and were mutually reinforcing, creating an imperial world that operated as a seamless whole.⁸⁰¹ His emphasis upon how ideas were created and precedents formed in interaction between the metropole and the various British colonies adds much to the collective understanding of the relationship between the imperial centre and the colonial periphery. However, his conception of knowledge transfer is too absolute. Medical practitioners in Africa were influenced by what they witnessed in Africa, developing new ideas about Africans and their bodies. These ideas often had little influence on metropolitan understanding of Africans and this created an intellectual distance. While the relationship between the metropole and periphery could be mutually reinforcing, there was, at least in term of Africans and their bodies in the period 1800-1860, a real intellectual divergence between the metropole and periphery.

British medical practitioners who worked in the empire, similar to other colonial officials, often served in a variety of different locales. Their movements allow the thesis to contribute to the fields of globalization and health while adding to our knowledge of epistemic communities. It adds to this growing literature by writing medical men (a neglected cohort) into the literature of imperial intellectual exchanges. Examining the medical ideas and therapeutic innovations that

⁸⁰⁰ Gordon, "Some Observations on Medicine and Surgery," 532.

⁸⁰¹ Lester, *Imperial Networks*, passim.

physicians carried within the empire tells us about how British medical practitioners understood the relationship between medicine, climate, and population. While the tropics were often constructed as a monolithic whole, British medical practitioners in Africa disputed this by championing local difference. Their experience taught them that remedies employed elsewhere were of very limited use in Africa. They argued that Africa was so different that a new set of therapeutic practices needed to be developed.⁸⁰² Thus, while medical practice for Crown employees in the nineteenth century British colonial world was frequently global in its experiences and perhaps in outlook, there were limits to its ability to achieve uniformity especially as practitioners, at least in Africa, insisted upon difference. Such a conclusion augments the literature upon globalization and epistemic communities which celebrates the way in which ‘imperial careers’ contributed to a more integrated world.⁸⁰³

Contexts and Further Questions

This research contributes to our understanding of British medicine in West Africa during the first half of the nineteenth century. By selecting the first half of the century, a period when British medicine struggled and had a vision of dynamic science but limited African influence, the thesis emphasizes the challenges of establishing a fully functioning system of medicine in British West Africa. Continuity defined British medicine in West Africa in the period 1800-

⁸⁰² Morris Pritchett and James Ormiston McWilliam both argued that fever cures that worked in the West Indies were of no use in Africa. Pritchett, *Some Account of the African Remittent Fever*, 164-65; McWilliam, *Medical History of the Expedition*, 195.

⁸⁰³ See for example, Lambert and Lester, ed. *Imperial Careering in the Long Nineteenth Century*; Zoe Laidlaw, *Colonial Connections*.

1860. Much later, medical practitioners were aided by developments in medical science, including the germ theory and the discoveries of the mosquito-vector in the transmission of malaria (1898) and yellow fever (1900). But can the entire process be reduced to developments outside Africa? Did Britons and Africans in Africa have no part in this momentous change? Our knowledge of colonial medicine in West Africa would benefit from the study of the factors and processes that caused a relatively small medical system to become, in less than half a century, a dominant system of medicine capable of re-ordering African lives. To understand this change better, historians would benefit from examining the period 1860-1890, paying close attention to the shifts in British/African relations with a focus upon medical interactions. Such a study would be an important next research step for our understandings of British colonial medicine, not only in West Africa.

The thesis privileges the social history of health and medicine. Social history serves as the most potent method of learning African responses to and interaction with European medicine. It mentions large-scale morbidity and mortality rates, but it has been more concerned with how individuals approached and understood illness. An institutional social history focused upon the mechanism of patient management and the hospital structure in British West Africa would also be beneficial. It may be able to tell historians more about decisions made concerning hospital health care. It has been suggested above that from the earliest period the colonial hospital may have been a site of conflict. The

rise of the modern hospital in Western society during the nineteenth century has long attracted scholarly attention; here, it would serve as a focus for tracing shifts in the relationship between British medical practitioners and African patients. An institutional history of Kissy Hospital, executed as a comparative study with other hospitals in the non-settler colonies of the empire, would be enlightening. Such a study would enhance our understanding of British/African (medical) interaction while also providing insights into the development of colonial medicine.

By focusing on the health of Africans in Africa, the thesis has made a novel contribution to our understanding of African health. Although valuable research has been done to calculate the morbidity and mortality rates of enslaved Africans, both during the middle passage and as slaves in the Americas, the health of liberated Africans has been ignored. While British missionaries and colonial agencies undoubtedly publicized the most horrifying examples of liberated African health in order to condemn the slave trade and the countries that still permitted it, it seems clear that their health was indeed poor. Surviving statistics from Kissy Hospital reveal that over 40% of liberated Africans who entered the hospital died there.⁸⁰⁴ A useful next step would be to compare the health of liberated Africans with that for slaves landed in the Americas.

Continuity

The investigation supports an argument for continuity over change. While historians have labeled the 1840s as a defining decade in British attitudes towards

⁸⁰⁴ Clarke, *Sierra Leone*, 79-83; Clarke, "Prevailing Diseases," 80.

race, the thesis finds the period - in West Africa itself - marked by the same variety and flexibility characteristic of earlier periods. Much has been made of the widely publicized racism of Knox and others, but was this any more influential at the time, or characteristic of the public mind, than Edward Long who published three-quarters of a century earlier? The argument that a degree of racial hardening did occur is convincing, but it failed to dominate public thought as some scholars suggest.⁸⁰⁵ There remained a spectrum of opinions and attitudes concerning the meaning of race and bodily difference. This variety becomes very evident when the focus of study is widened to include positions articulated within the non-settler colonies of British West Africa, where it was flourishing until at least 1860.

Medical understanding of the West African climate and disease environment also remained much the same, 1800 to 1860. Practitioners still debated the existence of racial immunities, and the causes of and ways to limit exposure to tropical fever. There was no dominant position and a wealth of contradictory evidence. Britons in 1860 knew little more about the causes of tropical fevers than they had in 1800. The same factors were blamed: wet and marshy land, noxious airs, and low lying ground. Travelers, both with and without medical training, continued to reinforce the same known 'facts,' emphasizing the importance of acclimatizing fevers.

⁸⁰⁵ Stepan, *The Idea of Race and Science*, 4.

Direct medical experience, particularly in Sierra Leone, with liberated Africans, did little to alter medical understandings of African physiology. British medical practitioners could not determine conclusively whether racial immunities were inherited or acquired. Despite the treatment of numerous patients and corresponding opportunities to critique or to develop racialized theories of medicine, all the British medical practitioners who saw service in West Africa during the first half of the century and who published on the topic avoided this step. Indeed, one of the lasting legacies of care for liberated Africans is how little it did to shape the overall British understanding of Africans and their physiology. Practitioners were more concerned about the future of Africa than participating in the direct relationship of race to medicine. Many took African humanity as a given, and focused upon the practicalities of treatment. The inability, or lack of sustained interest, of practitioners on the ground to apply their experience to influence metropolitan constructions, in print and in correspondence with the Colonial Office, allowed those who lived in the metropole to become the leading ‘experts’ on Africans and their bodies. This would, especially in the second half of century, have disastrous repercussions for Africans.

Medical practice in British West Africa changed very little between 1800 and 1860. Little separates the therapeutics of Winterbottom and Clarke although they practiced medicine and published their accounts of Sierra Leone nearly forty years apart. The most substantial change was that European practitioners learned from African healers what they believed to be valuable substitutes for European

remedies, especially new ways of treating fever, and incorporated these remedies into their therapeutics. This development was hardly revolutionary but serves as evidence of practitioners' willingness to learn from local medical practices. While the British established a European hospital-based system of medicine, Africans continued to seek out a variety of practitioners in their quests for cures. European hospital-based medicine became another medical option for those Africans who possessed a relationship with the British colonial officials and agents. For many Africans, it was their last and final option. European hospital based medicine in 1860, as in 1800, remained on the fringes of African medical options.

In Sierra Leone, colonial officials believed that Africans largely decided whether and when to submit to European care. Missionaries much to their dismay found that converts would often reject European medicine. Missionaries complained about such backsliders, lamenting that even communicants, whose faith was supposedly unshakeable, would in times of poor health employ 'traditional' medicines.⁸⁰⁶ In the Royal Navy, surgeons reported that Africans not only disobeyed direct orders but that they interrupted care by employing their own local remedies.⁸⁰⁷ Even on the highly structured and close confines of a Royal Navy ship, Africans found ways to tend to their medical needs.⁸⁰⁸ In Sierra Leone

⁸⁰⁶ *Church Missionary Record*, vol. 5 (1834), 123.

⁸⁰⁷ N.A., ADM 101/130: Hart Ginlette, General Remarks of HMS *Arrogant*.

⁸⁰⁸ N.A., ADM 101/82/1: Medical Journal of HMS *Albatross*.

avoidance was a constant complaint made by British medical practitioners.⁸⁰⁹

While liberated Africans immediately freed had little control over their care and were often in desperate need of attention, those who were settled in the colony made their own medical decisions from a restricted range of healing arts. British medicine, if employed, became by necessity, much to the chagrin of British medical practitioners, one of a variety of medical options employed by African patients. In this way, European medicine was incorporated into the African practice of visiting a variety of healers in search of a cure. The medical system could not have coped with a provision of colony-wide access, thus it is an open question whether liberated Africans had many occasions to decline European medical attention.

The study has examined how the theory and practice of medicine intersected in British West Africa. The thesis determined that medical practitioners in British West Africa, possibly because of the great variety of cases they attended, did not create – or at least disseminate - sweeping medical or racial theories. One of the most striking aspects about those who practiced in West Africa was their reluctance to create or validate theories of race, medicine, and the African body. While ideally placed to create such commentaries, practitioners shied away from fixed constructions, emphasizing their lack of knowledge about Africans while emphasizing the variety of African people.⁸¹⁰ An important

⁸⁰⁹ For instance, N.A., CO 267/209 fo.93: Aitken to Grey; Sierra Leone, 24 October 1849, 12-13; N.A., CO 267/103 fo.7: Findley to Murray; Sierra Leone, 28 August 1830.

⁸¹⁰ Winterbottom, *An Account of Native Africans*, Vol. 2, 256-257.

exception was Robert Knox, who had served in Africa. However, it is worth noting that Knox's *The Races of Men* first appeared thirty years after he left Africa. British medical practitioners appear to have been influenced more by what they witnessed first hand, not what they had heard or read. This allowed them to recognize African variety. There were exceptions. It seems likely that the harsher, more aggressive, treatments applied to Africans in the Royal Navy were influenced by medical theories concerning race and the strength of the African body. Surgeons rarely treated fever as a threat to African health, but this may have been more the product of direct observation than influenced by theory. Nonetheless, there remained a divide between those who formulated racial theory and the practitioners themselves. This diversity is in marked distinction to the theory and practice of tropical medicine in the second half of the century when medicine rested in the same authorities and became much more enmeshed and used to separate Africans from Europeans.⁸¹¹

The racial constructions formulated in Europe in the late eighteenth and first half of the nineteenth-century were not rigidly applied in Africa. While individual commentators in the metropole, such as Charles White, attempted to reduce 'the African' to a single image, Britons on the ground generally emphasized variety. This recognition in turn became policy. The Royal Navy preferred certain African personnel, missionaries believed some Africans to be better candidates for conversion than others, and liberated Africans, because of

⁸¹¹ Curtin, "Medical Knowledge and Urban Planning," 235-255.

the barbaric experiences on board slavers, were believed to require accommodation and special treatment. In the first half of the century, reductionist theories did not dictate the understanding and application of race for Africans in British West Africa.

This thesis has provided an in-depth examination of British and African interactions within the field of health and medicine. It challenges the notion that a single conception of 'the African' held a sway over British minds; it emphasized the importance of studying 'the African' as that designation existed in the minds of metropolitan Britons and those at the periphery. This approach ensures that a fuller picture of British understanding and interaction with Africans is achieved. The thesis emphasizes the multiplicity both in forms of medical practice and in approach to 'the African' body. Africans in a variety of contexts found ways to avoid British medicine and to make it fit within their own medical customs; European medicine had a limited reach during the years covered. The thesis also highlighted the willingness of British practitioners to adopt African healing methods and how these practices were carried elsewhere within the empire. During this period, the British attempted to implement a European hospital-based system of medicine but with only very limited success, mainly because of their paltry dedication of personnel and the monumental task associated with the care of liberated Africans. British medical practitioners and officials believed that Africans rejected European medicine but to what extent, beyond several specific episodes, we can not determine.

**Appendix A: Percentage of Royal Navy Ship Personnel
Entered onto the Sick List⁸¹²**

<i>Atholl</i>	1 Jun 1831- 24 Feb 1832
Europeans	113 of 140 = 80.7%
Kroomen	6 of 18 = 33.3%
Total Ship	119 of 158 = 75.3%
<i>Aetna</i>	13 Oct 1837 – 9 Nov 1838
Europeans	81 of 99 = 81.8%
Kroomen	9 of 25 = 36%
Lib African Boys	6 of 6 = 100%
African Total	13 of 31 = 31.7%
Total ship	94 of 130 = 72.3%
<i>Scout</i>	25 Nov 1837 – 30 May 1838
Europeans	55 of 113 = 48.7%
Liberated Africans	2 of 2 = 100%
Lib African Boys	4 of 6 = 66.7%
Krooman	7 of 19 = 36.8%
Africans	2 of 2 = 100%
African Total	14 of 29 = 48.2%
Total ship	69 of 142 = 48.6%
<i>Wilberforce</i>	29 Jan 1840 – 23 Aug 1842
Europeans	40 of 47 = 85.1%
Krooman	6 of 11 = 54.5%
Africans	14 of 24 = 58.3%
African Total	20 of 35 = 57.1%
Blacks	7 of 11 = 63.6%
Total ship	67 of 93 = 72.0%

⁸¹² Calculated from the sources identified in Graph 1.1.

Rapid 2 Dec 1846 – 31 Dec 1847

European	36 of 71 = 50.7%
Krooman	7 of 14 = 50 %
Africans	0 of 2 = 0%
African Total	7 of 16 = 43.8%

Total Ship	43 of 87 = 49.4%
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Trident 10 Sept 1858 – 7 Nov 1859

Europeans	62 of 72 = 86.1%
Krooman	11 of 27 = 40.7%
Africans	0 of 3 = 0
African total	11 of 30 = 36.7%

Total Ship	73 of 102 = 71.6
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Arrogant 1 Aug 1861 – 4 Nov 1861

Europeans	322 of 399 = 80.7%
Kroomen	25 of 86 = 29.1%

Total Ship	347 of 485 = 71.5%
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Ranger 2 Jan 1861 – 31 Nov 1861

Europeans	50 of 60 = 83.3%
Krooman	12 of 19 = 63.2%

Total ship	62 of 79 = 78.5%
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All Ships

Europeans	759 of 1001 = 75.8%
Kroomen	84 of 220 = 38.2%
Liberated Africans	2 of 2 = 100.0%
Liberated African Boys	10 of 12 = 83.3%
African	16 of 31 = 51.2%
African Total	112 of 265 = 42.3%
Blacks	7 of 11 = 63.6%

Total All Ships	874 of 1276 = 68.3%
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