

African Indigenous knowledge versus Western science in the Mbeere Mission of Kenya

**Author:**Julius M. Gathogo^{1,2,3} **Affiliations:**

¹Research Institute for Theology and Religion (RITR), Department of Christian Spirituality, Church History and Missiology, Faculty of Humanities, University of South Africa, Pretoria, South Africa

²Department of Philosophy and Religious Studies, School of Law, Arts, and Social Sciences, Faculty of Humanities, Kenyatta University, Mombasa, Kenya

³Faculty of Theology, ANCCI University, Amarillo, United States

Corresponding author:Julius Gathogo,
jumgathogo@gmail.com**Dates:**

Received: 25 Aug. 2022

Accepted: 21 Nov. 2022

Published: 06 Feb. 2023

How to cite this article:

Gathogo, J.M., 2023, 'African Indigenous knowledge versus Western science in the Mbeere Mission of Kenya', *HTS Teologiese Studies/Theological Studies* 79(1), a8036. <https://doi.org/10.4102/hts.v79i1.8036>

Copyright:

© 2023. The Authors.
Licensee: AOSIS. This work is licensed under the Creative Commons Attribution License.

Read online:

Scan this QR code with your smart phone or mobile device to read online.

This article sets out to explore the way in which Western science and technology was received in the Mbeere Mission of central Kenya since August 1912 when a medical missionary, Dr T.W.W. Crawford, visited the area. In his dalliance with ecclesiastical matters, Crawford, a highly trained Canadian medical doctor, was sent by the Church Missionary Society (CMS) at Kigari-Embu, in 1910, to pioneer the Anglican mission in the vast area that included Mbeereland, where Mbeere Mission is situated. Contending with the African indigenous knowledge in medicine, environmental conservation, agriculture and other forms of indigenous science, the introduction of Western science and technology, 1912 to 1952, the article argues, did not erase the former; rather, it complimented it. Pockets of general resistance were evident, though Mbeereland, unlike its neighbouring Mutira Mission of 1912, did not offer elaborate opposition to the Western science and technology, partly because the locals could have learnt about it from their neighbours who had experienced it much earlier. Through a historico-narrative design, the research article endeavours to primarily review the coming of Western medicine in Mbeereland: Did it conflict with the African medicine? Methodologically, the data have been collected via archival sources, oral interviews and by reviewing applicable literature.

Contribution: The input of this research article to the HTS Journal's vision and scope is seen by appreciating its focus on the interface between African indigenous knowledge and the European science and technology. Although the main focus is African versus western medicine, and how it was historically received in Mbeere Mission of Central Kenya, it largely speaks for the tropical Africa. The article is within the multidisciplinary areas in missiology and historiography.

Keywords: Mbeere Mission; African medicine; African indigenous knowledge; science and technology; Kenya.

Introduction

In this research article, science is seen, as the organised knowledge that seeks to understand, critique and appreciate the natural world, as in the case of social, human and physical sciences. It also views scientific capabilities as the ability to learn, understand and apply skills acquired so as to solve cosmological challenges. Further, technology is viewed as the application of gathered information so as to meet set goals and provide goods and services for sustainable and holistic development (Gathogo 2001; Kariuki et al. 2014:8). It is the process through which human beings strive to modify nature so as to meet their numerous needs and desires. In light of this, we can talk of 'computer technology' in reference to the applied computer knowledge, and this implies that we have broad ways of defining science and technology, as the duo terms have been with us, albeit under different terms, from time immemorial. In African indigenous society, technological innovations for human survival manifested themselves through tool-making industry, as in the case of stone tool, bone tool, iron tool and calendar invention during the Paleolithic period (pre-historic or old stone age) – when stargazing began over 40 000 years ago (Bargblor 2003; Kariuki et al. 2014:9–11). The most significant outcome of the 'Nilotic stargazing was the invention of the calendar as the basis for the modern astronomy' (Kariuki et al. 2014:4). Technological inventions in Africa also include the proto-technology, that we experience in the modern world, is traceable to the iron-ore mining 43 000 years ago in Southern Africa and the emergence of 'pro-mathematics' from the Africa's Great Lakes region, over 25 000 years ago. (Gathogo 2001:21; Kariuki et al. 2014:10; Zulu 2008:12)

Such anthropological recollections point to the humble beginnings that science and technology underwent in its steady development in Africa and give credence to the continent being the

originator of formal mathematics, astronomy, architecture, navigation, engineering and map-making among others (Bargblor 2003).

As will be noted in this research article, the tensions and conflicts between Western science and the African indigenous knowledge became evident when some newly inaugurated African Chiefs (formerly Athamaki or ideal African elders) sought to resist it. The conflict also becomes clear when the European missionaries dismissed African medicine as non-existent. In view of this, it is clearly observable that the 19th and 20th century European missionaries 'returned' to Africa (Kenya) with more sophisticated scientific breakthroughs that were by-products of post-industrial revolution. Although only a few of these scientific strides will feature in this research article, this 'return' was accompanied with airplanes, motor engines, combine harvesters and/or versatile machines, road construction machines ('excavators, crawler dozers, wheel loaders, articulated haulers, compact track loaders') (Bargblor 2003:16), agricultural tractors (utility, compact, row crop, industrial, garden, earth moving, bulldozer, excavator, backhoe loader and two-wheel among others), bicycles, motorcycles, Western education that was largely technical based and diverse forms of farming tools among others. It also included new crop varieties, new forms of environmental preservation, new animal breeds and so on. With these post-industrial revolutions in science and technology, African indigenous knowledge did not necessarily find a rival and/or a competitor but was enriched by these new developments, albeit with pockets of conflicts.

Hypothesis

Besides this, African indigenous industries, such as clay manufactured pots, "textile making, cloth weaving, bronze casting, aluminum metal scraps, leather tanning, and bronze casting did not get totally erased by the western science and technology" (Kariuki 2014:4). Further, African indigenous techniques in producing iron smelting, carding and weaving, brewing, blacksmithing, iron smelting and production of arts and crafts were not totally erased by post-industrial world (Kenyatta 1938), just as in the case of indigenous medicine that has been critical in reversing the gains of coronavirus disease 2019 (COVID-19). As noted in Julius Gathogo (2022):

This is clearly seen as African-Christians make concoctions that seeks to treat (COVID-19). Clearly, the use of ginger, a natural antioxidant, lemon and honey as Dawa (medicine) has gained a momentum in the [Kenyan context], and is seen as one which provides COVID-19 healing properties amongst other creative ways rooted in African indigenous society. Whilst ginger is found to be critical in boosting people's health as it protects against colorectal cancer, lemon is, on the other hand, seen as rich in vitamin C and critically important for detoxification. Other herbal methods of treating COVID-19 in [the Kenyan context] ... include steam therapy or steam inhalation to fight respiratory tract infections, use of hot steam mistily wafts from a pan, use of culinary herbs and neem trees, amongst other medicinal plants. (p. 3)

This further clarifies that Western science and technology did not erase African indigenous knowledge and/or knowledge relationally based on African world view and culture. This indigenous knowledge that is basically relational includes community, ethos of wholeness, harmony with the stranger (Ubuntu) and appreciation of knowledge and/or technology that promotes humanity for all. This drives us to build on the premise that postcolonial Africa has paradoxically embraced hybridity of western science and the indigenous heritage by design or by default. In turn, hybridity is used in literary, artistic and cultural studies and other social sciences to show how variables combine or dialogue so as to usher in new practices or to reshape their respective worldviews. For example, in Chinua Achebe's (1958) novel, *Things Fall Apart*, hybridity ushers in a new lifestyle among the people living in Umuofia village. This was after the coming of the European missionaries and the colonial authorities.

Jomo Kenyatta (1938:42ff.) analyses the various industries that were prevalent in African indigenous society as including 'ironwork, hut building, pottery, basket making, skin tanning, musical instruments, and agricultural activities'. Other activities that required technical knowledge included: 'the building and repair of houses, land cultivation and clearance of bushy areas, hunting, and fishing among others' (Gathogo 2008:279). This further confirms our hypothesis on hybridity and continuity of African indigenous knowledge systems with the Western science, as was presented by the European missionary societies and the colonial authorities. Instead, African knowledge systems, with their resultant 'science' of survival, did not suffer from a radical discontinuity, even though the Western science stamped its 'superiority' elaborately, as missionaries and the colonial authorities were largely seen as viewing the matter from the same lenses.

African indigenous knowledge

African indigenous knowledge, which is holistic, humane (Ubuntu) and relational, traces its roots in the precolonial context and is by no means extinct over 100 years after the European penetration in the interior of Africa (since the late 1800s). In this article, African knowledge systems are synonymous to African medical knowledge and related activities that are compared with the Western science and technology. Certainly, the dominance of the Western knowledge system (Western science) in Africa, since the post Berlin Conference of 1884–1885 that resulted in European (colonial and missionary) activities, has had profound effects, on post-colonial Africa, that are visible right into the 21st century. The challenging effects of both the breakthroughs of the industrial revolution and the European enterprises in post-Berlin Africa have been experienced in all domains. In particular, Schwab (2001:5) concedes that Africa in the post-Berlin Conference of 1884/85, 1950s and 1960s, was not given a chance to rediscover her own knowledge systems, as the Soviet Union, the United States, the United Nations and Europe stamped their presence and influence in every corner of Africa. It appears that the 21st century Africa has not

experienced substantial change from the above hegemonic dominance.

Although the World Health Organization (1978, 1995) has variously urged the African governments to embrace their indigenous medicine, this is sadly framed within the Western canons or standards, as it includes: subjecting indigenous science to clinical trials, Western logic, randomised trials and scientific research, as it ignores the metaphysical concern in African medicine (Gibson 2011). This means that the World Health Organization's acceptance of African indigenous knowledge while still subjecting it to the ethical codes of Western knowledge systems and worldviews has not been smooth sailing. Hence, the reason for its being challenged by African scholars who contend that 'scientific proof' has to be seen within the context (Mazrui 1986; Ngubane 1977).

Historically, contestations between African medical knowledge and practice, or generally the entire indigenous knowledge, with Western science and technology trace its background from the aftermath of the industrial revolution (Yinger 1970). Indeed, it was in the 19th century when scholars such as Edward Burnett Tylor (1832–1917), Herbert Spencer (1820–1903) and James George Frazer (1854–1941) began to formulate various theories of religion. In their schema of things, religious explanations were viewed as primitive behaviour, which engaged cultures at a lower level of human progress than those of 'scientific' explanations (Appiah 2012; Yinger 1970). Auguste Comte (1798–1857) who came before Tylor, Frazer and Spencer propounded the doctrine of positivism, which argues that all societies have their own form of science and laws, just as we have physics and chemistry; hence, he went beyond the above trio. He, however, believed in the natural rather than the supernatural and insisted that the 1800s were in a more advanced positivist stage, where hierarchies of Western sciences, from mathematics, astronomy, terrestrial physics, chemistry and physiology, were the vogue (Yinger 1970). Comte, a French philosopher, who is largely regarded as the pioneer philosopher of science, hypothesised that the so-called European rational knowledge system is a by-product of evolution that all human races have to subscribe to (Giddens 2016:12–13). He contributed in the 'pride' of Western science when he asserted that reality is only confirmed when it is in reference to the European 'rational' knowledge and must be empirically sensible (Giddens 2016:12–13). Undoubtedly, Africa has contributed to the world history especially in regard to scientific knowledge, as seen in the early Egyptian education (Hieroglyphics - that brought together logographic, syllabic, sequential and alphabetical components with one thousand distinctive characters), architecture, mathematics, medicine and library science (Bargblor 2003, Zulu 2008, Appiah 2012). Hence, Africa has always remained active in the so-called scientific activities.

In Mbeere land as in the rest of Africa, African indigenous knowledge has remained a misunderstood phenomenon in the European worldview. To some, African indigenous and medical knowledge is nothing but a desolate sideshow of

superstitious beliefs. To others, it is merely embryonic science, witchcraft, sorcery, primitive magic and/or false magic (Mutwa 1996; Yinger 1970). In this article, African indigenous knowledge in medicine and the resultant practices will be seen as 'still' relevant in the 21st century and to an extent transcend positivistic logic that Comte propounded. This is due to its being a lived reality that addresses holistic concerns. Considering that indigenous knowledge cannot be rated wholly from the perspective of the Western canons, a hybridity and/or dialogue of sorts remains the better way forward.

Western medicine at Kwa Rumbia, Mbeere land-Kenya

At Kwa Rumbia (Siakago) camp, Mbeere land of the present day Embu County, Kenya, in August 1912, locals and others who had heard about the Church Missionary Society (CMS) caravans came in and gathered around the European missionary-medical doctor who was then based at Kigari-Embu, Dr T.W.W. Crawford and his assistants, to listen 'to the story of our Saviour's love' (Crawford 1913: 158). Additionally, those who were sick were invited for a free medical camp; but before they were treated, they were taught about the workings of the lord Jesus Christ; hence the relationship between the European missionary work and the Western science and technology is clearly evident. Subsequently, the boxes were 'rapidly opened up, bottles, ointments, and bandages were produced, and the ministry of healing was soon in full swing' (Crawford 1913:159; Gathogo & Nthukah 2019:67). They stayed for 4 days at Rumbia's village where hundreds of Mbeere people and their voluntary and involuntary hosts (non-Mbeereans) were ministered bodily and spiritually. In other words, August 1912 gave Mbeere people of central Kenya a golden opportunity to compare the beauty of the Western and African forms of medical practice. As Dr Crawford and his medical assistants, Josiah Gathu, Mariko Kuhutha and Simeon Githinji treated people, the locals could now draw informed comparisons between the African and Western medicine. Indeed, the interdependence between the six supports of culture, as in the case of religion, economics, ethics, kinship, aesthetics and politics, could evidently be established in both cases (Mugambi 2002). During the August 1912 session, Chief Rumbia wa Ngotho of Nthawa location attended all the ecclesiastical services that were conducted by Dr Crawford's and other members of his medical-missionary team (Crawford 1913).

It is worthwhile to concede that ecclesiastical dalliance with science and technology and/or Western medicine is evident when we consider the passion with which the European missionaries were keen to train their African converts to this new trajectory. Dr Crawford in particular trained his medical team from his young African converts, something that went hand-in-hand with conversion to the Christian faith. One of his trainees, Mariko Kuhutha was a brother to Gideon Mugo, a leading evangelist and politician at Kahuhia-Murang'a whom Dr Crawford trained as his medical assistant (Gathogo & Nthukah 2019:67). Others

whom he trained as medical practitioners included Josiah Gathu and Simeon Githinji. Mugo had joined Kahuhia mission so as to learn more about the 'Whiteman's magic' (literacy). Mark Kuhutha, also written as Mariko Kuhutha, served as a cook. All the five African assistants were baptised at Kahuhia-Murang'a between 1906 and 1909. They were confirmed at Kigari-Embu by Bishop William G. Peel, of the then Mombasa Diocese in early 1911 upon his pastoral visit in the area. Bishop Peel and his daughter visited them again in January 1912, at Kigari Station, to reassess one year's progress as he confirmed some people (Crawford 1913:160; Gathogo & Nthukah 2019:67).

Yearning for more Western medicine

The CMS team, in their August 1912 stay at Kwa Rumbia (Siakago), in Mbeereland of Embu County, was visited by another Chief from the vast area, named Mugo. During this encounter, Mugo pleaded with Dr Crawford and his team to pay a visit to his village and thereby administer Western medicine to his sick people (Crawford 1913:160). Without wasting time, Dr Crawford agreed with Mugo's request. Why? Though a missionary doctor, Dr Crawford took his primary calling as taking the Great Commission (Mt 28:18–20) to those who have not encountered the resurrected Christ.

In the researches that were conducted by Prof. John Karanja, a Kenyan Church Historian, in 1998, it was established that Western science and technology was mainly seen in the many dispensaries that were established across central Kenya by 1915 (Gathogo 2001). These dispensaries made the locals to view the new Western medical practitioners as 'other' versions of African medicine practitioners, who, in retrospect, were not in competition but complementing one another in promoting the general human well-being. By then, all the established seven CMS centres in central Kenya had elaborate medical stations that were scattered in the vast area. The present-day Emmanuel Kigari, Embu, had trained medical doctors who were relied upon, though the African converts still consulted indigenous medicine specialists (*Andu Ago*), albeit secretly (Karanja 1999:54, 80). This was mainly experienced when Africans were confronting evil powers, misfortunes, and other metaphysical challenges; a fact that points to the resilient nature of indigenous religion.

Opposition by African chiefs

As noted in Emily Crawford (1913):

[T]he Provincial Commissioner, the Kenya Province of the then British East Africa [referring to both Kenya and Uganda which were British Protectorates], C. R. W. Lane, instructed Chiefs, on 2 December 1912, to stop interfering with the work of the European Missionaries. (pp. 150–152)

It was drafted by Lane after 'some Chiefs started fearing the missionary influence on their subjects' (Gathogo 2022:6). To this effect, they 'stopped their subjects from consuming western medicine and western religion' (p. 6). Although this

was not necessarily a Mbeere Mission phenomenon, it had profound effects on all mission work across the then British East Africa protectorate. Further:

Emily May Crawford cites the case of Chief Gutu wa Kibetu of the present day Kirinyaga County, who despite being treated twice by Dr Crawford still rioted against the CMS team upon recovery. (Gathogo & Nthukah 2019:70)

While at the new Kigari-Embu station in early 1911, a messenger arrived from Rukenya near Kabare Mission centre (Kirinyaga today), where Dr Crawford's brother, Rev (later Canon) Edmund Crawford, had started off in 1910 as the pioneer resident Clergy. As they moved on to Kigari CMS station, they briefly stayed at CMS Kabare centre. 'Gutu's messenger implored upon Dr Crawford to go to his assistance' (Crawford 1913:151), as he was seriously ill. Subsequently, Crawford put together the relevant drugs and appliances and with his assistants, Josiah and Simeon Githinji, he hurried off to Rukenya-Kirinyaga village and reached there after several hours. Fortunately, the dying Chief's health was restored, after 2 weeks of cautious attention, a phenomenon that turned out to be a great advertisement for Western medicine in Ndia, Mbeere, Gichugu, Embu and their surroundings. With stories doing round about how a dying Chief was resurrected by Western medicine, more people got interested in knowing the European ways of living. In turn, this led to the flocking of hundreds of Gutu's subjects, a development that alarmed him. Are these people going to settle near the mission stations? Are these missionaries taking away my powers as a leader? Is Dr Crawford getting too powerful? Don't I need to check on him? He wondered. He now forgot the successful medical attention that he had previously received from the same missionary station and 'became inflamed with jealousy' (Crawford quoted in Gathogo & Nthukah 2019:66).

Gutu then summoned all the sub-Chiefs and other leaders and eventually issued an order that in the future, no sick person would be allowed to go to the hospital/dispensary without permission being obtained from them, and every individual case was to be handled by its own merit. After seeing this form of cruelty, where Chief Gutu wa Kibetu stopped people from diversifying medical practices, Dr Crawford's team made an appeal to the protectorate government. As a result, the Provincial Commissioner of the Kenyan Province of British East Africa, CRW Lane, issued a tough letter that gave direct instructions to all Chiefs. The instruction was to tell them to stop interfering with the European missionary activities and also to allow the sick Africans to obtain succor from the hospital/dispensaries. While some Chiefs continued to secretly carry on with their opposition to Western medicine, dispensary attendance (by the local people) generally dropped to about one half. At one stage, a Chief from a village that was several miles away from Kigari-Embu, most likely from Mbeereland, was brought to Dr Crawford, apparently in a dying condition. Emily Crawford (Crawford's wife), wrote, thus:

The treatment he received was the means under God of restoring him to health. The day after his return home, he appeared again with the present of a goat and kid for his *Muvonokia* (saviour

from death), as he called the Doctor. Such an evidence of gratitude touched us deeply ... Another case was that of a tall, fine-looking warrior, who was carried here on a litter by his relatives. He and a warrior friend had both been poisoned at the same time. The latter preferred to remain under the care of a native medicine man, with a fatal result, while the other who had been brought to the hospital made a good recovery. Cases of injury from wild beasts are not at all uncommon ... The work of the medical mission is now known far and wide, and we cannot but praise God for the lives that have been rescued, and the thousands who have heard the news of His great salvation. (Crawford quoted in Gathogo & Nthukah 2019:66)

In his annual report to the CMS, in November 1910, Crawford (2022) reported thus:

Upon our arrival the natives came out in hundreds to greet us and give us a welcome. The local Chief showed his friendly attitude by bringing us a present of a sheep. We had to live in our tent for a month until a small corrugated iron house could be put together for our accommodation. The people swarmed about us whenever we appeared and every movement we made seemed to be of great interest to them, as we are the first Europeans to live amongst this tribe. The Embu are a branch of the Kikuyu tribe [sic] and inhabit the slopes and foot hills on the North East side of Mount Kenia [Kenya]. They resisted the advance of the government force and every effort to get into touch with them failed; and some expeditions sent in to make terms with them were repulsed with the loss of several men, until a punitive expedition was sent in about four years ago and this resulted in their complete subjugation.... The work has opened out in a most encouraging manner & from the very first a great interest has been awakened. (p. 1)

Crawford (2022) went on to explain that:

The local Chief [Kabuthi] has shown a friendliest attitude towards our work and seems to realise that we have come to help his people. The attitude has been strengthened by the fact that after our arrival he was stricken down with a virulent form of fever. We did our utmost to help him, but in spite of it he did not seem to gain ground and upon investigation we found that he was not taking our medicines regularly but that the witch doctors were gaining an influence over him in his weakness. I suppose every missionary in this part of Africa, certainly every Medical Missionary, sooner or later must feel the opposition of these people. The result of their interference was that finally the Chief had a relapse and was on the point of death. Then following the cruel custom of the tribe he was carried out of his village to die in the thickets lest his ghost should forever haunt the village after his decease. The news reached us just in time to save him. He was carried on the hospital stretcher to a mission hospital hut and restoratives administered. Day by day he has gradually regained strength until now he has been completely restored to his people and work again ... (p. 1)

Pioneer African practitioners

In following the footsteps of Dr T.W.W. Crawford, Simba wa Mwitha became the first medical practitioner in Mbeereland as he now became a nurse or dresser. He was dressing wounds, bandaging and ministering medicine. Mwitha started his medical ministry at Kiritiri Health Centre, around 1933. The Health Centre began at a place called Ngumi Mwanyari wa Kiara, also called Nyangwa Hill. Later, it was transferred to the present site, Kavondore, Kiritiri, in 1938.

Simba came from Karambare. Another pioneer nurse/dresser in Mbeereland was Jamlick Kiringa from Siakago, in the early 1940s. He was administering medicine at Kiritiri in 1940s. A third pioneer nurse/dresser is Justus Kagoro, from Mayori. He was serving at Kiambeere Dispensary in the 1940s. His area of specialty was catering for people suffering from leprosy and strived hard to stop it from spreading further. This was a unique medical practitioner from Mbeereland (W.N. Thiriku [Njarange-Ishiara home] pers. comm., 19 April 2019).

Besides Western forms of medicine, Julius Mutembei is widely seen as the first person to train people in 'modern' agricultural farming in 1930s. Mutembei led people in soil conservation, tree planting and in planting cash crops like cotton, groundnuts (*njugukaranga*), mangoes and *Melia Volkensii* (*Mukau*), which has the best timber production in the locality, among others, as:

[A]n indigenous tree to Kenya's arid areas, *Melia Volkensii* has very good hard timber. Additionally, it is drought and termite resistant, which makes it ideal for the arid climate where other tree species perform poorly. (J.N. Nderi [Gataka Village home] pers comm., 17 April 2019).

Later on, Mutembei introduced more species. Before Julius Mutembei changed Mbeere's agricultural paradigm, via Western science and technology, the locals were planting few seeds of maize, just for preservation (*Kuiga Mbeu ndikaure* – just for preserving).

Another interesting area that demonstrates Mbeere people's embrace of Westernisation is in regard to the collection of revenue. In this, Johana Ngari Kabindu became the first African tax collector in the present-day Mbeere sub-county, Embu County. He went on to collect the colonial government taxes from 1932 till he died in 1952, still in his prime age (Karani 25 June 2019). This is evident as he used the Western magic of recording through writing, in a society that was largely illiterate by then. Kabindu was also an interpreter during the public *barazas*. As the British colonial administrators spoke in English, he would be called upon to act as their interpreter in their public meetings. In such shores, he would richly employ the various figures of speech effectively, in a manner that pleased his local audiences (E.N. Karani, [Shanzu-Mombasa home], pers comm., 25 June 2019).

As in the case of the neighbouring Mutira Mission, the coming of Western science and technology did not erase or demonise African indigenous crops, animals, trees and general economic activities. It also did not erase the indigenous forms of environmental eradication J.N. Nderi [Gataka Village home] pers comm., 17 April 2019). Rather, like the latter, they or the European missionaries introduced exotic crops, animals, trees and new forms of preventing soil erosion in areas that needed to be attended. In the Mutira Mission, the European Missionaries who entered the area in 1912:

... [I]ntroduced exotic species of trees, animals (refer to grade cows such as Gurnsey, Friesian, Jersey, Ayrshire and beef cattle such as Charloris and Sahiwal among others); exotic goats such as the Torgensberg, German Alphine, Aglo Nubian, etc; and exotic sheep such as Merino and Dorpa, fruits such as mangoes, oranges, pineapples, papaws, guava, macadamia, lemons, plums, apples, peaches, and pears; and exotic foods (maize, beans, Irish potatoes, and new banana species). In the 1930s, the missionaries introduced coffee and tea as cash crops. (Gathogo 2013:33–56)

The Dilemma: African or Western medicine?

The coming of Christianity did not totally erase some elements that defined the African worldview. Even in the 21st century, there are cases where Christians have been heard or seen consulting traditional pantheons, especially when the so-called modern medicine fails. The challenge here is the secrecy behind it. If the proper dialogue between African heritage and Christianity is openly given room, it would be easy to tell what is compatible and incompatible; hence, elements that must necessarily be discarded would be sorted out. Nonetheless, it is worthwhile to concede that from 1930s onwards, people in Mbeere had embraced modern or Western education, as informal education began to be relegated to the periphery (W.N. Thiriku [Njarange-Ishara home] pers. comm., 19 April 2019). In particular, Evurore-Mbeere as in other corners of Mbeere found itself rapidly aligning itself towards that end. Why? CMS and Consolata Fathers had midwived Western education, a phenomenon that created the new society of *wasomi* [educated ones], and a people who were no longer keen to continue subscribing to the 'old religion'.

The Mbeere Mission case compares with the neighbouring Mutira Mission case, as one of the pioneer Western-leaning medical practitioner, Hezekiah Ngigi 1889–1985, trekked from Kirinyaga County to Mombasa County (700 km) in pursuit of Western education only to return in a company of European team (*Mabibi*), in 1918 (E.G. Gathumbi 2016 [Kiamugo Town home] pers comm., 13 April 2016). By then, the coastal city of Mombasa was the only city in East Africa where Arabic and Western medicine was at its peak by early 1900s. Nevertheless, Ngigi, as a pioneer practitioner in Western medicine, came after Zachariah Gakure. From our interviews, it was clearly established that the practice of indigenous circumcision, as was practised by Mararo wa Matumbi (Kamuiru-Mutira area) and Njimia wa Kathiga (Kabaro-Mwirua area), died with the coming of Western hospitals and dispensaries in the second half of the 20th century (A. Murage, [Kagumo Town home] pers comm., 13 April 2016). (W.M., Kamakia, [Giakathiani Town home], pers comm., 12 November 2022). (E.G. Gathumbi, [Kiamugo Town home] pers comm., 03 February 2016). (A. Murage, [Kagumo Town home] pers comm., 13 April 2016). (J.N. Nderi [Gataka Village home] pers comm., 17 April 2019). The situation was also replicated in the neighbouring Mbeere Mission as the practise of boy circumcision by the

'indigenous surgeons' had died by 1960s, as dispensaries and hospitals had undertaken such roles.

To this end, Hezekiah Ngigi Ngare (1889–1985) had defied the dictates of the indigenous society and developed a strong faith in the Western science and technology till he was viewed as a traitor by his fellow Africans. As noted above, his travels, in 1913, from central Kenya to the coastal region, over 700 km, by foot, were meant to look for Western education. This was a difficult decision to make for him, as his other option was sticking to the more popular form of education (indigenous) then. This makes him a unique case study. After the railway started operating normally, he would, from time to time make use of it. He would first travel by bus and alight at Sagana Town, where there was a railway station. From there, he would travel to Mombasa by train. Earlier in Mombasa, he got a job with the CMS, Buxton. It is here where he stayed with health providers and eventually became a First Aid giver. His return to his Kanugu-Kanyeki-ini birthplace was greeted with open rejection and near-death encounters. In other words, his ancestral home, which was situated around Senior Chief Njega wa Gioko's (1865–1948) homestead, did not welcome him or embrace his return from distant lands. In turn, wa Gioko hated Euro-Christian cultures strongly; and this must have influenced the general populace as the latter's powerfulness was immense. As a result, Ngigi also refused to cooperate or subscribe to the dictates of his *Anjiru a Mbari ya Kibia* clan, as a *msomi* [educated one] could not team up with the *Wasenji* [non-Christians]. He hated all people who drink beer, and as his *Anjiru a Mbari ya Kibia* clan leaders were taking liquor, he disconnected himself from them. To harmer his point home, he refused to contribute a single cent to their welfare society in his local Kibia lineage at his Kanugu-Kanyeki-ini birthplace.

Ngigi's *Anjiru a Mbari ya Kibia* clan-mates released their arsenal during the 1957–1958 land demarcation when they conspired against him and failed to allocate him any piece of their communal land. In general, *Athomi* [the emerging missionary trained African elites] were hated as they were wrongly accused of being 'drinkers of tea with human skulls' (Gathumbi 03 February 2016; Murage 13 April 2016). As a matter of fact, Chief Njega wa Gioko, like other pioneer African chiefs, discouraged Western education; hence, returning with European missionaries (in 1918) meant that Ngigi had declared war against the local leadership (Gathogo 2021:69). He thus decided to settle near the European-dominated Mutira Mission Centre (Njumbi), where he assisted the sister-in-charge of Mutira Mission Dispensary. In particular, he assisted in immunising people against leprosy. He also dressed wounds and administered medicines and would constantly walk to the neighbouring Kabare Mission Centre so as to look for more medicines whenever it was in short supply. This he did, from 1918 to 1985 when he died, at the age of 96 years (A. Murage, [Kagumo Town home] pers comm., 13 April 2016).

Ngigi's case compares with Paul Ngoci Kabugua's (1885–1982) encounters. It is Kabugua who teamed up with Rev John

Comely, of the neighbouring Kigari-Embu Mission, to co-establish the present day Nyangwa Mother Church of Mbeereiland, in 1919. This was upon Kabugua's return from Buxton-Mombasa in 1918, after he had gone through Western education. Paul Ngoci Kabugua's pioneering role had seen to it that Mbeereans had embraced Christianity and Western education by 1933 onwards. After 1933, the area could boast of its educated people as including: Paul Ngoci Kabugua, Njiru Guciutha, Karenga Mbogo, Ngarari wa Ngutuimwe and Isaac Magoto among others (Nderi 17 April 2019). The area also produced the second group of Christianised and Western-schooled people and who included: Eric Njiru, Obednego Kagundu, Johana Kabindu, Gilbert Kimotho, Grace Kibico mwara Guciutha and Lydia Guciutha mukwa-a Isaiah Kithumbi (J.N. Nderi [Gataka Village home] pers comm., 17 April 2019).

Kabugua first went to Buxton and Freetown, Mombasa, where there was one of the most successful CMS schools in East Africa. Buxton school had been established before the beginning of the First World War in 1914 (Gathogo & Nthukah 2019:28). Buxton School compares with Maseno School, among other African-educating schools, which was equally critical in shaping up the pioneer African elites in the colonial Kenya. In retrospect, it is worthwhile to submit that:

Buxton School, in Mombasa, produced the early educated Kenyan Africans from upcountry who went there only to return as Bible readers, teachers and other aspects of modernity. Buxton School has variously been compared with South Africa's Lovedale [which was founded by the Glasgow Missionary Society in 1841 as a place for higher education for Africans], Adams College (KwaZulu-Natal, founded in 1853 by Revd David Rood of the United Congregational Church of Southern Africa) and Healdtown [a Wesleyan school near Fort Beaufort and established in 1855], St. Matthew's Anglican Mission School at Keskammahoek that was established by Bishop Armstrong in 1856, Lesseyton Methodist Mission School that was established at Queenstown in 1857, Blythwood school at Butterworth that was established in 1877 by the Free Church of Scotland, and Zonnebloem College in Cape Town – established by Bishop Gray in 1858, which were preparatory schools where the pioneer African elites trace their roots (Gathogo 2021:54, Pretorius 2018:102).

In Kenya some of the Africa students, in these coastal schools, were enrolled to fight on the side of the British, as they battled with Germans. In his book, *The Making of Mission Communities in East Africa*, Strayer (1978) explains that some of the leading CMS schools such as Freetown and Buxton provided the bulk of employees in colonial era. He says:

CMS schools at the coast, particularly Freetown, produced the great bulk of these employees during the first two decades of the colonial regime ... It was in Mombasa, the early commercial and political capital of British East Africa, that the CMS first encountered these new conditions which gave rise not to a community of professing Christians but to an institution, Buxton High School, which stood at the apex of the CMS education system. (Strayer 1978:61)

Strayer (1978) further explains the nature and workings of CMS schools in Mombasa in early 1900s. He says:

Within the evangelical missionary movement, there had long been a certain suspicion of too great an involvement in education on the grounds that it was at a tangent to the major religious goal of the entire enterprise. Missionaries in the field, particularly in the early years, could also view it as harmful to the character of their converts. Around 1906, the hours of education for girls in the mission were cut from five to three per day in the hope that such action would make the girls more willing to engage in manual labour and would reduce the time that they were withdrawn from home industries. The mission furthermore attempted to restrict the number of years that a student could attend school. Four years of elementary school were recommended for all children but entrance into the three standards of higher-grade school and the two standards of final-grade school was strictly controlled, as was entry into such specialized institutions as the Divinity School, Normal School, and Buxton High School. (Strayer 1978:91)

Despite Buxton school's pioneering role in Western education and the missionary attitude against the African indigenous knowledge, especially in medicine, it could not erase the entire African world view. Despite the missionary's description of indigenous medicine as witchcraft, sorcery, wizardly and evil, the Western science did not solve all the Africans' medical woes (Idowu 1973). Additionally, viewing medicine, magic and divination as paganistic, primitive and archaic was counterproductive as the locals continued to value them, even right into the 21st century when the Western science and technology has become the vogue (Baka 1991). In Africa, magic is largely viewed as the art of making use of nature so as to find answers for human concerns (Baka 1991). With divination being seen as the mode of forecasting the future, it remains part and parcel of Africa's medical practitioners. Without it, there is no full healing, as healing in African context, from time immemorial, has always addressed both the metaphysical and the physical parts. Attempts at emphasising the superiority of Western science could not, however, stand so long as the healing process is not holistic and/or addressing the whole spectrum of the human well-being.

Conclusion

The article has explored the medical history of Western science in Mbeere Anglican Mission of Kenya since 1912 and its dalliance with African Indigenous Knowledge. While the Western science enriched African indigenous knowledge, the latter no longer remained intact but is by no means extinct. With African medicine getting consulted, even during the era of COVID-19 in the 21st century, the complimentary role of Western medicine is clearly evident, as both are relevant to Africa today. In other words, despite the dominance of Western science and technology, in Mbeereiland, and in the rest of tropical Africa, African indigenous knowledge is still relevant in all life domains. The fact that Westernisation was largely welcomed in Mbeereiland, unlike with her neighbours, shows how human nature embraces diversity and plurality as God's economy for the world. With further breakthroughs of science and technology remaining an integral part of

development trajectories in the 21st century Africa, and indeed an essential part of our production, the continent will no longer remain a slave to the natural forces, as the duo creates an environment that encourages one to make informed decisions. Hence, the duo have always ensured that the tropical Africa is never restricted in its living by ignorance or ill health. Ecclesiastical society in Africa has equally benefited from both the African indigenous knowledge and the Western science and technology.

Acknowledgements

I wish to acknowledge that I have followed full ethical considerations and authors acknowledged appropriately.

Competing interests

The author declares that they have no financial or personal relationships that may have inappropriately influenced them in writing this article.

Author's contributions

J.M.G. is the sole author of this research article.

Ethical considerations

This article followed all ethical standards for research without direct contact with human or animal subjects. No ethical clearance was needed and/or required for this article.

Funding information

The author acknowledges that the Research Institute of Religion and Theology (UNISA) for its research output of 2021 that made it possible for me to complete this task.

Data availability

Data sharing is not applicable to this article as no new data were created or analysed in this study.

Disclaimer

The views and opinions expressed in this article are those of the author and do not necessarily reflect the official policy or position of any affiliated agency of the author.

References

- Achebe, C., 1958, *Things fall apart*, Heinemann, London.
- Appiah, B., 2012, 'African traditional medicine struggles to find its place within health-care', *Canadian Medical Association Journal* 184(16), E831–E832. <https://doi.org/10.1503/cmaj.109-4277>
- Baka, T.K., 1991, 'Tiv God Talk, Aondoshonology: A prolegomenon', unpublished MA thesis, Spiritan School of Theology, Attakwu, Enugu.
- Bargblor, Z.E., 2003, *Africa's contribution to contemporary Western civilization: The perspective*, Atlanta, GA. viewed 09 July 2022. from <https://www.theperspective.org/africacontribution.html>.
- Crawford, E.M., 1913, *By the Equator's snowy peak: A record of medical missionary work and travel in British East Africa*, Church Missionary Society, London.
- Crawford, T.W.W., 2022, *Church Missionary Society Archive*, viewed 23 June 2022, from http://www.ampltd.co.uk/digital_guides/cms_section_IV_parts_16_to_19/Introduction-to-Part-18.aspx.
- Gathogo, J., 2001, *The truth about African hospitality: Is there hope for Africa?*, Salt, Mombasa.
- Gathogo, J., 2008, 'Some expressions of African hospitality today', *Scriptura* 99(1), 275–287. <https://doi.org/10.7833/99-0-669>
- Gathogo, J., 2013, 'Environmental management and African ancestral resources: Echoes from Mutira Mission, Kenya (1912–2012)', *Studia Historiae Ecclesiasticae* 39(2), 33–56.
- Gathogo, J., 2021, *The imprints of NITD-Kabete in Mutira Mission, Kenya: Recollections on Josphat Kathogo Kamoni (1918–1978)*, Kairos, Nairobi.
- Gathogo, J., 2022, 'Njega wa Gioko and the European Missionaries in the Colonial Kenya: A theo-historical recollection and reflection', *HTS Teologiese Studies* 77(2), 1–11. <https://doi.org/10.4102/hts.v78i3.6790>
- Gathogo, J. & Nthukah, M., 2019, *A fallow goldmine: One hundred years of Mbeere Mission in Kenya, 1919–2019*, Kairos, Nairobi.
- Gibson, D., 2011, 'Ambiguities in the making of an African medicine: Clinical trials of *Sutherlandia frutescens* (L)', *African Sociological Review* 15(1), 124–137.
- Giddens, A., 2016, *Sociology*, Polity Press, Cambridge.
- Idowu, E. B. 1973. *African Traditional Religion: A Definition*. London: Student Christian Movement Press.
- Karanja, J., 1999, *Founding an African faith*, Uzima, Nairobi.
- Kariuki, W. & Odondo, M., 2014. *Science, Technology & Innovation*. Nairobi: Kenya Education Management Institute.
- Kenyatta, J., 1938, *Facing Mount Kenya*, Heinemann, London.
- Mazrui, A.A., 1986, *The Africans: A triple heritage*, Little, Brown, and Company, Boston, MA.
- Mugambi, J.N.K., 2002, *Christianity and African culture*, Acton, Nairobi.
- Mutwa, C. 1996. *Zulu Shaman: Dreams, prophecies, and mysteries*. Rochester: Destiny books.
- Ngubane, H., 1977, *Body and mind in Zulu Medicine: An ethnography of health*, Academic Press, New York, NY.
- Pretorius, DM., 2019, *Private schools in South African legal history*, *Fundamina* 25(2), 94–134. <https://dx.doi.org/10.17159/2411-7870/2019/v25n2a5>
- Schwab, P., 2001, *Africa: A continent self-destructs*, Palgrave, New York, NY.
- Strayer, R.W., 1978, *The making of mission communities in East Africa*, Heinemann, London.
- World Health Organization, 1978, 'Declaration of Alma-Ata', in *International conference on primary health care*, Alma-Ata, USSR, September 06–12, 1978.
- World Health Organization 1995. "Traditional practitioners as primary health care workers," Traditional Medicine Programme, Geneva, WHO/SHS/DHS/TRM/95.5. viewed 16 July 2022, from https://www.paho.org/sites/default/files/pm-who-traditional-medicines-consumer_0.pdf (Accessed 16 July 2022).
- Yinger, J. 1970. *The Scientific Study of Religion*. New York: Macmillan.
- Zulu, I.M., 2008, *The ancient Kemet roots of library and information science*, Center for Afro-American Studies, University of California, Los Angeles, CA.