CHAPTER 3

The 'Africanisation' of Psychiatry

As preparations for decolonisation started to accelerate after the Second World War, the need for knowledge on what was 'normal' and 'abnormal' in the African was increasingly noted. 'We need extensive research on African mental health not in the future but now', claimed Donald Mackay, mission doctor in Northern Rhodesia: 'We need mental clinics in every township. We need men trained in psychiatry and steeped in African background to stem the tide of threatening maladjustment. We hear much of development—but where is there development so pressing as this'.[1] Most European doctors, Mackay stressed, were ignorant about psychiatric and psychological medicine: 'The neurosis, the small maladjustment, have passed us by', meaning psychiatry was limited to 'when some obstreperous lunatic is certified and packed away to some Institution, dead to the world of his fellows'.[2] Yet the 'mental consequences' of 'detribalisation', as articulated by those in the East African School of Psychiatry and Psychology, were inescapable: 'time waits for no master. If we do not face the problem now, and deal with maladjusted individuals, the problem will face us in another generation and we shall have a maladjusted nation to deal with'.[3] In Mackay's opinion, the subject was best approached by 'hard grinding study' of the African's 'background, his faiths, his hopes, his fears, his sex life—and everything that makes up the mosaic of his mental environment'.[4] Others, however, contended that Africans were better placed to understand what was 'normal' and 'abnormal'. Responding to Mackay in 1948, John A. Carman, editor

Y. Pringle, *Psychiatry and Decolonisation in Uganda*,
Mental Health in Historical Perspective,
https://doi.org/10.1057/978-1-137-60095-0_3

of the *East African Medical Journal*, argued that because of the complex variations in African mentality and 'the hidden secrets of the hills and forests', 'the right type of African doctor is the only person who can hope to approach the subject in the proper way'.[5]

What constituted the 'right type' of African doctor had long been debated in East Africa—not least in Kenya, where Europeans feared that African doctors would 'get too big for their boots'.[6] In Uganda, the colonial government was more open to the technical training of Africans, including through their own medical programme at Makerere Medical School, based at Mulago Hospital, which accepted students from across East Africa. While the interest in medical training set Uganda apart from Kenya, it should be remembered that Africans did not receive equal status as doctors until 1951, being, as John Iliffe has stressed, 'merely assistants, embittered by subordinate status and unrewarding conditions of work'.[7] Colonial officials also frequently justified the extending of training to Africans on the basis of notions of cultural difference. W. H. Kauntze, Director of Medical Services (DMS), noted on the training of sanitation officers in 1937 that 'A European can never quite look at matters from the African point of view….Hence the prime essential is to build up an enlightened body of Africans who can be taught to appreciate the scientific reasons lying behind sanitary law, and who will have such an intimate knowledge of the African mind that the cogent arguments which can be brought forward in favour of sanitary ideals can be so framed as to find favour in spite of inherited beliefs'.[8]

As African doctors started to come together as a professional group in the run-up to Independence in 1962, these ideas did not disappear, but were reworked as political claims to knowledge and status. Opening an article on African patients, Eria M. Babumba noted that he 'was brought up among his own people and knows what his fellow Africans are likely to think, their old beliefs and superstitions, and their usual fears'.[9] The Makerere Medical Graduates' Association, too, argued that African doctors, by right of birth, had 'more direct communication with our fellow African than any other people….Patients trust us more'.[10] Such sentiments were supported by contemporary medical thinking about the importance of psychology in doctor–patient relationships. Addressing the Uganda branch of the British Medical Association (BMA) in 1955, H. C. Trowell described how with his own African patients, 'I seldom feel really at home and I feel sorry for my students that they see this travesty of a physician, one who cannot really talk fluently with his patients

and even then has almost no understanding of the medley of motives, hopes, fears, reserves and evasions which are encountered in our African patients'.[11] 'I often wish', he added, 'my students could see me practising among my own people, among whom I detect more quickly the anxieties and background of every case'.[12] In Trowell's opinion, Africans possessed natural cultural 'insight' into their patients' fears and anxieties that could be harnessed through medical training, just as doctors in Europe might come to 'detect' these signs in their own patients.

In the decades following the Second World War, calls for further research into mental illness and the training of Africans in psychiatry coincided with the 'Africanisation' of British colonial rule in Africa. Officially initiated in Uganda in 1952, Africanisation consisted of policies aimed at increasing the number of Africans in the administration through training and promotion. Such policies, which had the most visible effects in the army, the police and the legislative council, were intended to allow Africans to 'stand on their own feet without support, to manage their own affairs without supervision, and to determine their own future for themselves'.[13] Within medicine, Uganda's colonial government attempted to accelerate the process through increased funding for postgraduate training from 1957. In 1960, the first African doctor was appointed to Medical Headquarters, and in 1962, Ivan Kadama became Chief Medical Officer of the newly independent Ministry of Health.[14] Within psychiatry, Stephen B. Bosa, who had worked at Mulago Mental Hospital since 1948, was promoted to consultant psychiatrist in 1961 and finally made head of mental health services in 1964. Africanisation was not revolutionary, however. Nor should it be equated with a decolonisation of psychiatry. Africanisation was a slow devolutionary process that concerned staffing—a transitionary period intended to be good for social, economic and political development, rather than a concession of independence.[15] It also entailed little immediate change in psychiatric practice and organisation. As I show in this chapter, even in his newly promoted position, Bosa was unable to convince those at the Ministry of Health to act on his proposals for psychiatry. When Makerere Medical School decided to open a Department of Psychiatry in 1966, moreover, the new curriculum was modelled along English lines.

This chapter, and the one that follows, is concerned with the experiences of African doctors and psychiatrists as they took over responsibility for psychiatry at the end of empire. Much of this concerns training, from the inclusion of psychiatry on the syllabus at Makerere Medical

School and the use of Mulago Mental Hospital for short-term placements, to the overseas training of Uganda's first psychiatrists, Bosa and Benjamin H. Kagwa, and to the programmes implemented by Makerere Medical School in the years following the opening of the Department of Psychiatry. But it is also concerned with the place of Ugandans, first within the institutions and structures governing psychiatry during colonial rule, and then in the mental hospital in the early 1960s. Ugandan doctors were not isolated from local or nationalist politics; indeed, as became clear during widespread disturbances in the 1940s, they were often at the centre of it. The Africanisation of psychiatry between the 1940s and the 1960s thus reveals not only an uneasy relationship between psychiatry and colonial politics, but also the practical difficulties facing Ugandan psychiatrists at the end of empire.

Uganda's First Psychiatrists

Psychiatry was included in the curriculum at Makerere Medical School from the outset. Just as medical education in England had by the 1920s incorporated psychiatry and psychological medicine as compulsory, if minor, elements of the Bachelor of Medicine degree, so it was considered a necessary part of the medical course in Uganda.[16] In practice, however, training in psychiatry depended on the ability and availability of a willing tutor. While in 1946, Philip Hutton, Physician at Mulago Hospital, gave lectures on neurology, psychiatry and therapeutics, in the following year, his absence from Mulago Hospital necessitated the removal of psychiatry from the syllabus altogether.[17] In line with the practical emphasis of training at Makerere Medical School, which used Mulago Hospital as a teaching hospital, the mental hospital also acted as a training ground for psychiatry and psychiatric nursing. From the early 1940s, a small number of African Medical Officers (AMOs) were assigned to Mulago Mental Hospital for periods of up to a few months. In addition to assisting in the routine physical and mental examination of all new patients, they made regular notes on the mental progress of patients and administered specialist treatments.[18] Charles Baty, Superintendent of Mulago Mental Hospital in the early 1940s, kept detailed notes on a range of procedures, including electroconvulsive therapy (ECT), and it is likely these were used for training purposes.

Medical training created a new group of individuals through which psychiatry was able to operate in Uganda. While their knowledge of

psychiatry and psychology was limited, it was hardly any less than that of most European medical officers (MOs), whose medical training and lack of cultural knowledge had left them ill-prepared for the types of mental illness they would face in their daily practice.[19] As the number of graduates grew, AMOs also formed an increasingly prominent part of the Colonial Medical Service. While as a group of graduates they remained small until the 1960s, by the late 1930s, their numbers had begun to rival those of European MOs. In 1938, there were 31 AMOs (then called Senior African Medical Assistants) working in government service alongside 33 MOs, 5 Senior MOs, and an assortment of hospital superintendents, surgeons and administrators.[20] Such was the reliance on AMOs, particularly in remote out-stations, that in 1938 the colonial administration granted them limited powers in the certification of mental illness. In a move that was unique in British colonial Africa at the time, the 1938 Mental Treatment Ordinance allowed registered African and Indian medical practitioners to provide one of the two medical reports required by a magistrate, the other being provided by a licensed European practitioner. This amendment, it was noted, was necessary to provide 'more protection to the public', as 'in a number of outstations it would be impossible to assemble two registered practitioners quickly'.[21] In practice, it meant that while Europeans retained a superior status as 'licensed' doctors, responsibility for the mentally ill was increasingly devolved to the new group of Western-trained African doctors. It is unlikely that this had any noticeable effect on diagnosis or treatment, however. With most AMOs originating from Buganda until the 1950s, and lacking language skills in the diverse and often remote areas to which they were posted, problems of communication remained.[22]

While AMOs were exposed to psychiatry and psychological medicine, specialisation in psychiatry was not encouraged. This reflected the lack of regard for psychiatry among Europeans in Uganda, who felt that even short-term placements at Mulago mental hospital 'may not be in the best interests of the A.M.O.' due to its low status, poor working conditions and lack of resources.[23] But it was also indicative of more general restrictions placed on AMOs, who were not offered opportunities for progression or specialisation until after the Second World War. The first Ugandan doctor to qualify in psychiatry did so not in Uganda, or even in the UK, but in the USA. In 1928, Benjamin H. Kagwa, son of Paulo Bakunga, a former Mukwenda (chief of Singo county), left Uganda, travelling first to France and England, before continuing to America in pursuit of higher education.[24] Kagwa later noted that he had

been inspired to study medicine by observing Church Missionary Society (CMS) doctors Albert, Jack and Ernest Cook while at Mengo High School, Kampala. 'Their mannerisms, friendliness, apparatus, and handling of patients', he recalled, 'as well as their seeming omniscience, had him spellbound'.[25]

With financial support from his father, the Buganda Kingdom, and the Phelps-Stokes Fund, Kagwa studied at Lincoln, Columbia, and New York Universities, gaining an MD in 1940.[26] As he approached his graduation, however, the colonial government informed him that they would not recognise his American qualifications. If he decided to return to Uganda, he would be registered as an African Assistant Medical Officer (AAMO), the highest position an African medical practitioner could hope to achieve in Uganda at the time, but would not be registered as a doctor. Any higher position, it was noted, would undermine efforts to promote Uganda's own diploma in medicine which, following the recommendations of the 1937 de la Warr Commission, it was hoped would one day be recognised as a full medical degree by the British General Medical Council (GMC).[27] The absurdity of the situation was highlighted by J. E. W. Flood, Director of Colonial Scholars, in December 1939, when he complained that 'it occurs to me that the Uganda Government is simply being sticky for stickiness' sake. It is a perfectly lunatic situation that a black gentleman wearing a string of beads and a smile can practise "native medicine" if he likes, but poor Kagwa, who is a highly educated gentleman, would not be allowed to practise even with the M. D. of New York University unless he cares to set up as a "native" practitioner'.[28]

Refusing to accept these conditions of return, Kagwa went on to complete residencies in neuropsychiatry at the Homer G. Phillips Hospital, St. Louis, as well as Chicago, before finally settling in New York.[29] According to Kagwa, he had been drawn to psychiatry in the second year of his medical degree when he had accompanied the Viennese psychiatrist and neurologist Paul Schilder on ward rounds at New York's Bellevue Hospital. Kagwa recalled a 'tantalizing' case involving an elderly chronic alcoholic white male, from whom he and a fellow student were able to elicit 'random ideas and fantastic yarns'.[30] Yet it was the 'scientific exactness' of clinical neurology, he later decided, that drew him to neuropsychiatry.[31] Over the next twenty-five years, Kagwa worked variously as a psychiatrist, electroencephalographer and neurologist at a range of hospitals in New York, and became an active member of the

Manhattan Central Medical Society, the New York Neurological Society, the American Academy of Neurology, the Brooklyn Psychiatric Society, as well as the American Medical Association, among other bodies.[32] At a time when his colleagues in Uganda were still fighting for recognition of their qualifications and status, Kagwa was establishing a reputation for himself as a neuropsychiatric expert.

Kagwa may have been the first Ugandan to qualify as a psychiatrist, but he was not the first to practise in Uganda. That title goes to Bosa, who received his medical diploma from Makerere in 1945, started work as an AMO attached to Mulago Mental Hospital in 1948 and received a Diploma in Psychological Medicine (DPM) from the Maudsley Hospital in 1961.[33] The decision to appoint an AMO to Mulago Mental Hospital on a full-time basis originated in a report by J. C. Carothers, who had visited in early 1943 on the request of the colonial government. Carothers was tasked with reporting on existing arrangements for mental patients and to suggest ways of ensuring uniformity in psychiatric provision across East Africa, particularly in the legal and practical arrangements for European lunatics.[34] Carothers' report confirmed much of what the medical authorities in Uganda already knew: the mental hospital was overcrowded, the accommodation inadequate (particularly for European cases, who were still held for short periods prior to being transferred to Kenya or South Africa), and specialist therapies lacking.[35] But it also raised the question of the appointment of a full-time (European) Specialist Alienist to take over as Superintendent of Mulago Mental Hospital. While they were being recruited, Carothers added, an AMO would be welcomed at Mathari Mental Hospital, Kenya, for training as a Hospital Assistant.[36] J. P. Mitchell, Medical Superintendent of Mulago Hospital, with responsibility for Mulago Mental Hospital and Makerere Medical School, took issue with these last two points. Rather than appointing a European directly to the hospital, he argued that 'an interested A.M.O. would suffice'. Not only was the treatment available at Mulago Mental Hospital limited, but there were not enough European patients to justify the appointment of a specialist.[37] Mitchell was also keen for the AMO to take on more than the assistant role Carothers had in mind. His views were indicative of more general attitudes towards medical education in Uganda, which in the 1940s saw Makerere Medical School raise entry standards and revise the curriculum with a view to securing recognition for the medical diploma by the British GMC.[38]

In October 1948, Bosa was selected among the AMOs at Mulago Hospital for the new position at Mulago Mental Hospital. By 1948, Bosa was working full time in the women's wards at Mulago Hospital, where he was described as 'competent' but liable to carelessness, for which he was reprimanded on at least one occasion.[39] Considering the reports against him, Bosa's transfer to mental work may be seen as a punishment, as career prospects for AMOs at Mulago Mental Hospital were almost non-existent. He had aptitude and an interest in the work, however, and by 1955 had decided to pursue postgraduate study. Studying abroad was an ambition of many of East Africa's doctors during the 1950s. A small number of scholarships had been available from the late 1940s for postgraduate study in the UK, expanding from the mid-1950s as the Africanisation of the colonial administration got underway and as GMC recognition afforded more opportunities for African doctors in British medical schools. With the exception of experiments in postgraduate surgery, studying abroad remained the only way to secure a postgraduate qualification through the 1950s.[40] Bosa was no exception in his desire to specialise. Clearly aware that his position as the only African doctor willing to work at Mulago Mental Hospital gave him power to negotiate his future, Bosa made postgraduate study a condition of him continuing to work with the mentally ill. If studying abroad was not possible, Bosa stressed to the Medical Department in 1955, 'he wished to be posted away from the Mental Hospital back into some hospital where he could do general medicine'.[41] While AMOs were not usually given a choice about their location, they were able to leave and go into more lucrative private practice from 1949, something that led to an exodus from the Colonial Medical Service during the 1950s.[42]

In December 1955, Bosa travelled on a government scholarship to the Institute of Psychiatry at the Maudsley Hospital, London, to embark on the DPM. By 1955, he already had extensive experience of all forms of treatment used at Mulago Mental Hospital, including ECT, insulin shock therapy, leucotomy, drug abreaction and antipsychotic drugs.[43] Having had no information about the course or life in London, however, he reported feeling bewildered on arrival. The problem stemmed in part from the fact that, due to lack of staff at Mulago Mental Hospital, he had only been granted a period of one year's leave in order to complete a two-year course. As D. L. Davies, Dean of the Institute of Psychiatry, noted in 1957, Bosa was a good student and appeared 'very happy with the instruction he has had', but had been

required to attend first- and second-year lectures at the same time.[44] Perhaps unsurprisingly due to the pressure on his time, Bosa failed to pass Part I of the examinations. While Bosa's scholarship was later extended to cover the full two years of the course, he was at a disadvantage because it had never been made clear to him that what was required was 'wide reading with relatively superficial knowledge, rather than [a] sound grasp of fundamental principles'.[45] Bosa returned to London in November 1959 to retake the DPM, which he was awarded in 1961.[46]

The inclusion of Bosa and other AMOs within the formal institutions and structures of psychiatry comprised only a minor part of the Africanisation of the colonial administration in the 1940s and 1950s. Most AMOs continued to have only a rudimentary knowledge of psychiatry, despite facing cases of mental illness in clinics and hospitals across the country. Yet their presence is important for our understanding of the relationship between psychiatry and politics at the end of empire. This came to the fore in the political dissent that erupted in Buganda in the 1940s. The attempted removal from office in 1944 of Samwiri Wamala, *Katikiro* (prime minister) of Buganda, on the grounds that he was suffering from a serious mental disorder, and the involvement of Bosa in public disturbances in 1949, point to an ambiguous role for psychiatry, and for Uganda's growing contingent of AMOs. It reminds us that psychiatry was not a unified force operating in the service of empire.

Dissent in 1940s Buganda

Samwiri Wamala became *Katikiro* in 1941 in the wake of the *Nnamasole* (Queen Mother) affair, a controversy surrounding her proposed remarriage, and against a backdrop of increasing political, economic and social tension in Buganda.[47] In the years following the Second World War, farmers complained of poor wages, diminished by post-war inflation, colonial cotton regulations and exploitative middlemen.[48] Bataka protesters such as Jemusi Miti and Ssemakula Mulumba also developed populist critiques of Buganda's hierarchy and relationship to colonial power, constructing, as Carol Summers has argued, 'a new sort of citizenship grounded in local concerns over land, graves, and inheritance'.[49] According to David Apter, Wamala was 'the first *Katikiro* to reckon with public opinion', harnessing widespread fear and distrust of missionaries and administrators in his attempt to achieve political reform.[50] His attempt to prevent the colonial administration from forcing the

Lukiiko (Buganda Parliament) to pass legislation that would allow the *Kabaka* (King of Buganda) to acquire land for public use, for example, saw Wamala not only advising the colonial Resident of Uganda that the Bill would be exceedingly unpopular, but also directing public outcry towards his political rivals. While he was by no means the most outspoken of the Ganda activists of the 1940s, his prominent position in the *Lukiiko* and his criticisms of the colonial government's acquisition of land at Mulago (for Mulago Hospital) and Makerere (for Makerere College) placed him at the centre of British attention and concern.[51]

The decision to summon Wamala to a formal medical board was taken in the face of these strained relations between Buganda and the colonial government. Yet it does not appear to have been without some medical justification. In May–June 1944, Wamala had consulted two AMOs—Erifazi Mukibi-Mwanjale and Samuel B. K. Mukasa, Wamala's son-in-law—about a number of physical and mental complaints.[52] By 1944, Mukibi-Mwanjale, a member of the Lugave (pangolin) clan that comprised Wamala's main political support base, was a well-established surgeon at Mulago Hospital.[53] According to Mukibi-Mwanjale some months later, Wamala had exhibited signs of overwork and had improved following a period of 'rest, suggestion, reassurance talks about his hidden fears, [and] regulation of his diet with extra vitamins'.[54] He also admitted, however, to giving Wamala a course of tryparsamide, a treatment used in cases of neurosyphilis.[55]

It was the possibility of neurosyphilis that the medical board was most interested in when it met at Mulago Hospital at the end of October 1944. Formally organised by the Resident of Buganda, and supposedly without the knowledge of the *Lukiiko*, the medical board consisted of H. C. Trowell, who at the time was in charge of admissions to Mulago Mental Hospital, as well as A. W. Williams, Physician and later Medical Superintendent of Mulago Hospital, and an AMO from Buganda, Sebastiane B. Kyewalyanga.[56] Members of the Buganda Government were not obliged to undergo routine medical examinations, but they could be summoned to attend a government medical board if suspicion of serious ill-health arose. In an example that shows how medical missionaries were willing to intrude in local politics, CMS mission doctor Albert Cook stressed in 1926 that he considered it his 'duty' not just as a doctor but as a British subject to inform the colonial administration that his patient, *Katikiro* Apollo Kagwa, was suffering from 'alarmingly high blood pressure', something that Kagwa later claimed had been a

deliberate attempt to get him removed from office.[57] In Wamala's case, it is unclear if Mukibi-Mwanjale or Mukasa had passed on their concerns or if the information had reached colonial officials through other channels. Mukibi-Mwanjale was certainly (and unsurprisingly) keen to disassociate himself from the findings of the medical board when they were reported at the beginning of November. His medical testimony, he claimed, had been misinterpreted, and 'so framed as to indicate to any reader that my patient had no other symptoms but mental, and no other treatment but tryparsamide'.[58]

If Mukibi-Mwanjale was unhappy with the board's findings, Kyewalyanga, the board's only AMO, also found himself in an uncomfortable position. The board had failed to find conclusive evidence that Wamala was suffering from neurosyphilis: he had refused a lumbar puncture, something 'essential in the diagnosis of neuro-syphilis', and the board had found 'little outside information concerning the mental symptoms from those in close contact with the patient', without which it was near 'impossible to give a decision concerning [the] presence of mental disease'.[59] Following a brief physical examination, Trowell and Williams were ready to conclude that it was highly likely that Wamala was suffering from neurosyphilis. Kyewalyanga, on the other hand, was more cautious. On his request, the diagnosis of neurosyphilis was removed from the board's findings, and the final statement reworded to conclude that there was 'a serious mental disorder and that the presence of neuro-syphilis cannot be excluded'. Given this finding, the board recommended that Wamala be removed from office for a period of twelve months.[60]

In this instance, psychiatry was no unproblematic, conspiratorial 'tool of empire' for either the European or the African doctors. Even if Wamala's actions had given the British grounds to distrust him, all of the doctors involved agreed that Wamala was suffering from (or had suffered from) mental ill-health, however defined. In a note attached to the bottom of the medical board's report, Trowell and Williams urged Mukibi-Mwanjale and Mukasa to continue the treatment for neurosyphilis, 'as in our opinion the disease is probably there'.[61] Where the doctors diverged was in their view of what function the medical board could serve—the AMOs were particularly sensitive to the political and moral implications of a diagnosis of degenerative venereal disease.[62] Indeed, the whole episode was characterised by political and professional tensions: between Mukibi-Mwanjale and the medical board; between Wamala and the medical board; and between Kyewalyanga and his European colleagues.

These tensions were indicative of wider socio-economic and political discontent that was to prompt widespread disturbances in 1945 and 1949. The strikes and riots of January 1945 were primarily a result of wage grievances following the hardships of the Second World War, and saw workers from nearly every government institution walk out and demand higher wages.[63] At Mulago Hospital, large numbers of subordinate staff joined the strike, and on the second day, strikers entered the wards with sticks in an attempt to force the remaining African staff to leave.[64] In the weeks following the strikes, the education system came under attack from those who felt that the strike demonstrated how easily hospital workers 'could just chuck up their jobs and cause suffering to their own people'.[65]

While African doctors were not exempt from scrutiny, there is little evidence to suggest that they left their positions on the wards. According to E. Wilson, Physician at Mulago Hospital, Mukibi-Mwanjale 'stood and appealed to the strikers not to drive away those who were caring for their own people - we had several badly injured rioters on that ward'.[66] Indicating something of the position of the mental hospital in the mind of the public, one 'Onlooker' even jumped to the defence of the staff at Mulago Hospital by pointing out how: 'the Strike was confined to the menial staff, cooks, dhobies, sweepers, and the majority of the attendants in the Mental Section of the Hospital. None of the ward nursing staff or African doctors was absent from work, and all carried out their duties in circumstances of great difficulty despite intimidating threats'.[67]

In an attempt to analyse the disturbances, the colonial government focused on the political, rather than the economic causes, stressing 'the factional ambitions of a limited number of politicians in Buganda'.[68] Wamala again came under the spotlight, the strikes having been used by Wamala's supporters to secure his arch rival's dismissal in case he was promoted to *Katikiro* in Wamala's absence.[69] Forced to resign at the end of February, Wamala was promptly deported to Hoima along with four others suspected of inciting trouble.[70] The severity with which the colonial government pursued Wamala was not lost on at least one observer, who questioned how the British could deport a man found to be mentally unwell to a place of 'ill treatment'.[71] Deportation, it appears, was a more straightforward way of dealing with suspected troublemakers than formal certification and confinement in a mental hospital.

If the relationship between psychiatry and colonial rule was made problematic by the involvement of AMOs in medical examinations,

it was further complicated by the suspicion that fell on staff at Mulago Hospital following the 1945 disturbances. Mukibi-Mwanjale, for example, was accused of harbouring sympathies towards the activists and was subsequently transferred to the remote station of Moyo where, according to Iliffe, 'he could not practise surgery, was kept under surveillance, suffered a mental breakdown, retired, and never recovered'.[72] Bosa was also reported as being 'anti-European' in confidential reports submitted to the Medical Department, and his progress closely monitored until well into the 1950s.

Particular attention was paid to Bosa during the summer of 1949, when he was arrested in connection with further disturbances that spread across Buganda in April 1949. Bosa had provided a medical certificate to a man calling himself Yusufu Musoke, which showed he had been in hospital suffering from dysentery for the duration of the disturbances.[73] According to Bosa, while he was working in the outpatient department at Mulago Hospital in June, a young man approached him with an old Medical Form 5 (record of patient treatment). The form was 'wrinkled and partially torn', and the accompanying Medical Certificate, due to having been accidentally 'washed in his trouser pocket', 'was now illegible and therefore not acceptable by his employer who threatened to cut his pay'.[74] Bosa agreed to rewrite and sign the certificate, 'which at the time I thought was genuine and therefore I did not think of checking up the number in the Register….Apparently this man knew me very well although I did not know him at the time'.[75] 'From that time I forgot everything about the affair', Bosa added, 'until I was approached by a Police Officer on 13th August, and I was only then made to understand that that man had come to me with a false certificate, and under a false name; and that he had subsequently attempted to use my signed Medical Certificate to cover another person under charge of a criminal offence'.[76]

Bosa was arrested on charges of false certification and suspended from duty. The evidence was hardly in his favour: the certificate Bosa had provided had been used as an alibi by a man accused of setting fire to the house of a county chief, and the man who had approached Bosa for the medical certificate, whose real name was Petero Nsubuga, was an employee of the mental hospital.[77] In his interview with the police, Bosa admitted wrongly certifying sickness, but claimed that it was due to negligence on his part rather than any conspiracy to subvert the course of justice.[78] Bosa was acquitted, but faced a disciplinary interview with DMS Henry S. de Boer before he was allowed to return to

work. Recounting his version of events to de Boer, Bosa observed that his case was only serious because of its 'political connections'—he could see 'No other reason except general need for accuracy'.[79] Indeed, as Bosa was likely aware, the political sympathies of AMOs from across Mulago Hospital again came under suspicion in the months following the disturbances.[80] However much responsibility was being devolved to AMOs, they were still firmly located within the rigid structures of a paternalist colonial hierarchy and were by no means exempt from scrutiny during political troubles.

Bosa was found guilty of negligence and narrowly avoided losing his job, but was allowed to remain at Mulago Mental Hospital. His actions during the 1940s, like those of his colleagues in the Wamala case, belie any straightforward relationship between psychiatry and politics at the end of empire. Was Bosa complicit in Nsubuga's attempt to avoid arrest, using his position at Mulago to undermine the state? Bosa's superiors certainly continued to distrust him, regarding him throughout the 1950s as an 'excellent clinician', yet one who was not above suspicion politically or ethically. Alternatively, was this incompetence, or a disregard for rules and authority? Bosa found himself in trouble with the law again in 1954, having failed to keep a proper register of cocaine hydrochloride as required under the Poisons and Dangerous Drugs Ordinance.[81] He was reprimanded and fined under the Ordinance, but again escaped dismissal. If anything is clear, it is that Bosa had made himself essential to psychiatry, holding onto his job despite repeated reprimands by medical boards and other superiors, as well as ongoing suspicion about his motivation. This uneasy relationship with hierarchy did not go away as the newly independent Ministry of Health took over responsibility for psychiatry in 1962.

Bosa and Hierarchies of Power

Bosa returned to Uganda from postgraduate study at the Maudsley Hospital in January 1958 and, following Tewfik's resignation later that year, was made Acting Superintendent of Mulago and Butabika Mental Hospitals. As a temporary position while a replacement for Tewfik could be found, it gave him first-hand experience of managing a full clinical and administrative workload, as well as the challenges facing African doctors within a rapidly Africanising administration. While Bosa appears to have been popular and generally respected by the European nursing staff at the mental hospitals, there were a number of 'more awkward

officers' who refused to work beneath him.[82] Responsibility for this was something that the colonial Medical Department placed firmly on Bosa. Rather than this being a question of racism, Bosa reportedly did not have a 'strong enough personality', lacking confidence, being too sensitive, and avoiding administration in favour of clinical work.[83] He was also unwilling to facilitate research, whether due to a desire to protect patients who were not capable of giving consent, or because he had other priorities. In 1959, for example, it was suggested that Bosa had attempted to sabotage a medical survey of tuberculosis conducted on mental patients by G. Murray Short by 'losing' a series of X-rays and generally being 'uncooperative'.[84] These views shaped official assessments about Bosa's ability to successfully manage mental hospital staff in the long term. While they acknowledged that Bosa was working in a 'difficult position' and showed great skill with patients, in 1960, the Medical Department decided to appoint an Australian expatriate psychiatrist, T. W. Murray as Superintendent of Mental Hospitals.[85]

On the award of the DPM in 1961, Bosa was made a consultant psychiatrist. Emboldened by the promotion, Bosa started to send suggestions for the reform of mental health services to senior administrative officials, including Kadama, Chief Medical Officer of the Ministry of Health in 1962, and Permanent Secretary from 1963. Among these were calls for the introduction of a Registered Mental Nurses course, more psychiatric training for African doctors and the expansion of psychiatric wards at up-country hospitals. Ministry of Health officials refused to include Bosa in discussions about the future of medical services, however.[86] In their opinion, Bosa was breaking the chain of command by coming directly to them—he was to address all his concerns to Murray for consideration.[87] Yet they were also annoyed that Bosa had 'committed his ideas to paper before we made a comparable move on our side'.[88] Jealous of their new power as policymakers, they did not want to be seen to be taking advice from a doctor who was not aware of his position in the hierarchy, even if he was Ugandan.

By 1964, Murray and Bosa shared a huge workload, including clinical work at Butabika Hospital and Mulago Hospital Mental Health Clinic, the teaching of undergraduate medical students at Makerere University College, court work and the management of up-country psychiatric wards in Soroti and Mbarara. When Murray took his overseas leave in September 1964, he was requested to 'step aside' to make way for Bosa to become Superintendent of Mental Hospitals.[89] On Murray's return,

Bosa stayed on as Superintendent, and the division of clinical duties between the two was reversed, with Bosa taking on a greater part of the administration. The relationship between the two remained ill-defined, however. Murray was given a new role as 'Adviser', a title he held until his departure in 1966, but this served only to complicate matters: Was he to be an adviser to Bosa, or an independent adviser to the Ministry of Health? As Bosa complained: 'This is a new situation which has not existed here before. One cannot say that Dr. Murray and myself are just reversing the relationship that existed before Dr. Murray went on leave in September 1964. Then I was subordinate to him and could not make direct contact with [the] Ministry of Health' except via Murray, as Medical Superintendent.[90] When an attempt was made to clarify the relationship, again the Ministry of Health remained vague in its response: 'You will see from these letters that you are the substantive Medical Superintendent and that Dr. Murray is a consultant psychiatrist. He will carry on with his normal duties and may advise you if you so wish, he may of course sign correspondence on your behalf but any personal letters written to me by Dr. Murray should be sent' through Bosa, if they refer to official matters.[91]

It was only with Murray's resignation in April 1966 that the ambiguity in the hierarchy at Butabika Hospital was resolved. By that point, however, the Ministry of Health had already demonstrated that it was no more willing to listen to Bosa's petitions for the improvement of psychiatric services than it had been to Murray or any previous psychiatrist. The neglect of psychiatry by the Ministry of Health prompted a clearly frustrated Bosa to protest in October 1965 that the 'work-output which is being demanded from the small number of doctors is ridiculously fantastic. I have often put in a warning that there is such a thing as "demanding too much out of too few for too long"'.[92] The problem was that:

> The Ministry have entirely refused to awaken to the modern concept that Psychiatry is medicine; - a type of medicine that is difficult, exacting and very time-consuming. They have refused to appreciate that Butabika Hospital is practically the only and total psychiatric service for the whole of Uganda (you can more or less discount the ridiculous so-called psychiatric units in the Eastern and Western Regions; I always regard them as an insult to psychiatry), and that as such, the medical team at Butabika has to put in a terrific amount of hard work to keep pace with the very high admission rate in the already overcrowded Wards. Can any doctor carry on

> at this rate indefinitely? No Sir. In the long run the efficiency must drop, and that may be followed by disasterous [sic.] consequences. THIS HAS STARTED TO HAPPEN HERE.[93]

Just because a Ugandan was in charge of mental health services, it did not mean that the financial or professional support required to develop psychiatry was more forthcoming. Exhausted by the administrative workload, Bosa resigned as Superintendent at the end of 1965, but continued to work as a consultant psychiatrist at Mulago and Butabika. J. Bulwanyi, a non-specialist Senior Medical Officer and Superintendent of Fort Portal Hospital, was chosen as the new Superintendent of Mental Hospitals, allowing Bosa to commit himself more fully to his clinical duties.[94] In the longer term, the indifference of the government towards psychiatry was reinforced by the realisation that Makerere University College were allocating funds for a Department of Psychiatry within Makerere Medical School. In response to one of Bosa's petitions in 1964, a senior official within the Ministry of Health noted that 'We are lucky that Makerere has now decided to create a Chair of Psychiatry… [as]…the whole question of psychiatry will be adequately handled'.[95] Not only would the department result in more funding and specialist personnel for Butabika and the mental health unit at Mulago Hospital, but responsibility for the development of mental health services would no longer be solely in their hands.

The Department of Psychiatry

When the question of psychiatry was first considered by the Faculty Board of Makerere Medical School in 1959, A. W. Williams and colleagues gave three main reasons for the urgency of its development as an academic subject. First, in practical terms, the colonial administration had encountered difficulties in recruiting a psychiatrist to replace Tewfik at Mulago and Butabika Mental Hospitals following his resignation in 1958. In the context of a rapidly decolonising empire, positions within the Colonial Medical Service no longer carried the prestige or opportunities for career progression. As a part-time lecturer for the Medical School, Tewfik had provided courses on mental illness and psychology to first and third clinical year students yet now, despite new recognition of the importance of 'the psychological factors in health and disease, we have no one with the time or qualifications to give to this essential part

of the medical course'.[96] Second, there was 'accumulated evidence' from the Student Health Service at Makerere University College on the social and personal stresses facing students. While the Faculty Board noted that there was nothing new in this, or indeed unique to African students, 'it has a specially urgent importance in East Africa where the potential output of graduates is so small in relation to the need, and the social and personal stresses to which this small population of educated adolescents is subjected are correspondingly greater'.[97] Finally, the Board stressed their conviction 'that because of language difficulties and cultural attitudes psychiatry among Africans will best be practised by Africans'.[98] For this, the Board stressed that Makerere had 'a special responsibility to undertake a study of the psychological implications of higher education in East Africa', and that an understanding of the 'conditions in which [the] postgraduate training of African psychiatrists to work in Africa can be undertaken are needed'.[99] Makerere had a unique status in East Africa as the premier institution for education and research and had close ties with the East African Institute of Social Research (EAISR) under Audrey Richards, making it an ideal setting for psychiatric education and research.

In looking for advice, Makerere Medical School turned to the Nuffield Foundation's visiting consultant scheme. Makerere had already benefited from the scheme on numerous occasions since the late 1940s, though none had been psychiatrists.[100] The application revealed a Faculty Board that was keen to proceed with the development of psychiatry as an academic subject, but which was concerned that due to the financial implications, it would 'have to face a rigorous examination by the East African Governments', so requiring expertise to ensure a strong case for support.[101] While Makerere was a semi-autonomous institution, control over administrative and financial decisions was not always clear, particularly within medicine, where Mulago Hospital was both a government hospital and a university teaching institution. Makerere sought a consultant for a three-month visit, who would be able to provide advice on appointments, recruitment, the relationship of staff with the Education and Social Anthropology departments, as well as the Student Health Service, the relationship of the teaching department to the mental hospital, priorities for research, and the training of Africans in psychiatry.[102] The application was successful, and a few months later, Davies, of the Maudsley Hospital, arrived for an eight-week tour.

Echoing wider sentiments within Africa about the unique potential of African psychiatrists, Davies noted that 'Psychiatry is the one branch of medicine in which the African doctor starts with an advantage over his expatriate colleague by reason of his greater knowledge of local language and custom'.[103] The current curriculum, however, involved only minimal instruction in psychiatry which, combined with short-term placements in the under-funded and overcrowded mental hospital, gave 'no hope for the recruitment of Makerere graduates to this specialty, and this will nullify any attempt to improve the government services substantially'.[104] Davies suggested the creation of a Department of Psychiatry at Makerere Medical School, with a Professorial Chair, to be organised along English lines.[105] In addition to the chair, the department would require two lecturers, two house officers, one psychiatric social worker, one clinical psychologist, an occupational therapist, nursing staff and a secretarial assistant.[106] A unit focused on rehabilitation would also be required, away from Butabika Hospital, which was still predominantly engaged in the long-term care of patients, and included a wing for criminal lunatics. As Davies noted, 'If prestige factors are important, and if psychiatry is to take its place alongside medicine and surgery as a major branch of medicine in this country then the medical student must be introduced to it in a place freed from the aura of prisons'.[107] A new unit at Mulago Hospital was required, with teaching space and a ward for 30–40 patients, to be selected according to the teaching and research needs of the professor. There was little comment on how the curriculum could be made relevant to East Africa, however. Instead, Davies drew on recent articles from *The Lancet*, reports of the Royal College of Physicians and recommendations of the GMC. The only indication that the reach of psychiatry in Uganda differed from that in the UK was Davies' reminder that the selection of doctors for specialist training and the local recruitment of student mental nurses should be done 'with an eye to the language problem'.[108]

Makerere University College received Davies' report with interest, and in 1960, the principal formed an internal committee to advise on how Davies' recommendations might be implemented.[109] Despite the enthusiasm of the committee to implement Davies' plan, however, neither Makerere University College nor the colonial government felt they could commit to funding a Department of Psychiatry.[110] Not only was medical expansion in general constrained by finances, but psychiatry remained a low priority in a country where government expenditure

was directed towards revenue producing activities and general education.[111] Instead, the committee turned to external funding sources, considering the suitability of joint Makerere-Government applications to a range of international bodies, including the Ford Foundation and the US International Cooperation Administration (ICA).[112] Funding bodies already supported teaching at Makerere Medical School—UNICEF most recently providing for a Foundation Chair of Paediatrics—but in the early 1960s there was little international interest in the promotion of psychiatry in Africa, and with only limited support from the Ministry of Health, it was a further six years before Makerere was able to allocate funds.[113]

The Department of Psychiatry at Makerere Medical School opened in March 1966 with the arrival of the Foundation Professor of Psychiatry. Born in Scotland, G. Allen German had been advised to apply for the position by Sir Aubrey Lewis while working as a Senior Psychiatric Registrar at the Maudsley Hospital.[114] A few weeks after German's arrival, Murray left the country, leaving German and Bosa as the only psychiatrists in Uganda. Looking to fill this government vacancy with someone who would be keen to support his plans for development, German wrote to his brother-in-law, James F. Wood, a Senior Registrar at the Ross Clinic, Aberdeen, inviting him to join him in Uganda. Wood accepted, arriving at Butabika Hospital as a government consultant psychiatrist a few months later. From the start of his professorship, German was able to wield considerable influence over appointments like that of Wood, as well as clinical practice at Ward 16 (the mental health ward at Mulago Hospital), Mulago Hospital Mental Health Clinic (an outpatient department that had opened in 1964) and Butabika Hospital.[115] While German was technically employed by Makerere University College, on his arrival he became the de facto head of mental health services in Uganda.

One of the key features of the new Department of Psychiatry was the cooperation it demanded between university and government. In the original plans for the department, it was intended that the department and outpatient psychiatric unit at Mulago Hospital 'should be complementary to that of the Butabika hospital….Butabika psychiatrists should be appointed visiting consultants at the Mulago Unit, and the professor and lecturer at Butabika Hospital'.[116] The department and unit at Mulago Hospital would mark the start of a new, 'modern' era of mental

health care, providing a space for the training of African doctors as well as psychiatric nurses, psychiatric social workers and occupational therapists.[117] This collaboration, of course, had financial implications—salaries, equipment and travelling expenses all required negotiation—but it also meant that the staff available for clinical, teaching and forensic work was immediately increased: as was usual practice at Mulago Hospital, all government psychiatrists were appointed as honorary lecturers at Makerere University College, and the academic psychiatrists were consultants in government service.[118] In contrast to other specialisms, this collaboration appears to have caused little tension or resentment on either side.[119] Indeed, the fierce negotiations between university and government over the duties of other staff at Mulago Hospital during the 1960s, with its widespread 'ill-feeling', appear to have passed the psychiatrists by. This did not, however, prevent personality clashes between individual psychiatrists. The relationship between Bosa and Bulwanyi, for example, was plagued by constant personal disagreements, dividing staff at Butabika Hospital and eventually requiring Ministry of Health intervention.[120] Responsibility for teaching and clinical work also remained ill-defined, with teaching requirements not written into contracts until the end of the decade.[121]

Between 1966 and 1969, teaching provision in psychiatry at undergraduate level expanded from twenty hours to three hundred, more than that in most medical schools in the UK.[122] Such was the extent of the changes that on a return visit in 1969 Davies remarked on how impressed he was by the amount of time devoted to psychiatry, as well as to the behavioural sciences more generally, something 'in line with the most advanced views in medical education'.[123] Teaching consisted of clerking on inpatients and outpatients, as well as lectures and small group seminars designed to prepare doctors to have 'sufficient grounding in Psychiatry to be capable of providing basic psychiatric care in district hospitals and up-country areas' not just in Uganda but across East Africa.[124] While the syllabus broadly followed that of medical schools in the UK, the lecturers were aware of the need to make teaching locally relevant. John H. Orley, an anthropologist and psychiatrist attached to the Department of Psychiatry, 1966–1968 and 1971–1973, gave occasional lectures on his research on mental illness and epilepsy among the Ganda. Wood, moreover, took organic causes of mental illness as one of his subjects, something he felt was key to reducing the high number of unnecessary

referrals to the mental health clinic.[125] His lectures on the topic included the definitions, features and causes of mental confusion and acute brain syndromes, as well as the steps involved in a basic examination.[126]

While the teaching at undergraduate level aimed primarily at producing general practitioners who had a good understanding of how to recognise and manage mental illness, these lecturers also hoped to encourage African medical practitioners to specialise in psychiatry. Those wishing to attain an MMed, introduced at Makerere Medical School in 1968, were required to complete a three-month attachment to Butabika Hospital.[127] By 1971, the one-year course of instruction for the Diploma in Public Health (DPH), a requirement for doctors aspiring to be a Medical Officer of Health or to any senior administrative post in the Ministry of Health, also included a full week of thirty-seven hours (practical and theoretical) in mental health.[128] These training schemes were supported by grants from international bodies, which allowed the Department of Psychiatry to appoint new lecturers and researchers. Orley, whose interest in East Africa had been developed by E. E. Evans-Pritchard and John Beattie at the University of Oxford, was funded during his first two years in Uganda by a Nuffield Foundation research grant.[129] The Norwegian aid agency, NORAD, sponsored the secondment of Arvid Aas, a Professor of Clinical Psychology at the University of Oslo, to Makerere University College for a period of two years.[130] The World Health Organization (WHO), too, provided financial support for a lecturer in psychiatry, a position that was awarded to H. G. Egdell, a specialist in child psychiatry, in 1968.[131]

Despite these efforts, the number of African doctors specialising in psychiatry remained low throughout the 1960s. Just as Bosa had been transferred to Mulago Mental Hospital in 1948, African doctors were placed at Butabika Hospital, with few opting to pursue it independently. Once attached to Butabika Hospital, graduates were assessed for their suitability for further training, and if interested might then be allowed to pursue a formal postgraduate qualification. E. B. Ssekabembe, who had qualified as a doctor in India, had been attached to Butabika Hospital since 1964 at least and by 1966 was in London preparing for the DPM.[132] Wilson Acuda, too, graduated from Makerere Medical School in 1970. His initial placement at Butabika Hospital for a period of one year was not of his choosing, but he ‘fell in love with Psychiatry within a few weeks’ and was determined to specialise in it. After six months at

Butabika Hospital, he was offered a scholarship by the British Council to study at the Maudsley Hospital from April 1972, an opportunity that he accepted.[133]

The expansion of training at postgraduate level was assisted by the creation in 1966 of three Senior House Officer (SHO) positions in psychiatry. These were designed for doctors who had not undertaken formal training in psychiatry but who had considerable experience in psychiatric practice.[134] A. T. Kikwanguyira, who had been attached to Butabika Hospital since 1966 at least, was raised to one of these positions, allowing for the recognition of his experience with the mentally ill.[135] Intending to make full use of these new positions, German noted in 1967 that '[i]t is envisaged that S.H.O.s will train on an in-service basis and that, for the moment, they will continue to proceed to London to take their Diploma in Psychological Medicine. A series of lectures at postgraduate level has been given over the past session and the present S.H.O. is due to take the first part of the D.P.M. in London in May 1967'.[136] This SHO was Joseph Muhangi, who on his return to Uganda worked as a Special Grade Medical Officer (Psychiatry) before being appointed as a lecturer in the Department of Psychiatry in November 1969.[137] Another SHO, A. M. Kitumba followed a few years later, completing the MRCPsych in London in 1972.[138]

In the years following the opening of the Department of Psychiatry in March 1966, Uganda saw an increase in the number of expatriate psychiatrists from one to six by 1969 (including one psychiatric social worker). With formal and informal programmes designed to train African doctors, too, the number of African psychiatrists also rose from one to three.[139] When Davies returned to Uganda in 1969 to re-evaluate the state of psychiatry, he was particularly impressed by the speed of change and reported finding a united group of psychiatrists, led by German, but with posts filled evenly between Ugandans and expatriates.[140] This divide between expatriates and Ugandans broadly reflected that at Makerere Medical School more generally, where by 1971, 38% of staff was Ugandan. While this was better than the situation in 1965, when only 11% of the academic staff was Ugandan, it was still nowhere near that of the university administration, where 81% of staff was Ugandan.[141] 'Despite political pressure to "Africanize" as rapidly as possible', W. D. Foster has noted, 'the senior Ugandan members of the college were as

unwilling as anyone to see' people they regarded as 'unsuitable men appointed to chairs merely because they were Ugandans'.[142]

Conclusion

It is perhaps ironic that the body of research on detribalisation, developed by the East African School of Psychiatry and Psychology, and premised on assumptions of racial and cultural difference, had provided the first arguments for the training of Africans in psychiatry. Summing up the expectations for this new generation of doctors, H. J. Simons, of the University of Cape Town, noted that in East Africa, African psychiatrists 'would combine, as few other practitioners can do, the required knowledge of medicine and psychiatry with an intimate knowledge of the people's physiognomy, language, and traits'.[143] In practice, as I explore further in subsequent chapters, the idea that Africans might have natural cultural 'insight' into their patients' fears and anxieties was deeply flawed, and overlooked the vast cultural, social and linguistic gap that also existed between Western-trained African doctors and many of their patients. Before the 1960s, however, it received little overt criticism from Ugandan doctors. In the context of professionalisation and attempts to secure better working conditions, pay and status within the colonial medical hierarchy, such arguments served an important political purpose.

While concerns about the need to prepare for psychiatry to respond to the challenges and pressures of rapid social and political change were expressed across Eastern and Southern Africa, it was Uganda that claimed a 'special responsibility' to act. Enacted as part of broader policies of 'Africanisation' at the end of empire, the Africanisation of psychiatry encompassed the secondment of African doctors to Mulago Mental Hospital (and later Butabika) for short-term placements, opportunities for doctors such as Bosa to undertake postgraduate study in the UK, and the eventual elevation of Bosa to Medical Superintendent. Taking up the call to promote psychiatry as a field of study and research, Makerere University College also led a rapid expansion of clinical and academic psychiatry during the 1960s and early 1970s. The influx of expatriate psychiatrists that this entailed was, nevertheless, at odds with the processes of Africanisation, and would have implications

for the decolonisation of psychiatry, and who had a say. One of the ways Makerere navigated this was to increase the turnover of expatriate staff, appointing new lecturers on contracts of up to six years rather than on a permanent basis.[144] Yet it was not without its limitations, particularly for psychiatry, where communication was central. As F. J. Bennett noted in 1965, the 'disadvantages of employing foreigners on short contracts in a country with at least 25 language groups can be imagined'.[145]

The increase in the number of doctors trained in psychiatry may have had limited practical effect on the willingness of government administrators to provide additional resources for psychiatry, but it is nevertheless important for our understanding of the role and power of psychiatry at the end of empire. The inclusion of African doctors within the formal structures and institutions of colonial psychiatry remind us that psychiatry was no straightforward tool of 'social control' wielded by the colonial government. African doctors were working in contexts rich in actors and politics of their own, with psychiatry operating in spaces that show a much more complex relationship to colonial power than that of 'tool of empire'. The potential use of psychiatry to subvert colonial authority during political dissent in Buganda during the 1940s, for example, provides an important counterpoint to narratives of the mobilisation of psychiatry in the service of empire during the years of decolonisation. Indeed, it proved impossible to separate psychiatry from politics that extended beyond the strictly 'imperial'. In a letter to Davies in 1960, Bosa relayed fears that if he were to leave the relative safety of government service he doubted being able to 'survive very long in the present "political" climate'.[146] Traders in Wandegeya market had refused to sell to him because 'they did not like my attitude towards the trade boycott campaign, and because my children rode on the bus to and from school'.[147] If he were to open a private clinic and did not follow what he regarded as the ridiculous demands of the Ganda elite, he speculated that he 'would probably end up in Kololo Mortuary with multiple bullet holes from a "made in Masaka" rifle. I doubt whether my children would like that'.[148] Psychiatry may have been neglected and underdeveloped as a medical discipline, but it did not mean that psychiatrists occupied a neutral political space. Local and national politics would only become more relevant for psychiatry in the years following Independence.

Notes

1. D. Mackay, 'A Background for African Psychiatry', *East African Medical Journal* 25(1) (1948), p. 4.
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3. Ibid., p. 3.
4. Ibid., p. 2.
5. 'Editorial', *East African Medical Journal* 25(1) (1948), p. 1.
6. H. C. Trowell, as cited in J. Iliffe, *East African Doctors: A History of the Modern Profession* (Kampala, 2002), pp. 45–46.
7. Iliffe, *East African Doctors*, p. 60. See also: M. Lyons, 'The Power to Heal: African Medical Auxiliaries in Colonial Belgian Congo and Uganda', in D. Engels and S. Marks, eds., *Contesting Colonial Hegemony: State and Society in Africa and India* (London, 1994).
8. Uganda Protectorate, *Annual Report of the Medical Department for the Year Ended 31 December, 1937* (Entebbe, 1938), p. 6.
9. Eria M. Babumba, 'An African Patient', *East African Medical Journal* 31(8) (1954), p. 373.
10. Uganda Ministry of Health Archives (UMOHA) PH/ASC/46 (Box 29) (Makerere Medical Graduates Association), f. 9, 'A discussion between the Hon'ble the Director of Medical Services and the Makerere Medical Graduates Associations' Delegation', 1950.
11. H. C. Trowell, 'Training Medical Practitioners', *East African Medical Journal* 33(7) (1956), p. 257.
12. Trowell, 'Training Medical Practitioners', p. 257.
13. As cited in F. Heinlein, *British Government Policy and Decolonisation 1945–1963: Scrutinising the Official Mind* (London, 2002), p. 25.
14. Iliffe, *East African Doctors*, pp. 118–120.
15. Heinlein, *British Government Policy*, p. 25.
16. J. L. Crammer, 'Training and Education in British Psychiatry 1770–1970', in H. Freeman and G. Berrios, eds., *150 Years of British Psychiatry* (London, 1996), pp. 221–228.
17. The National Archives, Kew, United Kingdom (TNA) BW 90/16 (East Africa—Medical School Mulago), memo by E. G. Holmes, Makerere College, 'Makerere College Medical School and Mulago Hospital—An Appreciation of the Present Situation', 24 November 1947, pp. 2–3; *Report of the Council to the Assembly for the Year 1946* (Kampala, 1947), p. 11.
18. Bodleian Library, University of Oxford (BOD) Mss.Afr.s.1589 (Baty Papers), 'Hospital Routine', ff. 2–3, 'Instructions on routine to be carried out by A.M.O. attached to Mental Hospital, 28 March 1946'.
19. Crammer, 'Training and Education in British Psychiatry'; Trowell, 'Training Medical Practitioners', p. 255.

20. Uganda Protectorate, *Annual Report of the Medical Department for the Year Ended 31st December, 1938* (Entebbe, 1939), pp. 67–68.
21. TNA CO 536/199/7 (Mental Treatment Legislation), 'Legal Report on an Ordinance entitled "The Mental Treatment Ordinance, 1938"', p. 2.
22. J. E. Goldthorpe, *An African Elite: Makerere College Students 1922–1960* (Nairobi, 1965), p. 46; F. G. Sembeguya, 'The Growth of an Indigenous Medical Profession', *East African Medical Journal* 41(2) (1964), p. 40.
23. UMOHA C90/ACR (Bosa Stephen B—Consult. Psychiat.), f. 35, letter from W. A. Wilson to G. Campbell Young, 17 February 1953.
24. Uganda National Archives (UNA) C1304 (Benjamin Kagwa).
25. B. H. Kagwa, *A Ugandan: Defiant and Triumphant* (Hicksville, 1978), p. 23.
26. TNA CO 536/207/11 (Kagwa B—Native Student).
27. TNA CO 536/207/11, f. 4, extract from letter from Dr. Kauntze to Dr. O'Brien, 9 March 1940.
28. TNA CO 536/207/11, f. 1, letter from J. E. W. Flood to A. J. R. O'Brien, 27 December 1939, pp. 4–5.
29. TNA CO 536/207/11, f. 5, 'Negro Physician from Central Africa', *St. Louis Post-Dispatch*, 27 August 1940; Kagwa, *A Ugandan*, p. 113.
30. Kagwa, *A Ugandan*, p. 91.
31. Kagwa, *A Ugandan*, p. 105.
32. Kagwa, *A Ugandan*, pp. 114–115; 'Manhattan Central Medical Society—N.Y.C.', *Journal of the National Medical Association* 41(1) (1949), p. 38.
33. UMOHA C90/ACR.
34. BOD Mss.Afr.s.1589, 'Correspondence', ff. J. C. Carothers, 'Report on the existing organisation in Uganda for the care and treatment of persons of unsound mind and the question of the future development of this organisation', 1 February 1943.
35. BOD Mss.Afr.s.1589, 'Correspondence', f. 11, copy of the 'Recommendations of the Mental Hospital Enquiry Committee', 11 February 1942. Complaints about the lack of accommodation for Europeans, for example, had been made in 1941 in UNA D107/12 (Transport of Mental Patients).
36. BOD Mss.Afr.s.1589, 'Correspondence', ff. 15–16, J. C. Carothers, 'Report on the existing organisation in Uganda for the care and treatment of persons of unsound mind and the question of the future development of this organisation', 1 February 1943, p. 4.
37. BOD Mss.Afr.s.1589, 'Correspondence', f. 14, letter from J. P. Mitchell, Medical Superintendent, Mulago, to Director of Medical Services, Entebbe, 30 March 1943.

38. Iliffe, *East African Doctors*, pp. 65–67.
39. UMOHA C90/ACR, f. 1, 'Annual Confidential Report for the Year Ending December 31st 1947'.
40. Iliffe, *East African Doctors*, pp. 99–100.
41. UMOHA C90/ACR, f. 37, letter from E. M. Clark, for Director of Medical Services, to the Specialist Alienist, Mental Hospital, Mulago, 7 July 1955.
42. Iliffe, *East African Doctors*, p. 100.
43. UMOHA C90/ACR, f. 36, letter from G. Campbell Young to the Director of Medical Services, Entebbe, 1 July 1955; Uganda Protectorate, *Annual Report of the Medical Department for the Year Ended 31 December, 1953* (Entebbe, 1954), p. 40; Uganda Protectorate, *Annual Report of the Medical Department for the Year Ended 31 December, 1954* (Entebbe, 1955), p. 54.
44. UMOHA C90/ACR, f. 38, letter from D. L. Davies, Dean, Institute of Psychiatry, to L. A. Mathias, Uganda Students Adviser, London, 28 October 1957.
45. UMOHA C90/ACR, f. 45, letter from D. L. Davies, Dean, Institute of Psychiatry, to L. A. Mathias, Uganda Students Adviser, London, n.d. (likely January 1958).
46. UMOHA C90/ACR, f. 68, letter from K. E. Underwood Ground to Stephen B. Bosa, 8 September 1960; UMOHA, C90/ACR, f. 72, 'Recommendation for Promotion'.
47. F. Mulindwa, 'The Bataka Agitation and Resistance in Colonial Uganda', *Muwazo* 10(3) (2011), pp. 17–18.
48. J. L. Earle, 'Reading Revolution in Late Colonial Buganda', *Journal of Eastern African Studies* 6(3) (2012), pp. 507–508.
49. C. Summers, 'Grandfathers, Grandsons, Morality, and Radical Politics in Late Colonial Buganda', *International Journal of African Historical Studies* 38(5) (2005), p. 427. During the 1940s, the term Bataka came to refer to those who wished to redefine British and Ganda policies and roles. Historically, it had other meanings, notably as a term denoting hereditary clan leaders. For a fuller treatment of political dissent in 1940s Buganda, see especially D. E. Apter, *The Political Kingdom in Uganda: A Study of Bureaucratic Nationalism* (Princeton, NJ: Princeton University Press, 1967), p. 141; F. Mulindwa, 'The *Bataka* Agitation and Resistance in Colonial Uganda', *Muwazo* 10(3) (2011), pp. 12–24; R. Reid, *A History of Modern Uganda* (Cambridge, 2017), pp. 297–311; and G. Thompson, 'Colonialism in Crisis: The Uganda Disturbances of 1945', *African Affairs* 91 (1992), pp. 605–624.
50. Apter, *The Political Kingdom in Uganda*, p. 226.
51. Ibid., pp. 226–227.

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66. E. Wilson, as cited in Iliffe, *East African Doctors*, p. 89.
67. '"Onlooker" on the Strike', *Uganda Herald*, 7 March 1945, p. 4.
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that by the time he came out of detention after the 1945 strike, he seemed "mentally unbalanced"'. Summers, 'Radical Rudeness', fn. 8.
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75. UMOHA C90/ACR, letter from Bosa to Director of Medical Services, 5 September 1949.
76. Ibid.
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92. UMOHA C90/ACR, f. 94, letter from Stephen Bosa to the Permanent Secretary/Chief Medical Officer, Ministry of Health, 16 October 1965.

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