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The Impact of Colonial Disease Control Measures on Socio-Economic Activities in Western Kenya, 1895 to 1963

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Abstract: ***This study examined the impact of colonial disease control measures on the socioeconomic activities of the Luo, Gusii, and Luhya communities in Western Kenya between 1895 and 1963. Using a qualitative case study design, data were collected through interviews, focus group discussions, observation, and document analysis in Kitutu Chache South, Lurambi, and Kisumu Central. Findings indicate that colonial disease control measures, including quarantine, livestock movement restrictions, mandatory vaccination, cattle branding, forced resettlement, and vector control interventions, significantly disrupted trade, mobility, livelihoods, cultural practices, and ecological systems. Community resistance emerged where interventions conflicted with indigenous beliefs and economic survival. The study concludes that colonial health policies prioritized administrative control over community participation, resulting in long-term socioeconomic consequences. The findings underscore the importance of culturally responsive public health policy design.***

Keywords: Colonial health policy; disease control; socio-economic impact; Western Kenya; indigenous healthcare; colonial medicine; public health history; traditional healer

1. Introduction

The study discusses the impact of colonial disease control measures on socioeconomic activities in western Kenya from 1895 to 1963. The study adopted a case study design with indepth investigations of several sources of data. The results of the study demonstrate that these policies significantly disrupted the social fabric and economic activities of the Luo, Gusii, and Luhya communities, particularly through movement restrictions on livestock intended to curb animal diseases, which negatively affected trade and access to essential resources like water and pastures, resulting in tensions within these communities. Furthermore, the extensive administration of drugs and the drainage of swamps were found to harm local biodiversity, complicating the ecological balance. Overall, the colonial disease control measures fundamentally altered the socio-economic landscape of western Kenya, leaving lasting impacts that echoed through subsequent decades. The study concludes that these measures overlooked local customs and needs, leading to considerable disruptions in community life. The study offers some policy recommendations such as fostering community inclusion in health decision-making to ensure that modern interventions respect traditional practices, creating flexible mobility and trade regulations that balance essential activities with disease control measures, prioritizing ecological sustainability in environmental policies, and promoting transparent communication between health authorities and local populations to rebuild trust and enhance the effectiveness of disease control efforts.

2. Methodology

The study adopted a qualitative case study design with a total sample size of 72 respondents drawn from three sub-counties, Kitutu Chache South, Lurambi, and Kisumu Central, distributed as 54 purposively and snowball-sampled community members, 5 retired colonial chiefs, and 8 representatives from religious and non-governmental organizations, alongside traders and knowledgeable elders. The criteria prioritized elderly residents with lived or witnessed experience of colonial medical policies, key informants with expert or historical knowledge, and selected younger participants only where they had relevant proximity to information, while individuals lacking such experiential or contextual knowledge were excluded. Data were collected primarily through oral interviews, focus group discussions (10 participants per sub-county), document analysis, and observation protocol guide. Qualitative data were analyzed using content and thematic analysis frameworks, involving transcription, coding into sub-themes, and critical comparison across oral, archival, and documentary sources. Ethical procedures included obtaining research permits (NACOSTI and county authorities), securing informed consent, ensuring voluntary participation, maintaining confidentiality, and requesting permission for audio recording and use of photographs (Patton, 2002). The study upheld validity and reliability through careful instrument design, internal and external criticism of historical sources, and consistent questioning techniques. Recollections of historical events were validated through triangulation (Marshall & Rossman, 1989; Schmuck, 1997), corroborating oral testimonies with archival records, written documents, and observational evidence to minimize bias and enhance credibility.

3. Results

The choice of respondents who had critical information based on age, gender, level of education, and the regions that were affected by these colonial medical policies were considered to

enhance the credibility of the information collected. The results were as follows:

Quarantine Policy in Western Kenya

Quarantine policies in Western Kenya have deep historical roots, originating from colonial strategies aimed at controlling disease spread among local populations. The term "quarantine," derived from the Italian phrase for "forty days," marks its establishment as a public health measure during the 14th century. Rooted in colonial ambitions, these policies sought to manage the health of imperial subjects, yet often resulted in significant socio-economic and cultural disruption for indigenous communities. According to Tognotti (2013), while essential for controlling disease, quarantine measures raise ethical concerns, reflecting tensions between public health and individual rights, a discourse that remains relevant in contemporary contexts.

The evolution of quarantine practices shifted dramatically with advancements in medical understanding, particularly post-bacteriological revolution when perceptions of infectious diseases were transformed (Farre et al., 2017). This shift can be traced back to the late 14th century when early quarantine measures were established in European cities like Dubrovnik and Venice, where dedicated lazarettos were built to isolate the sick (Municipality of Venice, 1979). Though designed to combat the spread of illness, colonial application in Kenya was fraught with contradictions, as health officials struggled to balance intentions with the realities of increased disease burdens brought on by violent conquest and disrupted living conditions (Tilley, 2011).

Strict quarantine measures, however, met resistance from various socio-economic realities faced by pastoral communities. Livestock movement, vital for cultural and economic sustenance, clashed with imposed restrictions, making compliance difficult (KNA/BV/12/209). As local communities adapted to these oppressive regulations, such as drastic eradication measures that destroyed residences and increased mistrust towards colonial authorities, the colonial government transitioned toward more aggressive strategies aimed at disease eradication, ignoring the complex socio-cultural contexts of pastoralist life (Agatha Kemuma, O.I., November 16, 2024).

The impact of quarantine extended beyond economic disruptions, often undermining the very social fabric of indigenous communities. The isolation enforced by quarantine measures severed economic ties and community relationships, exacerbating hardship and poverty within affected populations (Alex Odero, O.I., December 28, 2024). Furthermore, the dichotomy between "clean" and "dirty" zones in the livestock trade reflected colonial priorities, complicating traditional pastoral practices and stigmatizing indigenous herders, while reinforcing the boundaries drawn by colonial powers (Waller, 2012).

Quarantine was not merely a public health issue but became a tool for broader social control, characterized by the systematic marginalization of pastoralist practices and the enforcement of racial segregation. Policies designed to manage disease outbreaks were often intertwined with colonial strategies to regulate land use and tax compliance among indigenous communities, as evidenced by restrictions on land ownership imparted to local populations (KNA: KLC/1933). In contemporary times, these structural inequities continue to affect livelihoods and resource management, illustrating the long-term consequences of colonial quarantine policies and their ongoing implications for socio-economic stability in Kenya.

Mandatory Vaccination Campaign in Western Kenya

The mandatory vaccination campaign in Western Kenya, initiated by colonial authorities during the inter-war years, was primarily aimed at controlling smallpox. These vaccination efforts were heralded as a triumph of colonial governance, presenting Western medicine as beneficial to public health. However, this approach was flawed, as it emphasized immediate disease control without enhancing the broader health infrastructure or providing adequate health education. Consequently, communities were left vulnerable to outbreaks due to inadequate vaccination coverage, perpetuating a dependency on external interventions instead of fostering sustainable health practices (Schneider, 2009).

In addition to human vaccination, there was a focus on immunizing livestock against diseases like East Coast Fever and rinderpest. However, the campaign faced significant challenges, particularly due to insufficient veterinary personnel and poor communication, which hindered effective service delivery. Many herds suffered from outbreaks because the vaccination was administered too late, compounding the effects of existing illnesses. Local resistance to the vaccination efforts was fueled by a lack of clear communication about the campaign and highhanded measures imposed by authorities, including penalties for non-compliance, which further alienated cattle owners (KNA, PC/NZA/2/8/6, on Livestock Trade, 1931-50).

The broader public health strategies during this era also included malaria control initiatives in urban centers such as Mombasa and Kisumu, though these cities did not face the same epidemics as Nairobi. The reliance on vector control measures during labor shortages highlights the limitations of these campaigns. Furthermore, racial segregation was institutionalized as a means of public health control, particularly under the Public Health Ordinance of 1913, which aimed to prevent malaria transmission among urban populations. This racialized approach not only indicated a misalignment of health policies with the needs of local communities but also had longterm social and economic impacts, reinforcing existing inequalities in health care access and disease management in Western Kenya (KNA/DC/NBI.1/1/1:6; KNA/PC/NZA/1/4: 2; Curtin 1985: 610).

Policy on the Movement of Animals to Control Diseases.

The movement of livestock is a critical component of pastoral life in Africa, driven by the quest for natural resources and market access. These mobility practices are shaped by various

geoclimatic and sociocultural factors, which include drought, flooding, disease outbreaks, and conflicts. According to Garland et al. (2011), the need for mobility is particularly pronounced during the dry season when water resources become scarce, forcing farmers to relocate with their herds. The situation is further complicated by conditions like drought that not only disrupt livelihoods but also lead to significant migrations and potential conflicts as communities vie for limited resources.

There are numerous sanitary and non-sanitary constraints associated with livestock movements in Africa, impacting animal health and food safety. High rates of uncontrolled crossborder movements and a lack of animal identification systems create challenges for regulation. Travis et al. (2011) note that such constraints threaten to alter the epidemiological landscape, complicating efforts to safeguard both animal health and food security. Drought, as highlighted by Oruko (2024), serves as one of the continent's greatest threats, contributing to pasture depletion and significant human and animal mortality, compounding the issues surrounding livestock mobility.

Foot and mouth disease (FMD) poses a considerable risk due to its highly contagious nature, which is exacerbated by the movement of infected livestock and animal products. Cattle are particularly vulnerable, while small ruminants can carry the disease in a less obvious form. As detailed by Garland et al. (2011), existing territorial control models meant to combat such diseases often simplify complex realities, focusing primarily on intervention strategies without addressing the myriad social and economic factors that contribute to disease spread. This lack of nuance in control measures can lead to additional challenges, including the restriction of people's movements that directly impact economic activity.

The imposition of territorial control, particularly in response to pandemics, often seeks to create a sense of security but can simultaneously foster tension and distrust within communities. This is particularly evident in Kenya, where marginalized groups, such as the youth, have been portrayed as being indifferent to health risks, according to Anderson (2002). The obsessive focus on controlling movement rather than addressing public health fundamentally shifts community dynamics and exacerbates existing class and ethnic divides.

Historically, the colonial approach to disease management relied heavily on territorial control, characterized by stringent movement regulations, quarantines, and trade restrictions to manage outbreaks like rinderpest. Andayi et al. (2019) emphasize that while these measures were intended to protect livestock and public health, they had detrimental socioeconomic effects, including food shortages and increased poverty. The legacy of such control measures established veterinary and public health surveillance systems that are still relevant today, as noted by Kahariri et al. (2024). These systems continue to inform modern strategies for managing zoonotic diseases, highlighting the intricate relationship between historical governance practices and contemporary disease management in Western Kenya.

The policy on Cattle Branding in Western Kenya

Cattle branding was a significant colonial policy in Western Kenya, aimed at regulating livestock management. It was primarily executed during vaccination campaigns, as colonial authorities recognized livestock diseases—particularly rinderpest and foot-and-mouth disease- as major threats to the pastoral economy (Ndeda, 2019). Branding served various purposes, including identification, ownership, and disease management. This system allowed colonial authorities to monitor cattle health and control livestock movements effectively, thus enhancing disease surveillance. As noted by a participant, branding facilitated the identification of vaccinated animals and minimized the risk of theft and illegal movement between districts (Awino Mumbo, O.I., November 7, 2024).

The effectiveness of cattle branding was evident in its role during disease outbreaks. Branded cattle could be quickly identified for vaccination, which helped reduce the transmission of diseases like rinderpest and protected uninfected herds. This capacity for rapid monitoring reinforced the colonial administration's control over local pastoral communities, highlighting the intersecting interests of disease management and colonial governance (Samuel Nyangeri, O.I., November 29, 2024). The system also fostered economic regulations, as branding ensured that only healthy animals entered markets, contributing to market stability and safeguarding pastoralists' livelihoods, albeit at the cost of disrupting traditional livestock management practices (Alex Odero et al., O.I., November 4, 2024).

Socially, cattle branding represented colonial interference in local customs and traditions, with varying reactions among pastoralists. While some adapted to the system, others resisted it, viewing it as a violation of their rights and cultural practices (Ndeda, 2019). Branding not only aided theft prevention and disease control but also reflected broader conflicts with authorities. Participants reiterated the importance of branding for ownership identification and animal tracking, which was crucial for effective disease management and maintaining economic stability through proper livestock health practices (Berita Isiki, O.I., December 18, 2024).

Despite its intended benefits, cattle branding faced resistance from local communities who were skeptical about colonial intentions. Many cattle owners did not fully grasp the purpose of branding and viewed it with apprehension, diminishing its effectiveness in controlling disease and theft (KNA. PC/NZA/13/11/49, 1927-28). This skepticism stemmed from a broader distrust of colonial strategies, as they were often imposed without proper consultation, leading to tensions between authorities and pastoralists.

Policy of forced Resettlement and Construction

The policies of forced resettlement and the construction of medical hospitals during the colonial era significantly impacted the people of western Kenya. These policies were part of broader colonial strategies aimed at enforcing control over local populations, leading to extensive social, economic, and health-related consequences. Azevedo (2017) highlighted that forced

resettlement disrupted traditional livelihoods, where communities were relocated to promote agricultural production for export, disregarding their customs and land use practices. This resulted in the loss of ancestral lands critical for subsistence farming and cultural identity, contributing to increased poverty and food insecurity as communities struggled to adapt to new agricultural systems.

The construction of medical facilities during the colonial period further exacerbated the hardships faced by local populations. According to John Indongole, many communities, including the Gusii, Luo, and Luhyia, experienced significant disruption to their lifestyles and livelihoods due to forced resettlement. Hospitals built during this time primarily served colonial interests and often led to environmental degradation, leaving the local population grappling with economic challenges and cultural disintegration. The negative legacy of these policies persists, affecting the capacity of communities to reclaim their identities and land rights.

Support for the detrimental effects of colonial health strategies is echoed by Mtuy et al. (2022), who noted that the establishment of medical facilities was often inequitable and poorly funded. While some hospitals catered to the colonial administration and settlers, indigenous populations frequently received subpar care. This imbalance created significant health disparities, particularly in rural areas where access to essential medical services was limited. Consequently, health issues such as maternal and child mortality remained exacerbated, undermining traditional healing systems and fostering a mistrust of medical institutions among local communities.

Tilley (2016) analyzed the paternalistic attitudes reflected in colonial health policies, detailing how indigenous populations were viewed as subjects needing "civilizing" rather than partners in health development. This approach not only marginalized indigenous practices but also cultivated a lasting mistrust towards medical services that continues to impact health-seeking behaviors in western Kenya. Many individuals feel alienated from a healthcare system that fails to respect their cultural values, further complicating community health dynamics.

The enduring consequences of these colonial policies are vividly present in contemporary Western Kenya. The historical injustices surrounding land dispossession and inadequate healthcare access have led to persistent social inequalities. Azevedo (2017) noted that many communities continue to struggle with issues related to health access, economic opportunities, and cultural recognition, all traceable to the colonial era's strategies. The legacy of forced resettlement and the implementation of medical facilities during this period has created a complex backdrop of historical grievances that shapes current health outcomes and community resilience

Vector Control Policy in Western Kenya

Hay et al. (2002) explained that during the colonial era, Western Kenya underwent environmental modifications aimed at controlling diseases like malaria and smallpox. These interventions were significant in addressing the health crisis arising from increased agricultural activities and population settlement following World War I. The colonial government implemented measures, such as indoor residual spraying and mass drug administration, to lower malaria incidence, viewing health improvements as essential to sustaining agricultural productivity and economic stability in the region.

The agricultural expansion in the highlands, previously malaria-free, led to a resurgence of the disease. Reports indicated that land clearance and irrigation practices created breeding grounds for malaria-carrying mosquitoes, contributing to heightened transmission rates, especially among children (Nerea Akumu, O.I., December 28, 2024). Although these modifications aimed to enhance public health, they paradoxically increased the vulnerability of the local population to malaria and other diseases. The socio-economic effects of these health interventions were profound as well. The colonial emphasis on cash crops marginalized traditional subsistence farming, compromising food security and altering local economies. As communities became increasingly reliant on cash crops, malnutrition and disease rates escalated, reflecting a critical intersection between health and economic wellbeing (Schneider, 2009).

Munga et al. (2010) highlighted that swamp drainage was a significant public health initiative intended to combat malaria by reducing mosquito breeding sites. However, this intervention led to significant ecological disruption, transforming wetlands into agricultural land. Although it initially facilitated agricultural expansion, it also disrupted local biodiversity and diminished the natural resources essential for many communities' livelihoods, including fishing and foraging (Gerald Imbiakena, O.I., December 17, 2024).

Karpov (2023) emphasized that draining wetlands negatively impacted these ecosystems, reducing their ability to filter water, control floods, and serve as habitats for various species. The loss of wetlands contributed to resource scarcity for local populations and increased food insecurity. The colonial policies often prioritized European settlers' wellbeing over that of the indigenous communities, exacerbating their economic struggles and marginalization.

The drainage projects also resulted in the displacement of local populations, leading to social unrest and conflicts over land. Many residents lost their homes and traditional practices, which disrupted community cohesion (Karpov, 2023). Furthermore, Karanja and Muli (2015) found that these interventions did not adequately alleviate malaria; instead, they sometimes introduced new breeding dynamics. The focus on cash crop production further marginalized local needs and compromised food security, increasing poverty and malnutrition (Okech & Muli, 2016). This interplay of health, ecology, and socio-economic factors reflects the complex legacy of colonial health policies in Western Kenya.

4. Discussion

Colonial medical policies have been a constant source of controversy in the African continent's independent states, the establishment of colonial medical practices and regulations is one of the many "legacies" left by Western encroachment in Africa (Messac,2020). Colonial medical policies refer to the healthcare strategies, systems, and practices implemented by colonial powers in territories controlled during the colonial era. Colonial medical policies included on the movement of livestock to control diseases, policy on Vaccination programs and Quarantine measures, Policies of Forced Resettlement and Concentration, Medical Research initiatives, Collaboration policy, Hospital fees policy, Native authority policy, maternal and child health, Voluntary service Registration policy, Healthcare Infrastructure, Inadequate Indigenous Healthcare Systems, and vector control policy.

These policies were shaped by the priorities and interests of colonial rulers and often reflected the socio-political, economic, and cultural dynamics of the time. The introduction of Western material culture is accompanied by a set of powerful hegemonic ideologies. Religious missionaries, representatives of the law, educators, and health practitioners were all involved in attempting to persuade Africans to accept new concepts and modes of behavior (Wesseling, 1996).

Hokkanen (2017) argued that colonialism itself was 'fundamentally about geographical mobility', penetration into any space required the ability to move both into and out of that space, without falling severely ill or dying. This was the crux of the colonial enterprise: settlers, armies, mercantilists, missionaries, and colonial officials who were sick, dying, or dead could not execute a colonial vision. Colonialism, therefore, depends fully on moderately healthy travel. Using letters, newspapers, public debates, and government correspondence.

European efforts to improve the health of imperial subjects were typically be set with contradictions because disease burdens increased and health conditions were more challenging to control than officials expected. Conquest was violent and disruptive, radically altering landscapes and lives, and producing what medical specialist Patrick Manson aptly referred to in 1902 as a "pathological revolution" in tropical Africa (Tilley, 2011).

Colonial states used both civil and criminal laws to challenge and marginalize most forms of African therapeutics. This was especially true for those techniques that fell outside an individualistic and materialist approach to bodily and mental health and stressed connections to ancestors and the spirit world (Langwick, 2011). However, no matter how dominant colonial medical policies became in sub-Saharan Africa, they never "entirely usurped other forms of healing practices already present" (Lock, 2003). In other words, medical pluralism was the norm even when colonial services received the lion's share of resources and legal protections and set the terms of debate for what constituted acceptable medical policies.

In regions like East and South Asia, colonial powers such as the British and French sought to integrate local medical knowledge into their health systems, but often did so in a way that subordinated these practices to Western standards by employing their colonial medical policies and frequently marginalizing indigenous systems in favor of Western biomedicine (Lowes *et al*,.2021).

Between the 1920s and 1950s, French colonial governments conducted extensive medical campaigns in sub-Saharan Africa aimed at managing tropical diseases. In Cameroon and the former French Equatorial Africa, present-day Central African Republic, Chad, the Republic of Congo, and Gabon, the colonial governments organized campaigns against various diseases, including sleeping sickness, leprosy, yaws, syphilis, and malaria. The most extensive of these campaigns focused on sleeping sickness, a lethal disease spread by the tsetse fly. Over several decades, millions of individuals underwent medical examinations and were compelled to receive injections of medications with dubious efficacy and serious side effects, including blindness, gangrene, and death. The sleeping sickness campaigns represented some of the largest colonial health investments, and for many, these campaigns marked their first exposure to modern medicine (Headrick, 2014).

In Sri Lanka, during the nineteenth century and the first half of the twentieth century, the British colonial administration did not consider medical and sanitary services for indigenous people as part of government responsibilities. The government maintained the policy of "noninterference" as long as other organizations provided such needs. Hence, native medical services were left to missionary and charitable organizations, while the government provided medical services to European administrative and military personnel (Hewa, 1995).

Addae (1996) posits that Ghana inherited the colonial health infrastructure with a public health approach that focused on major outbreaks of epidemic diseases, such as smallpox and yellow fever. From the presidency of Nkrumah to contemporary times, changes in government have had a great impact on the health system in Ghana. The socialist state of Nkrumah brought about a free healthcare system in which the state was responsible for the general healthcare needs of its citizens. The postcolonial era saw the continuation of colonial medical policies. The health branch was equipped to perform the core functions. Vaccinations have also been intensified to prevent diseases such as whooping cough, tuberculosis, measles, tetanus, yellow fever, and hepatitis B. Health services after independence have undergone several changes; these changes were mostly influenced by political developments after independence. After independence, several regimes have implemented different policies (Langwick, 2011).

The Zimbabwean government inherited a racially divided health sector, skewed towards urban and curative healthcare. As a result, it sought to redress colonial racial inequalities and improve social service provision and the infrastructural base of the economy. For the majority of Africans, health and education were key areas that suffered decades of neglect and

underfunding (Lock, 2003). State-funded colonial formal healthcare was largely a preserve of the white community and was marginally directed towards African health. Colonial health policy was predicated on racialism, which categorized Africa as a second-class citizen to whom the state had no obligation. The neglect of African healthcare needs was most glaring in infrastructural disparities between white-dominated urban centers and rural areas where the majority of Africans lived. Africans operate without the most basic health services, and mortality rates are high due to untreated diseases and conditions (Agere, 1990).

In Tanzania, the Germans maintained a policy of neglecting people's health in rural areas. Medical institutions were established only in administrative centers and towns, mainly caring for their employees (Ferguson, 1977). Thus, the German colonial government did not hold itself entirely responsible for providing health services to the natives in the rural areas.

The period from 1895 to 1963 marked a transformative period in the history of Western Kenya as it navigated the complex terrain of colonial rule under the British Empire. Among the many aspects of colonial administration, the formulation and implementation of medical policy were the most important areas that had a major impact on the lives of the native population. During this period, the impact of colonial medical policies in western Kenya left lasting marks on the region's health landscape, social structures, and general well-being of its inhabitants (Hewa,1995).

Colonial authorities, driven by a combination of imperial motives and ostensibly cultural missions, sought to establish control over healthcare as part of their broader management strategies. The introduction of medical policies during this period was not only a response to health challenges but also reflected broader socio-political and economic concerns.

The construction of the Kenya-Uganda Railway, which passed through Western Kenya during the colonial period, played a significant role in the spread of diseases in the region. The railway project, initiated by British colonial authorities in the late 19th century, aimed to connect the interior of East Africa to the Indian Ocean coast. Railway construction requires a large and mobile labor force. In this case therefore, thousands of laborers, including African workers and Indian indentured laborers, were brought in to work on the project. The movement of these workers facilitated the spread of diseases as they traveled along the railway line (Lubega, 2016).

The living conditions of the laborers during railway construction were often unsanitary and overcrowded. Camps and settlements along the railway route lacked proper sanitation facilities, clean water, and adequate healthcare. These conditions provide fertile ground for the spread of infectious diseases. The influx of people from different regions and backgrounds brought with it the introduction of new diseases to which local populations did not have immunity. Diseases such as smallpox, cholera, and respiratory infections can spread rapidly in congested and often unhygienic environments associated with railway construction (Haraprasad, 1970).

The study found that the colonial government's quarantine policies, implemented to control disease outbreaks, significantly disrupted the social fabric and economic activities in Western Kenya. The movement restrictions imposed on livestock to curb animal diseases severely impacted trade and access to essential resources such as water and pastures, leading to community tensions.

The study also found that the controversial practice of cattle branding, mandated by colonial authorities but widely rejected by the local populace, also drew ire and resentment. Dog poisoning as a disease control measure affected pets and disrupted the cultural significance of dogs within these communities. Environmental modifications, including the extensive administration of drugs and drainage of swamps, were found to have detrimental effects on local biodiversity, further complicating the ecological balance. The study noted that the Colonial policies focused on controlling diseases like sleeping sickness, malaria, and smallpox. Quarantine measures and mass vaccination campaigns were implemented, but often without community involvement.

The study noted that the assessment of forced resettlement policies and the construction projects that were part of colonial strategies. These measures often disregarded local customs and needs, leading to significant disruptions in community life. The establishment of medical services, while a positive development, was overshadowed by the broader implications of colonial control and the socio-economic challenges faced by the affected populations.

The policy on disease control was used as a means to marginalize African economic setup, African seedlings were seen to be contaminated and they were not allowed to grow cash crop because they were not able to control the spread of diseases.

5. Conclusion and Recommendation

The study has examined the impact of colonial disease control measures on socioeconomic activities in Western Kenya from 1895 to 1963. This study demonstrates that colonial disease control measures in Western Kenya extended beyond public health intervention and significantly reshaped socio-economic life among the Luo, Gusii, and Luhya communities. Policies such as quarantine, vaccination enforcement, livestock movement restrictions, cattle branding, forced resettlement, and environmental interventions disrupted livelihoods, weakened traditional systems, and generated resistance where local realities were overlooked. The findings highlight how health governance under colonial rule functioned as both disease management and administrative control, leaving enduring socio-economic consequences for affected communities

The study recommends that the government and other stakeholders should conduct a detailed analysis of specific

colonial medical policies implemented in Western Kenya, such as vaccination campaigns, disease control strategies, and health infrastructure development. There is a need to evaluate the short-term and long-term health outcomes of colonial medical policies on local populations, including shifts in disease prevalence and changes in life expectancy.

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