Global Dimensions of the African Diaspora

Second Edition

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Prior to 1946 the records show repeated epidemics of smallpox at 5-10 year intervals, with a high continuous prevalence in the hinterland of West Africa. The United States Public Health Service Mission in Liberia became actively involved in the 1946-1947 outbreaks. The writer saw 42 cases of smallpox disease in hinterland villages within one day with three deaths during the night. Smallpox disease was so rampant in certain villages that one could observe children four feet tall and children who were three feet tall, but not children in between; and the people would say that was the year that the epidemic came, and all the babies died, causing the gap in the height of the children. . . . Locally trained vaccinators undertook to vaccinate the entire population of Liberia against smallpox in 1946-1948 . . . A 1950-1952 study of records showed less than one dozen cases reported for the entire country.  

Although this essay focuses on the medical profession, it should be understood within a historical context of the critical role, especially during the colonial period, of African Americans in providing assistance to Africa in education and other areas of development. Moreover, African American study and teaching of tropical diseases in Africa and the training of African students advanced the development of black American education and institutions. This reciprocity affirms the mutual benefits of the African/African American connection. In his field observations, Hildrus A. Poindexter (M.D., Ph.D., M.S., M.P.H.,
Sc.D.), professor at Howard University and pioneer of tropical medicine in the African diaspora, illustrates the impact of disease in West Africa, commonly referred to as the “white man’s grave” in the early nineteenth century. William H. McNeill, however, may have overstated the historical effect of disease on African development as a whole:

Obviously human attempts to shorten the food chain within the toughest and the most variegated of all natural ecosystems of the earth, the tropical rain forests and adjacent savanna regions of Africa, are still imperfectly successful, and continue to involve exceptionally high costs in the form of exposure to disease. That, more than anything else, is why Africa remained backward in the development of civilization when compared to temperate lands (or tropical zones like those of Americas), where prevailing ecosystems were less elaborated and correspondingly less inimical to simplification by human action.

But in contrast with the less disastrous relationship of human beings and their environment elsewhere in the world, humans and parasites in Africa have generally had a primary relationship to each other; because humankind originated in Africa, humans and infectious disease developed in competition with each other from the start. Through time, innovations in Western and African medicine have been significant in the reduction of disease on the African continent, and the physician has played no minor role in disease control. In the nineteenth century, Sierra Leone was a unique frontier enclave for the development of the pioneer West African physician. Trained and certified in Edinburgh and London, this elite class of African physicians included John Macaulay (1799), William Ferguson (1814), William Broughton Davies (1858), James Africanus Beale Horton (1859), John Farrell Easmon (1880), and Oguntola Sapara (1895)—to name just a few.

Classification of African Physicians

From a global perspective, the training of the African physician falls into four categories: (1) the African M.D. trained in Western Europe, primarily in Britain and France, prior to and after World War II; (2) the African M.D. trained in the socialist nations of Eastern Europe after World War II; (3) the African M.D. trained in the United States, the Caribbean, and Canada; and (4) the most recent development in African medical education, the African M.D. trained wholly or partially in Africa.

This essay focuses on a segment of the third category—the African M.D. trained in the United States at Howard University and Meharry medical schools. At these institutions, Africans matriculated and fostered links between Afro-Americans and Africa in the development of public health.

Colonial Era and African Physicians

Pseudoscientific racism triumphed with the onset of colonial rule in Africa about 1900. In West Africa, the British reversed an earlier trend of allowing Africans to be trained as medical doctors in Scotland and England. Furthermore, African physicians were paid lower salaries than their counterparts in the colonial service. Because some earlier African protonationalists had been physicians, the British may have sought to discourage further nationalist sentiment by reducing the dominance of African doctors.

In regard to public health in Africa, these developments occurred at an unfavorable time, for colonial rule, with its use of labor-intensive projects in the Cameroon, as a common example, shifted segments of the African population from areas with low malaria prevalence to areas of high prevalence. These newly shifted populations had little resistance to malaria and suffered disproportionately from the ravages of that disease. Wherever these dislocations occurred, the newly arrived populations were at greater risk to disease prevalent in the new environment. Available evidence shows that these migrations and changes in living conditions in the early years of colonization wrought unprecedented rates of mortality and morbidity.

Whatever the motive, discrimination ultimately reduced the numbers of African doctors to those serving the coastal elites and curtailed the extension of scientific public health services to the underprivileged urban and rural population. Because the unhealthiest period in all of African history was between 1890 and 1930, the new shift in colonial policy was detrimental to African health and vitality, a factor that did not go unnoticed by Africans. In 1911, the color bar prompted African doctors to send letters and petitions to the British Advisory Medical and Sanitary Committee. Some British colonial administrators supported them because, as the British medical register showed, those African doctors had received degrees from recognized European medical schools.

Although this political action was to no avail, the issue would not disappear. In 1920, Dr. Herbert Bankole-Bright (M.D. Edinburgh and London School of Tropical Medicine) of Freetown, Sierra Leone, not only used the Accra conference of the National Congress of British West Africa to call for gradual self-government within the British Empire, but
also presented research papers on topics of medical and sanitary problems in the British territories of West Africa. In his master’s thesis on Dr. Bankole-Bright, Mohammed Bah reports:

Attacking the colonial administration for residential segregation, Dr. Bankole-Bright called on members to urge the colonial administration to improve the conditions of local doctors. Included in his presentation was a direct attack against the British colonial administration for treating African doctors in a different manner from European expatriate doctors.17

Based on these conditions, one can understand how and why Howard University and Meharry medical schools made a unique contribution to the development of public health on the African continent. If Africans with medical aspirations wished to study outside the colonial world, these two institutions were their main source of medical education in the United States.

Black Medical Schools

Seven black medical schools were founded during the post-Civil War era. Howard University Medical School held its first classroom lecture on 5 November 1868. Eight students attended, but the class was opened to all persons without regard to sex or race. Meharry Medical School of Nashville, which opened in 1876 “solely for the education of Negro doctors,” was initially designated as the Medical Department of Central Tennessee College (1866) and enrolled eleven students with ex-slave status. To supplement the work of Howard and Meharry, five other medical schools were established from 1882 to 1903. In 1882, Leonard Medical School of Shaw University was founded in Raleigh, and by 1915 it had graduated over five hundred physicians, some of whom came from Liberia, Trinidad, and Jamaica. In 1888, the Louisville National Medical College was founded, followed the next year by the establishment of the Flint Medical College in New Orleans. In the Tennessee mountains, Knoxville Medical College began in 1895, with classrooms located over a funeral parlor. Strange as it may now seem, this location was beneficial to the college, for embalmed specimens were indispensable to pathologists and to students studying anatomy. And finally, the least known of all, Chattanooga (Tennessee) National Medical College came into existence in 1903. However, despite the uncertainties surrounding the foundation of these medical schools, their emergence represented a major transformation in black social-medical history. In the antebellum period, the first black physicians were either “self-taught healers,” such as James Still, David Ruggles, and William Wells Brown, or apprentice-trained, such as Martin R. Delany. James McCune Smith presumably had received the M.D. degree abroad at the University of Glasgow as early as 1837. By the end of the antebellum era, there were only three U.S.-educated black physicians with training equivalent to their Sierra Leonean counterparts: David J. Peck (1847, Rush Medical College), John V. Degrasse, and Thomas J. White (1849, Bowdoin College). The latter institution had a medical school at the time whose objective was to prepare blacks for medical service in Liberia.12

But despite the motivation and intent of the seven black medical schools in the post-Civil War era, by the early twentieth century the dispensers of philanthropy phased out all but two of those schools. In 1910, the Flexner report on the status of medical education in the United States and Canada appeared under the auspices of the Carnegie Foundation. The report encouraged various foundations to support only approved medical schools and recommended that “Meharry at Nashville and Howard at Washington are worth development—the upbuilding of Howard and Meharry will profit the nation much more than the inadequate maintenance of a large number of schools.”13 The Flexner report had a long-lasting impact on the training of black physicians in predominantly black institutions. For nearly half of the twentieth century, Howard and Meharry were the only historically black institutions accredited to provide medical education. It was not until September 1978, some sixty-eight years after the Flexner report, that the School of Medicine at Morehouse College in Atlanta enrolled twenty-four students as the third predominantly black medical school.14

Medical School Curriculum

The curriculum of neither Meharry nor Howard showed significant innovation in the nineteenth century. That both institutions were conceived in an era preceding the pioneer discoveries of the causation of infectious diseases is evident by their earliest views on these diseases. In the graduating class at Meharry in 1878, Lorenzo Dow Key reported a discussion on malaria:

Malaria was derived from two Latin words which means bad air. It is supposed that air in certain portions of this and other countries is filled with germs that are formed by the decomposition of animal and vegetable matter and it is thought by a large number of writers on the subject that persons who inhabit these districts take into their systems during respiration, these germs which enter the circulation.15
The medical school at Howard University held classes only in the evening, for daytime classes did not begin until 1910, and with only part-time faculty and without certain basic laboratory facilities or quarters for animal experimentation. For the most part, patients were treated as their ancestors and relatives had treated them—without the benefit of antibiotics or specific drugs. Clinicians instructed the sick to avoid certain types of night air and either purged them with cathartics or induced sweating. On the other hand, the curriculum of Meharry, as shown by Falk and Quaynor-Malm, used textbooks such as Gray's *Anatomy*, Dunglison's *Medical Dictionary*, and Meig's *Diseases of Children* without any reference to John Wesley's *Primitive Physick*. In the words of these researchers, the Meharry curriculum was a "thoroughly Anglo-Saxon white medical one."17

Religion and the religious experience were extremely important factors in the daily life of black medical students, black physicians, and their black patients. All Meharry graduates were active Christians, and some were part-time ministers. But the medical education that those students received bore little relationship to the tradition or the reality of the patients they were expected to treat. There was little difference between the Howard curriculum and that of Meharry. Both reflected the acculturation process that denied the existence of a rational medical system in ancient Egypt or Africa that was in fact more than three thousand years old.18

However, Howard and Meharry started curriculum innovations in the early decades of the twentieth century in ways more beneficial to the development of medical services in Africa. Many of these changes may have had late nineteenth-century antecedents. Courses in tropical medicine, hygiene, dietetics, and preventive medicine are found in the Howard catalog as early as 1912 and 1914. And in 1922, if not earlier, one finds a department of bacteriology with a course in public health, headed by Professor Algernon Brashear Jackson with Dr. Uriah Daniels, Mr. James Julian, Jr., and Mr. Felix Anderson as supporting faculty.19 Although Meharry's catalog showed change, it did not show a course listing in tropical medicine or epidemiology until 1922. This is not to say, however, that earlier students may not have been provided with medical knowledge useful in the management of tropical diseases. Further, in 1922, a course in parasitology and clinical microscopy appeared with the following course description: "A brief course in Parasitology is given in conjunction with Bacteriology of the second year of the medical course. The students are made acquainted with the methods of identifying malaria plasmodium and other pathogenic parasites."20

Although the white administration at Meharry brought significant benefits to medical trainees, the real sensitivity for substantive changes came with the inauguration of a black administration. In 1952, Dr. Harold D. West (Ph.D.) became the first black president of Meharry. And in 1966–1967, Dr. Lloyd Elam (M.D.) became the new college president, continuing the faculty renaissance of his predecessor.21

In 1926, Howard University installed Mordecai Wyatt Johnson (S.T.M., D.D.) as its first black president. During the thirty-four years of his administration, Howard University became a center of black scholarship, a black intellectual oasis. In 1929, a dynamic phase of development began in the medical school with the appointment of Dr. Numa P. G. Adams (M.D.) as its first black dean. Dr. Adams embarked on a bold program of institutional and faculty development. With the president's support, he recruited a full-time faculty for the first time. Shortly thereafter, in 1930, Edwin R. Embree, executive secretary of the General Education Board (Rockefeller Foundation), provided grants to Howard and Meharry for training beyond the M.D. degree, and Adams insisted on such training. Hence, Howard's outstanding medical graduates such as M. Wharton Young (M.D.) and W. Montague Cobb (M.D.) went on to obtain the Ph.D. in the basic biomedical sciences. Having joined the medical faculty in 1931 with his M.D. from Harvard, Hildrus A. Poindexter also obtained the Ph.D. (1932) in microbiology and immunology at Columbia University and later continued his studies in tropical medicine there as well as at the University of Puerto Rico.

Ernest E. Just (Ph.D., University of Chicago, 1916) apparently worked in liaison with the medical school before the medical faculty renaissance era and was probably the first Ph.D. to teach in the medical school. He directed most of his better students to enter medicine rather than graduate study because of the unfavorable job market. An outstanding scientist, his professional career included appointments at the University of Chicago, and from 1930 onward he studied at the Kaiser-Wilhelm Institute für Biologie at Berlin-Dahlem until Nazi Germany brought this activity to a halt. Among numerous other publications, Just published his seminal work, *The Biology of the Cell Surface*, in 1938. Finally, Charles R. Drew (M.D., McGill) joined the faculty in 1935 as instructor in the Department of Pathology, and in 1938 he was instructor in the Department of Surgery. He is best known for his pioneering work in blood plasma.22

Curriculum innovation was a natural outgrowth of the new faculty. The *Bulletin* of 1931 shows a course listing in vital statistics and epidemiology. Newer concepts in microbiology and immunology, following the reorganization of the bacteriology department in 1934, were the chief innovations along with animal experimentation and darkfield microscopy. The revised curriculum in public health was a direct result of innovations in the Department of Bacteriology. In 1936, a national
In the 1930s, African medical students at Howard and Meharry could take advantage of the knowledge about organisms for the prevention and control of diseases. For example, in the presulfonamide drug period, medical treatment was based on trial and error. Quinine was given to patients with fever, digitalis for heart disease, opiates or morphine for people with pain, and calomel for bowel disorders as well as other diseases, such as syphilis, typhoid fever, and even headaches. But the discovery of penicillin in 1928 and its first use in patient care in 1941 opened a new era; yaws, which is morphologically indistinguishable from syphilis, could now be cured quickly, as could pneumonia. Sulfonamides were discovered as far back as 1901, but their clinical use was delayed until 1933. Sulfonamides contained thirty-odd chemical properties useful to combat certain illnesses, such as syphilis and leprosy. With the development of vaccines, immunization could eradicate whooping cough, diphtheria, smallpox, and tetanus. Hookworms, trypanosomiasis (sleeping sickness), malaria, and leprosy could all be prevented or cured with proper medical services. Howard and Meharry now had laboratories where the study of most of these diseases could be undertaken. African physicians had only to apply what they had learned about vectors transmitting disease from the infected to the noninfected. Morbidity and mortality could be greatly reduced.\(^24\)

In another study, Leslie A. Falk distinguishes two major categories of health systems.\(^25\) The first is the "scientific" or "Western system"; the second consists of modalities normally considered beyond the role of accepted medical practice. Examples of so-called scientific systems include medical group practice, free clinics, and health centers that use physician or nurse practitioners, physicians' assistants, and so on. In contrast, the system of modalities includes acupuncture, traditional healers, yoga, transactional analysis, and biofeedback. In retrospect, there is no evidence that either medical school used the modalities category either in its curriculum or as an alternative method of health care. It is only within the past five years that serious attempts have been made by institutions of Western medicine, Howard and Meharry included, to incorporate traditional beliefs and practices in the standard medical curriculum.

Some of the African graduates from Howard and Meharry medical schools made significant contributions in the transfer of medical technology to their respective countries. J. H. Roberts, an Afro-American, was the first Howard M.D. graduate from West Africa in 1876; he entered private practice in Liberia and is believed to be the son of the first Liberian President J. H. Roberts (1848–1856, 1872–1876).\(^26\) Howard produced two other graduates during the latter part of the nineteenth century, but little is known about them. The records from 1900 to 1960 are more detailed.\(^27\) In 1935, Howard University graduated Dr. Malaku E. Bayan, who became Emperor Haile Selassie's personal physician in the 1930s; in 1942, Dr. David E. Boye-Johnson graduated and became the chief medical officer of Sierra Leone in 1944 and served in other public health capacities. In 1955, Dr. Aderohunmu O. Laja graduated and was posted in the pathology department of the Federal Ministry of Health in Lagos, Nigeria. Dr. Badejo O. Adenowojo also was a 1955 Howard graduate and served as the chief medical officer of the Lagos State Government of Nigeria. And there were other outstanding M.D. African graduates of the 1950s.

But the decade's most outstanding Howard University M.D. graduate was the late Dr. Latunde E. Odeku of Nigeria. (It is said that he and Andrew Young, the former U.S. ambassador to the United Nations, were dormitory roommates at Howard.) Odeku was also a poet, and in 1950, some four years before his graduation, he expressed his appreciation in a poem to Howard University:

\[\text{Alma Mater}\]
\[
\text{You are strong with thee forever rests,} \\
\text{Our usefulness, our pride;} \\
\text{Our struggles in the years to come} \\
\text{Shall beam our deeds and crowns to thee} \\
\text{In lasting thought of gratitude.}\]

Odeku returned to Nigeria, established the first neurosurgical unit at the University of Ibadan, and became its first head. He performed a wide range of neurosurgical operations with modest facilities.

Meharry produced its share of African medical graduates as well.\(^29\) Ironically, Meharry's initial contribution in the transfer of medical technology in the nineteenth century came not from a graduate of the African continent but from the United States. Dr. Georgia E. L. Patton, an Afro-American, was the first woman graduate of Meharry in 1893. The difficulty women graduates had in obtaining certification from medical associations during this era may account for Dr. Patton's going to Liberia to practice medicine from 1893 to 1895. Illness may have been her nemesis because shortly after 1895, she returned to the United States and settled in Memphis, where she died in 1900.\(^30\) Dr. Poindexter, whose remarks on disease control in Liberia prefaced this essay, reports that Dr. Patton is still remembered among the elders in Liberia.
On the other hand, Meharry had only one graduate of the African continent before 1900—John H. Jones of Liberia. Meharry had a more successful record of producing African graduates between 1900 and 1960. Paradoxically, two of Meharry’s best-known graduates prior to 1940 have made little or no contribution in the realm of public health. Daniel Sharpe Malekebu of Malawi arrived in the United States in 1908 with the support of black Baptists in New York and Ohio. He studied in North Carolina and at Selma College in Alabama; in 1917, he graduated as a surgeon from Meharry. All total, Malekebu spent fourteen years in the United States and established links with the medical staff at Meharry, the YMCA, the Baptist leaders, and Dr. Whittier H. Wright of Meharry. Further, he married Flora Ethelwyn, an Afro-American. Back in Malawi in 1926, Malekebu succeeded John Chilembwe (a Yao trained in Virginia by Baptists) as head of the Independent Providence Industrial Mission in Southern Malawi.

Dr. Hastings Kamuzu Banda is now life president of the Republic of Malawi. The African Methodist Episcopal (AME) Church of Johannesburg sponsored Banda’s first trip to the United States in 1925. He earned a high school diploma at Wilberforce University, studied at Indiana University, and received the bachelor of philosophy degree from the University of Chicago. His benefactors were black professionals and real estate owners in Ohio and Indiana. Banda was also able to exchange views in the United States with J. R. Rathebe of South Africa and with Dr. A. B. Yuma, who became leader of the African National Congress of South Africa in the late 1920s and early 1930s. After graduating from Meharry in 1936, Banda left the United States but was present to give the commencement address at Meharry in 1977.

Meharry graduated a number of other outstanding African physicians, but insufficient data preclude description of their contribution to the transfer of medical technology and skills. Two other figures, however, must not go unmentioned: first, Joseph Nagbe Togba of Liberia graduated from Meharry in 1944 and became an important figure in the World Health Organization; and second, Henry Nehemiah Cooper, also of Liberia, received the M.D. degree in 1954 and heads the John F. Kennedy Hospital in Monrovia.

Some general conclusions can be drawn from this exploratory distribution model. First, the fact that Liberia provided the earliest medical graduates attests to the Afro-American community in the United States; some Liberians even attended the Leonard Medical School of Shaw University before it went out of existence in 1915. Second, Nigeria has the largest “pipeline” of graduates that began in the last decade of the colonial period; all of them came from southern Nigeria, for northern Nigeria as a region did not graduate its first M.D. until 1973-1974 at Ahmadu Bello University Medical School, Zaria. Third, none of the influential Malawian graduates attended Howard; Dr. Malekebu, having been the first Malawian graduate from Meharry in 1917, controlled the “pipeline” and influenced subsequent Malawians such as Dr. Banda and others to attend Meharry.

The AME Church sponsored more students at Meharry than at Howard, which had a predominantly Congregationalist orientation in the nineteenth century. The AME Church had a long history of involvement in South Africa, which may account for the greater number of South Africans at Meharry (six) than at Howard (two). Ghanaian students in any significant numbers did not attend either of these institutions until the 1950s; it is likely that Kwame Nkrumah (Lincoln University, Pennsylvania), who became Ghana’s first president in the postindependence era, accelerated this trend.

During the colonial period (1900–1960), the African M.D. graduates appear at staggered intervals in the catalogs. This pattern developed partly because, as Donald Segal reports, the colonial governments discriminated against African physicians trained in the United States. Howard University and other U.S. institutions provided premedical undergraduate training for many Africans, who then continued their medical studies at either McGill University in Canada or in Europe because of the exclusionist policy of the colonial era. T. Bello Osagie, a Nigerian graduate of Howard in the early 1950s, obtained his M.D. at McGill because he feared that American credentials would exclude him from certification in Nigeria. The postindependence era marks a departure from this trend and apparently lifted the colonial ban of discrimination against African physicians trained in the United States.

Summary

Howard University and Meharry medical schools have contributed significantly in the training of African physicians since they were founded in the nineteenth century. Howard University Medical School, founded in 1868, and Meharry, established in 1876, were two of seven black medical institutions to emerge in that period. But the Flexner report of 1910 phased out all but Howard and Meharry, which continued to receive philanthropic support. Both institutions appeared at a propitious time, when pseudoscientific racism triumphed with the onset of colonial rule in Africa. At the same time, in West Africa, the British reversed an earlier trend allowing Africans to be trained as physicians at Edinburgh and London, and began to discriminate against African medical doctors trained in the United States.
A factor other than pseudoscientific racism may have been at stake in regard to the new colonial policy. Some earlier nationalists were physicians, and the British may have sought to diminish the domino effect of nationalist sentiment by reducing the number of African doctors, since they represented the dominant elite in the new class formation. The policy change, however, tended to confine the distribution of African doctors to the coastal settlements and restricted the expansion of scientific public health services for the mass of the population living predominantly in the rural and periurban areas.

Howard University Medical School and Meharry Medical School made a unique contribution to the advancement of scientific medicine on the African continent by adding to the pool of British-trained physicians in West Africa who had come initially from Sierra Leone. By the second decade of the twentieth century, these medical schools began to incorporate into their curriculum such innovative courses as tropical medicine, bacteriology, microbiology, animal experimentation, statistical epidemiology and the like. African medical doctors had only to apply these innovations to the development of medical services in their respective countries of origin.

Howard University and Meharry medical schools graduated more African students—about forty-one—between 1960 and 1978 than they did in the sixty years preceding the independence era. This fact confirms that transformation from African to African American neither severed the socio-cultural link with the homeland nor precluded black American involvement in the development of the continent.

NOTES

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5. Dr. Calvin H. Sinnette, oral interview on August 15, 1979, at Howard University Medical School; see also Paul E. Steiner, "Medical Education in Trans-Saharan Africa," Journal of Medical Education 34, 2 (1959):95-106.
13. Flexner, Medical Education in the United States and Canada, 181.
16. Dr. Hildrus A. Poindexter, oral interview on 23 March 1978 at Howard University Medical School, tape 1, side A; see also Todd L. Saviit, Medicine and Slavery (Champaign: University of Illinois Press, 1979).

19. Howard University Record: Howard University School of Medicine 13, 4 (June 1918); Howard University Bulletin 11, 7 (August 1930): 52–53.


23. Howard University Bulletin: School of Medicine 11, 3 (October 1931); Poindexter, My World of Reality, 116–19; Poindexter, oral interview, tape 1, side A.


28. E. Latunde Odekun, Twilight Out of the Night (Ibadan: University of Ibadan, 1964), 71. I thank Dr. Calvin H. Sinnette for bringing this source to my attention.