The History of Kaimosi Friends Hospital, 1902 - 1996

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NG Journal of Social Development

Vol. 15 Issue 1 (2024)
ISSN(p) 0189-5958
ISSN (e) 2814-1105
Home page
https://www.ajol.info/index.php/ngjsd

ARTICLE INFO:
Keywords
Conflict; East African Yearly Meeting; African Mission; Secular departments; Ethnic rivalry.

Article History
Received: 18th June 2024
Accepted: 4th December 2024

DOI:*https://dx.doi.org/10.4314/ngjsd.v15i1.13*

Abstract

This paper examines the history of Kaimosi Friends Hospital, located in western Kenya. Established in 1903 by the Friends African Mission (FAM), the hospital was a key component of the Friends Church's secular departments that supported the primary objective of converting Africans to Christianity. The main purpose of this study was to provide an overview of the hospital's history. Literature review was undertaken to identify knowledge gaps and collect pertinent written materials for the study. The analysis revealed that the hospital's history can be interpreted through two lenses: success and failure. The hospital experienced steady growth during the colonial era and even established satellite clinics. Following Kenya's independence, the management of the hospital was transferred to East African Yearly Meeting (EAYM) leaders. However, under African leadership, the hospital became a focal point of conflicts and disputes. Ultimately, the hospital ceased operations in 1996.

1. Introduction

In 1902, the Friends African Mission of the United States of America (USA) founded its first mission station at Kaimosi, in western Kenya. As pioneers in this area, the missionaries saw early on that for Christianity to be accepted in the area, there needed to be social and economic transformation (FAM, 1904). Initially, the pioneer missionaries attempted to reduce the impact of the African culture by setting up an industrial mission. As envisaged by the pioneer FAM missionaries, an industrial mission had two aspects: evangelism and culture change. FAM missionaries argued that the religious objective of conversion was to be accompanied by secular efforts to alter the cultural context of the Africans (FAM, 1904). Accordingly, evangelism was the main objective of FAM missionaries in their bid to convert Africans to Christianity. Secular policy was to complement and reinforce evangelization and win converts (FAM, 1904).

FAM missionaries held the belief that for Christianity to flourish in Africa, Africans needed to acquire new cultural attributes in various areas such as medical and nursing care, literacy education, industrial skills, and agricultural methods. They assumed that by becoming cultured in these attributes, Africans would embrace the gospel, as they would have "experienced an improvement in their material conditions" ((FAM, 1904). The acceptance or rejection of the Gospel was therefore seen as dependent on the potential of these new lifestyles to enhance the well-being of potential converts (FAM, 1904). As a result, FAM established four secular departments - medical, literacy education, industrial, and agricultural departments - in order to attract Africans to Christianity. Medical department in general and the Kaimosi Friends Hospital in particular, is the subject of this paper.

Kaimosi Friends Hospital was established by FAM in 1903 to fulfill its medical and nursing care objective. The hospital quickly became the leading institution in the medical department, marking a significant milestone in the provision of Western medical and nursing care in western Kenya as described by the Kenya National Archives document (North Nyanza, 1920). It is important to note that the tradition of Christian witnessing through medical and nursing care was deeply rooted in the missionary work of FAM in Kenya. FAM missionaries served as medical practitioners, despite - in some cases - lacking formal training, as they believed healing was an integral part of spreading the gospel (FAM, 1904). Therefore, FAM missionaries were actively involved in evangelization through medical work.

Kaimosi Friends Hospital had a slow start in its early years, but eventually gained popularity among Africans. By the 1920s, Africans were demanding for more services from the hospital and were even willing to pay for them. As the number of patients increased, the hospital opened satellite clinics at its outstations in Lirhanda, Lugulu, Malava, and Vihiga (FAM, 1924). With the establishment of these satellite clinics, Kaimosi Friends Hospital was upgraded to a referral hospital for the entire western region of Kenya. Major medical cases from both private and public hospitals were referred to Kaimosi Friends Hospital. However, the growing demand for medical and nursing services, coupled with the hospital's inability to meet this demand, resulted in criticism from Africans regarding the inadequate services provided (FAM, 1924). This increasing demand for medical and nursing care indicated that by the late 1950s, Africans had fully embraced Western medical and nursing care.

Following Kenya's independence in 1963, the management of hospitals was transferred to EAYM African leaders. The expectation was that, given their understanding of local medical requirements, the hospitals would flourish under African guidance. However, conflicts became prevalent under African leadership. Consequently, Kaimosi Friends Hospital encountered challenges stemming from perceived disparities in the distribution of benefits, resulting in factional divisions and extensive damage to the hospital's assets (EAYM, 1986). Instead of focusing on its fundamental objective of delivering medical services, the hospital became a focal point for disputes and discord. Ultimately, in 1996, the hospital ceased its operations.

1.1 Objectives of the Study

The main objective of this study was to provide a chronological examination of the establishment, growth, and eventual decline of Kaimosi Friends Hospital. The research focused on several key questions: What were the medical policies of FAM, and how were they implemented? What was the colonial government's perspective on faith-based hospitals? Were there area of agreement or contention between FAM's and colonial medical practices? How did the local community react to Western medical and nursing care? What were the key developments and factors that led to the rise and decline of the hospital? An analysis of existing historical records was conducted to address these questions and to bridge gaps in the literature concerning Kaimosi Friends Hospital.

2. Materials and Methods

This study utilised historical research methodology. Historical research involves systematically gathering and analysing data to achieve an objective understanding of important past events. As such, the study undertook an extensive literature review to identify gaps in available and documented knowledge regarding the history of the Friends Church in Kenya. According to Walliman (2016), literature review involves reading, analysing, assessing and summarising key points of current knowledge on a research topic. Thus, literature review was crucial for selecting relevant published and unpublished documents aligned with the paper's objective, as described by Snyder (2019).

To conduct this study, published materials on the subject were located and reviewed to identify gaps and debates in the literature. To address these gaps, a systematic analysis of unpublished records was undertaken at the Friends Church archives in Kaimosi, specifically focusing on East African Yearly Meeting (EAYM) reports, as well as relevant records at the Kenya National Archives (KNA). Various sources like meeting minutes, reports, correspondence, diaries, letters, and newspapers were thoroughly examined. The data was qualitatively assessed for authenticity and accuracy, ultimately leading to a narrative exposition of the findings.

The study is grounded in diffusion of innovations theory to understand the hospital's operations and interactions between stakeholders, as well as to structure the unknown aspects of the hospital's history. According to E.M. Rogers (2003),

> an innovation is an idea, practice or project perceived as new by an individual or unit adopting it. An innovation may have been created long ago, but if it is seen as new by people, it is still an innovation to them. An innovation's newness relates more to the knowledge, persuasion and decision stages of the innovation-adoption process (Rogers, 2003).

Furthermore, Rogers demonstrates that innovations spread through communication channels over time among members of a social system (Rogers, 2003). For Rogers, innovation can lead to adoption, defined as fully embracing an innovation as the best course of action available (Rogers, 2003). Diffusion of innovations theory illustrates how early Friends missionaries established Kaimosi Friends Hospital to encourage Africans to convert to Christianity. The hospital was a new innovation introduced by the missionaries, through which Africans were exposed to Western medical and nursing practices. Initially, missionaries persuaded Africans to adopt the new medical and nursing services. Over time, Africans not only adopted the innovation but also began demanding more of the services provided by the hospital. With the transfer of hospital's leadership to Africans, conflict over control and associated benefits led to mismanagement of the hospital and the downfall of the innovation (the hospital).

3. Data Analysis and Discussion

The data analysed in this section was sourced mainly from archival records housed at the EAYM headquarters in Kaimosi, the Kenya National Archives and variety of published materials. The analysis highlights the founding and development of Kaimosi Friends Hospital, the transition of the hospital's administration from FAM to EAYM officials, and the cessation of the hospital's operations.

3.1 Establishment of Kaimosi Friends Hospital

In 1902, the pioneer missionaries opted to establish their first mission at Kaimosi. Kaimosi, was selected as their primary location in Kenya for various reasons. The missionaries recognised the potential to harness water power from Goli Goli River for operating sawmills and producing flour. Additionally, the availability of timber for the sawmill and land for agriculture influenced their decision. Furthermore, the missionaries noted the friendly attitude of the people in Kaimosi, who were eager to support the mission through their labour (FAM, 1904). These practical considerations were instrumental in making Kaimosi the central hub of FAM and later the EAYM.

After establishing timber and flour mills, FAM missionaries shifted their focus towards providing medical services. The first FAM dispensary was built at Kaimosi in 1903, even before the arrival of the medical practitioners from the USA. Dr. Elisha Blackburn and his wife came to Kaimosi in 1904 to set up the medical department of the FAM mission. Upon the doctors' arrival, EAYM medical records indicated that the western Kenya region then known as North Kavirondo District had been severely affected by various epidemic diseases. The area was particularly plagued by illnesses like malaria, pneumonia, dysentery, smallpox, yaws, leprosy, elephantiasis, and venereal diseases, among others (FAM, 1904).

Despite the prevalence of preventable diseases in the region, the colonial administration had appointed just one medical practitioner for the entire area. The government's doctor was stationed in Kisumu, the district headquarters. The primary responsibility of the doctor in Kisumu was to provide healthcare for the European colonial officers in the district. He did not treat any African patients. Therefore, until the arrival of missionary physicians, traditional healing methods were the main way to treat most illnesses among the African population in the region (North Nyanza District, 1920). Consequently, with the arrival of Dr. Blackburn and his team, Africans slowly started experiencing Western medicine. However, due to the strong preference for traditional

medicine among Africans, only a small fraction of them sought treatment at the Kaimosi hospital during the initial years (FAM, 1905).

In 1906, the hospital experienced a notable increase in its daily visitors. The number of out-patients rose significantly to ninety per month during that year. A considerable portion of these visitors required surgical procedures, which were effectively carried out at the hospital (FAM, 1907). However, since there were no wards for overnight stays, patients were advised to return home after their operations. In addition to his duties at the hospital, Dr. Blackburn was also required to assist the government doctor in providing medical care to colonial officials and missionaries in the North Kavirondo District (FAM, 1907).

Between 1909 and 1910, Dr. Blackburn opted to take a leave of absence and traveled back to the USA to pursue further studies. During his absence, Arthur Chilson was appointed as the temporary supervisor of the hospital, despite having limited medical training. Surprisingly, even without a qualified medical doctor, the number of hospital visits continued to rise. For example, in 1910, the total number of Africans seeking medical assistance increased to 15,000 (FAM, 1912). With the significant demand for medical services, FAM appealed to the American Friends Board of Foreign Mission (AFBFM) for financial aid in constructing a larger facility and recruiting more doctors to accommodate the growing patient population. AFBFM was the main sponsor of FAM's activities in Kenya (FAM, 1912)

Luckily for the hospital, Dr. Blackburn came back to Kaimosi in 1911, providing the much-needed assistance to the mission hospital. Simultaneously, the AFBFM provided $200 to support building a new hospital facility. As a result, in 1912, plans were started to build a larger hospital. However, the beginning of World War I caused a delay in finishing the hospital until 1918. Further in 1913, the hospital staff received a boost with the arrival of Dr. A.B. Estock, a specialized dentist (FAM, 1919).

3.2 FAM and Colonial Government Partnership in Healthcare

The presence of Estock had a significant impact on both to Kaimosi Friends hospital and the European staff in the region, especially considering the absence of a government dentist. Previously, Europeans had to make the long journey to Nairobi for dental treatment. Dr. Estock's expertise enabled the hospital to effectively address the dental and various medical requirements of African and European patients, serving an average of twenty patients on a daily basis. However, with only two doctors available, the increasing demand for medical services became a source of frustration for Africans (FAM, 1914). Consequently, Africans began advocating for more doctors from the USA to address the shortage of medical doctors. Interestingly, they did not exert the same pressure on the colonial government to improve medical services.

The persistent requests by Africans for medical services prompted AFBFM to recruit an additional doctor in 1917. Dr. A.A. Bond's arrival brought about a slight improvement in the medical department, but the demand still outstripped the available infrastructure and human resources. (FAM, 1918). Shortly after his arrival, the colonial administration sought permission from FAM for Dr. Bond to assist at the military hospital in Kisumu. This request was granted, and Dr. Bond was tasked with supporting the government doctor in treating African soldiers injured during the First World War. A number of Africans had served in the British carrier corps during the war,

enduring harsh conditions like enemy attacks, strenuous labour, food shortages, and diseases while transporting equipment and supplies across war zones (Beck, 1970).

Dr. Bond collaborated with the government medical team in Kisumu to establish a strong partnership between the government and missionary teams in the field of healthcare and medical services. Undoubtedly, the provision of medical care to the carrier corps played a significant role in convincing a larger number of Africans to adopt Western medical services. This acceptance further burdened Kaimosi Friends Hospital, which was already grappling with a shortage of staff (Beck: 1970). During Dr. Bond's absence in Kisumu, Dr. A.B. Estock, the supervisor of satellite clinics, oversaw the operations at Kaimosi Friends Hospital.

After the war, a new outbreak of Spanish flu swept through North Nyanza District. By the end of 1918, the epidemic had caused around 3,500 deaths. Once more, this outbreak and the subsequent fatalities highlighted the colonial administration's negligence regarding the medical and health needs of the African people (Cashmore, 1965). Nevertheless, the colonial government's inaction did not prevent the FAM medical team from working to contain the epidemic. To combat the spread of the illness in the region, FAM's medical department urged its five mission stations to open clinics to care for those afflicted and refer more severe cases to Kaimosi Friends Hospital. FAM also sought a $100 grant from the USA to support their medical efforts (Painter, 1966). The growing reliance on Western medicine to treat epidemics in the area implied a declining reliance on traditional remedies.

3.3 Exponential Growth and the Establishment of a Nursing School

During the 1920s and 1930s, there was a significant rise in the number of out-patients at Kaimosi Friends hospital. In 1921, the construction of an in-patient ward was completed, which resulted in the mission acquiring additional medical equipment. This equipment consisted of surgical instruments, a steam sterilizer, and forty hospital beds. In that same year, Margaret Parker, a nurse from the USA, arrived to assist Dr. Bond at the hospital. It is worth noting that the first in-patient was admitted in 1921 and successfully gave birth (Painter, 1966). This successful delivery helped dispel rumours that patients would lose limbs at the hospital, leading to more surgical operations among Africans in-patients.

In 1925, FAM established its first nursing school at the Kaimosi Friends Hospital. The nursing school's objective was to teach African nurses about hygiene and pediatric care. Upon successful completion of the programme, the graduating nurses were recruited to work as nurses or hospital assistants at Kaimosi Friends Hospital. Some of the newly trained nurses were also posted to man the various FAM satellite clinics. Dr. Bond, stationed at Kaimosi Hospital, regularly visited the clinics to provide guidance to the nurses and handle complex cases requiring his expertise. Patients needing specialised care or surgeries were referred to Kaimosi Friends Hospital (Painter, 1966). Recognising the pioneering status and strategic value of the nursing school as the first of its kind in the district, the North Nyanza Local Native Council (LNC) awarded a grant of Shs. 1,050 to support the school's development (Painter, 1966). The services rendered by the African nurses convinced a greater number of Africans to seek medical assistance at the hospital and its satellite clinics, resulting in a significant increase in the number of African in-patients and out-patients.

Moreover, Kaimosi Friend Hospital pioneered in providing extensive medical care and therapy for epilepsy and leprosy in the early 1930s. Traditionally, these illnesses were thought to stem from ancestral curses placed on misbehaving family members. Consequently, those affected were separated from their families. It was believed that the diseases were highly contagious and incurable. Additionally, FAM built residences near the hospital specifically for individuals impacted by these two conditions. These individuals received free medical treatment from the hospital (FAM, 1928). As a result, the medical professionals linked with the mission disproved various conventional beliefs that contradicted scientific research. This led to more individuals seeking for services from the hospital.

The 1930s saw two contrasting developments. At first, there was a reduction in the financial assistance given to the hospital by AFBFM. AFBFM's financial contributions declined to less than $100 annually during the economic downturn (FAM, 1939). This drop was occasioned by the global economic crisis that started in 1933 in the United States and impacted economies worldwide. Yet, even with decreased funding, the number of patients visiting the hospital continued to rise. As a result, the hospital struggled to accommodate the escalating influx of patients. The hospital was thus forced to implement a fifty cent fee for out-patient services to offset the costs. As a result, in 1936, individuals who could not afford this relatively high fee were turned away, leading to a slight decline in both out-patient and in-patient visits (FAM, 1939). However, there was an increase in the number of people seeking maternity services, which can be attributed to the preference for hospital deliveries in the area.

3.4 The Establishment of EAYM and Demand for Health Centres

In the 1940s and 1950s, there was a substantial growth in the African Christian population in Kenya. This led to the formation of the East Africa Yearly Meeting (EAYM) of the Friends Church. The EAYM assumed the roles and responsibilities previously held by FAM in Kenya. This key development enabled African leaders to take charge of church affairs, while the FAM team continued to provide technical assistance in managing the hospital (Kay, 1973).

In the context of the Friends Church, a Yearly Meeting is an autonomous church organisation within the Friends Church community and its doctrines. The EAYM consisted of Quarterly Meetings (analogous to archdioceses), Monthly Meetings (comparable to dioceses), and Village Meetings (similar to parishes). Therefore, the Yearly Meeting functioned as the highest governing body of the Friends Church in Kenya.

Before the establishment of EAYM, the number of visits to Kaimosi Friends Hospital had significantly increased, often overwhelming the medical staff. During that period, the hospital was among the largest medical institutions in East Africa, boasting a bed capacity of ninety-seven. Notably, students from nearby schools received free medical treatment at the hospital. As a result, between 1942 and 1943, more than 28,000 patients were cared for at the hospital (EAYM, 1946). Furthermore, numerous out-patients sought medical attention at the hospital's satellite clinics.

Despite these challenges, the demand for additional medical facilities in the area persisted. In 1945, for instance, the medical department noted that Monthly Meeting leaders were "inquiring about the timeline for establishing dispensaries in their respective areas and the deployment of doctors from the United States to serve their communities" (EAYM, 1946). This demand suggests that

Africans preferred USA doctors over locally trained or British physicians. Moreover, the report underscores that Africans sought more services from Kaimosi Friends Hospital than from the colonial government's medical facilities (EAYM, 1946). This indicated that the hospital was more responsive to African medical needs than public health institutions.

In an attempt to reduce the large number of patients, Kaimosi Friends Hospital and its satellite clinics made the decision to increase the medical fees for all out-patient visits to one Shilling per visit (EAYM, 1946). The goal was to discourage the high number of patients. As described in the 1943 Kenya National Archives document (Nyanza Province, 1943), despite this fee increase, Africans continued to prefer Kaimosi Friends Hospital over government ones. They believed the mission hospital provided more personalised and attentive care compared to the government facilities.

3.5 Government's Financial Support

The sustained increase in visits to Kaimosi Friends Hospital and its clinics by Africans, and the resulting strain on the medical facilities and training provided by FAM, was a major topic of discussion at the 1945 conference of Christian Missionary Societies in Kenya. At the conference, the colonial administration pledged to support the medical facilities of the Christian missions through a grants-in-aid programme. This support was to be channeled through the Local Native Councils (LNCs). Subsequent to the conference, the North Nyanza LNC provided Shs. 3,000 in 1947 to assist Kaimosi Friends Hospital (EAYM, 1953). However, the financial assistance from the LNC was insufficient to meet the increasing demand for medical services at the hospital. In order to address this gap, EAYM leaders sought help from AFBFM in 1949 to bring in more doctors, train hospital staff, and oversee the satellite clinics (EAYM, 1953).

Regrettably, AFBFM was unable to offer additional financial support for the hospital. As a result, the LNC that had been renamed African District Council (ADC) and the central government became the only sources of funding for the hospital and its satellite clinics (EAYM, 1953). The ADC and the central government pledged to help Kaimosi Friends Hospital by funding a certain number of in-patient beds. As per this pledge, the ADC supported 14 out of 104 total beds, while the central government, through the Christian Council Medical Committee, funded 84 beds. The remaining six beds were financed by donations from EAYM church and fees from patients (EAYM, 1953).

With AFBFM unable to give further assistance to Kaimosi Friends Hospital, and the colonial government unable to sufficiently fill the gap in financial aid, only one doctor - Horst Rothe – remained at Kaimosi to care for the increasing number of patients. This led to conflict between EAYM and FAM. EAYM leaders criticised FAM for inadequate medical care, while the missionaries blamed AFBFM for not sending enough staff and supplies to the hospital. As a result, two contradictory trends emerged in the 1950s. On one hand, Africans' need for medical services was rising. However, the organisations responsible for providing these services - EAYM, FAM, ADC and the central government - could not keep up with the growing demands (EAYM, 1956). Tension thus developed between EAYM and FAM, EAYM and the colonial authorities, and EAYM and its own African members. The gap between demand and supply of medical services continued into the 1960s (EAYM, 1956).

3.6 Independent EAYM

During Kenya's transition from being a British colony to an independent nation, two main themes were prominent in the administration of Kaimosi Friends Hospital. The first theme centred on the deliberate efforts made by EAYM to gain complete control over the hospital. EAYM leaders were determined to have full authority and responsibility in governing the hospital. It is important to note that before Kenya gained independence in 1963, EAYM still depended on FAM for technical and financial support. Therefore, in order to assume full responsibility of the hospital, EAYM requested FAM to equip African medical teams with the necessary skills to effectively manage the hospital and its various clinics. In response, FAM agreed to train Africans and transfer all medical facilities to African leadership (EAYM, 1964).

The independent EAYM's constitution was officially approved on September 21, 1963. In this revised constitution, all administrative duties and assets of the hospital and its 12 satellite clinics were formally handed over to the EAYM trustees on October 1, 1963 (EAYM, 1964). Despite the adoption of the new constitution, EAYM leadership, persisted in seeking financial aid from Friends United Meeting (FUM). AFBM, was renamed as FUM in 1962. FUM, became the primary partner of EAYM Church development initiatives. For example, in 1964, FUM granted a financial assistance of $25,000, with a significant portion earmarked for the hospital (EAYM, 1964).

Following the complete handover of the hospital's administration to EAYM, the institution faced a series of challenges in terms of leadership and finances. Rather than improving the balance between medical care demand and supply, the quality of services at the hospital began to decline under EAYM's management. As a result, Kaimosi Friends Hospital collapsed and ultimately shut down in 1996.

4. Findings

The history of Kaimosi Friends Hospital up until 1963 is fairly well documented in archival sources. However, there is a knowledge gap regarding why the hospital deteriorated and eventually closed down in 1996. Research indicates that after 1963, African leaders who assumed management of EAYM began embracing capitalist values, believing the church's resources like the hospital could be leveraged for personal enrichment. This resulted in conflict among the EAYM leadership, which went against the core tenets of the Friends Church (Quaker): simplicity, peace, integrity, community, equality and stewardship. It is puzzling why EAYM members, trained in these values, turned to infighting and sometimes violence to resolve their differences. The initial conflicts arose from resentment over the pay of church leaders.

For example, EAYM members were envious of Mr. Thomas Lung'aho, who was the first general secretary of EAYM. When he was appointed in 1962, Lung'aho became a FAM official with full missionary status and a salary paid directly from Richmond, USA by FUM (Smuck, 1987). Lung'aho 's salary was set at Ksh. 7,200, the same level as a missionary's pay at that time. This salary was equivalent to what Permanent Secretaries in the government earned at that time. In addition to the high salary, Lung'aho had an official chauffeur-driven car. Other EAYM officials like the recording clerk and treasurer also earned over Ksh. 4,000, which distinguished them from others in their communities (Smuck, 1987:38). Indeed, these officials also used their positions in the church to secure overseas education scholarships for their children and close relatives.

As a result of Africans taking over leadership of EAYM in 1964, the church's concept of service was increasingly defined by how such leadership benefited an individual. Consequently, the desire to control EAYM's assets for personal benefits led to conflict among EAYM leaders. However, this urge for self-enrichment was disguised as benefits for the community. Tension and conflict subsequently emerged between the various ethnic groups within EAYM's membership, as each group's leaders increasingly accused the others of benefiting more from the church. The church elite began claiming there was unequal distribution of EAYM's resources, stating that some areas and ethnic communities were getting more resources than others (EAYM, 1986).

Initially, the inter – community disputes centred around the alleged unequal distribution of benefits between the southern and northern groups within the Friends Church. Eventually, these conflicts expanded to include differences between ethnic groups within the church. Since there 1920s, the Maragoli in western Kenya's south and the Bukusu in the north dominated membership of the Friends Church in Kenya. Over time, the Bukusu began to claim that their financial contributions to FAM and later EAYM were disproportionately benefiting the Maragoli, neglecting the needs of the Bukusu community (Smuck, 1987). As a result, the Bukusu demanded that their financial support be directed towards the development of their own region, leading to tensions within the church and eventually erupting into full-fledged conflict.

The perceived unequal allotment of church resources led to calls for the formation of new Yearly Meetings in Kenya. Following the independence of EAYM in 1963, the Elgon Religious Society of Friends (ERSF) Quarterly Meeting which mainly represented the Bukusu community, began to advocate for their own independent Yearly Meeting to address their specific needs (EAYM, 1983). Consequently, on 1st January 1973, the leaders of ERSF Quarterly Meeting organised a prayer meeting where it was agreed upon that ERSF would be established as the second Yearly Meeting in Kenya. Subsequently, on the 19th of April 1973, the leaders of ERSF applied for a certificate of registration from the government of Kenya (Republic of Kenya, 1986). The government promptly registered ERSF, granting it the status of an independent Yearly Meeting in Kenya. However, despite the government's recognition, the leadership of EAYM rejected this decision (Republic of Kenya, 1986).

After extensive consultations involving EAYM, ERSF, political leaders and government representatives, it was determined that a second Yearly Meeting in Kenya would be officially acknowledged as a separate entity. EAYM was obliged to recognize ERSF as an independent Yearly Meeting (Republic of Kenya, 1986). Subsequently, ERSF leaders initiated discussions for the division of all Friends Church properties in Kenya between the two Yearly Meetings. Notably, ERSF leaders raised concerns about the allocation of financial and equipment support to Kaimosi Friends Hospital and its satellite clinics from FUM and the government of Kenya.

ERSF leaders claimed that Kaimosi Friends Hospital was monopolising financial and equipment assistance from the government of Kenya, hurting Lugulu Health Centre. They provided examples such as when President Jomo Kenyatta visited Kaimosi Friends Hospital in 1965 and donated Ksh. 21,000 as a government contribution to the hospital's development. Additionally, in 1981 the government granted the hospital Ksh. 546,292 for development. The hospital also received Ksh. 105,000 from FUM (Kimball & Kimball, 2002). Furthermore, ERSF leaders argued that most employees at Kaimosi Friends Hospital were recruited from the Maragoli community. This meant

that Friends converts from the southern region, particularly the Maragoli, benefited more from the hospital, putting ERSF members at a disadvantage (Smuck, 1987). Given this situation, the ERSF leaders demanded that all funds received be equally shared between Kaimosi Friends Hospital and Lugulu Health Centre. Further, ERSF leaders demanded that Kaimosi Friends Hospital distribute employment opportunities evenly between the Bukusu and Maragoli communities (Smuck, 1987).

EAYM church leaders rejected ERSF leaders' demands. This rejection increased tensions between the southern and northern Friends Church members. In response, the leaders of ERSF intensified their efforts to transform Lugulu Health Centre into a fully-fledged hospital, similar to Kaimosi Friends Hospital. Consequently, they submitted an application for Lugulu Health Centre to be officially recognised as a hospital. As a result of Lugulu Hospital's registration, FUM decided to cease financial support to all medical institutions affiliated with Friends Church in Kenya. This decision had a negative impact on the operations of Kaimosi Friends Hospital (Smuck, 1987).

Lacking financial support from USA, ERSF leaders initiated a campaign to transfer fifty percent of Kaimosi Friends Hospital's property to Lugulu hospital. This request from the leaders of Lugulu hospital led to a division among the staff members at Kaimosi Friends Hospital, with their loyalties being influenced by their ethnic backgrounds. One group favoured the division of the hospital property, while the other group opposed it. As a consequence of these divisions, Kaimosi Friends Hospital suffered from a lack of accountability, ultimately leading to a decline in the provision of services (Smuck, 1987).

The registration of ERSF did not resolve the divisions within the Friends Church in Kenya. Instead, new divisions emerged within EAYM and ERSF. Conflict arose among the different ethnic groups that comprised the membership of EAYM and ERSF. For instance, the Maragoli under Vihiga Quarterly Meeting of EAYM began advocating for their own Yearly Meeting. With the backing of their political leaders, the Maragoli Friends registered EAYM - South as a third Yearly Meeting in Kenya in 1984 (Republic of Kenya, 1986). This registration further exacerbated the challenges faced by Kaimosi Friends Hospital.

Initially, the leaders of EAYM - South claimed that Kaimosi Friends Hospital should be under their jurisdiction instead of EAYM. They argued that as the majority within the Friends Church, they should have control, rather than the Tiriki, whose territory the hospital was located in. However, the Tiriki opposed the demands of EAYM - South leaders. As a result, violence erupted at the hospital, leading to the expulsion of the majority of Maragoli staff members from the premises. This violence caused significant damage to the hospital's property and had a negative impact on its operations (Republic of Kenya, 1986).

As a result of the violent incidents at the Kaimosi Friends Hospital. leaders of EAYM - South officially designated Sabatia Health Centre as a fully functional hospital (EAYM, 1994). Subsequently, a substantial amount of government funding originally allocated for Kaimosi Friends Hospital was reallocated to Sabatia Hospital due to political influence It is thus evident that during the 1970s and early 1980s, there was a significant power struggle among the Bukusu, Maragoli, and Tiriki communities for control of Kaimosi Friends Hospital. The end result of this power struggle was competition over funding between Sabatia, Lugulu and Kaimosi Friends

Hospital. Consequently, the lack of adequate funding led to a decline in the quality of services provided by Kaimosi Friends Hospital (Republic of Kenya, 1986).

In the late 1980s and early 1990s, further divisions occurred within the three Yearly Meetings already established in Kenya. During this period, the number of registered Yearly Meetings in the country grew to thirteen (EAYM, 1994). Unfortunately for the Kaimosi Friends Hospital, which was already struggling from insufficient resources, each of the thirteen newly registered Yearly Meetings claimed ownership of some of its assets. As a result, by 1987, Kaimosi Friends Hospital became prone to violence, theft, and mismanagement, reducing the hospital's ability to provide adequate medical services.

The situation forced the government to appoint a Commission to administer the hospital. However, by 1994, the hospital had deteriorated further and the Commission was dissolved with control returned to the East Africa Yearly Meeting (Kaimosi). Under the new agreement, the hospital retained some government-assigned staff, while EAYM appointed a board of governors. At that time, the physical infrastructure at Kaimosi Friends Hospital had degraded so severely that the "site did not look like a hospital at all" (EAYM, 1994). Consequently, the government ordered the hospital and the Nursing School be closed in 1996 (EAYM, 1997). This closure marked the end of the hospital's illustrious history spanning over ninety years.

5. Contribution of the Study to Knowledge

This paper has made two main contributions to existing knowledge. First, it addressed a gap in the literature through a systematic review, which revealed no previous comprehensive studies on the history of Kaimosi Friends Hospital. While some works mentioned the hospital in relation to other secular institutions within the Friends Church, this is the first attempt to examine the hospital's history. In particular, this is the first study to investigate the factors that led to the hospital's decline and closure - an overlooked aspect in prior research. By exploring this previously neglected area, this paper helps fill a gap in current knowledge. Second, this study contributes to the body of knowledge on Christian faith-based medical institutions in Kenya. Examining the hospital's history allows for comparison with other faith-based organisations in the country.

The study also identified two avenues for further inquiry. One is investigating how services offered by faith-based medical institutions in Kenya have changed over time. This research found Africans preferred faith-based hospitals during colonial rule, raising questions about why public hospitals are now favoured in post-colonial Kenya. The second knowledge gap is the lack of written materials on the histories of Lugulu and Sabatia hospitals, and various clinics that were managed by Kaimosi Friends Hospital. Further research could examine how these medical facilities have fared since Kaimosi Friends Hospital's closure.

In summary, this paper makes two key contributions - filling a gap in the literature by providing the first comprehensive history of the hospital, and adding to knowledge on Kenyan faith-based medical institutions. It also identifies opportunities for additional research into the evolving role of faith-based healthcare and the histories of associated hospitals and clinics.

6. Conclusion

This research aimed to examine the history of Kaimosi Friends Hospital in western Kenya. Established by FAM missionaries in 1903, the hospital functioned as a secular department within the mission organisation. Its primary objective was to introduce Western medicine to Africans and encourage their conversion to Christianity. Despite a slow beginning, the hospital gained wide acceptance among Africans, leading to increased demand for its services by the 1920s.

The study also revealed that before the 1920s, the colonial government showed no concern for the medical and health needs of Africans. As a result, it was the doctors at Kaimosi Friends Hospital who addressed the medical and health requirements of both Africans and colonial officials in western Kenya. This resulted in a partnership between the hospital's medical team and the colonial administration in providing medical and health services in Kenya, as they served both African and European populations. Over time, the hospital gradually expanded its medical services to meet the growing demand in western Kenya.

After Kenya gained independence, the management of Kaimosi Friends Hospital was transferred to EAYM African leaders. Under their leadership, the hospital became embroiled in conflicts and disputes between various ethnic groups in western Kenya. These ethnic groups, through their leaders, demanded a share of the hospital's resources. Leaders from different ethnic groups raised concerns about alleged unequal distribution of hospital assets, claiming their areas and/or ethnic groups were receiving fewer benefits compared to others. As a result, backed by politicians, church leaders pushed for the establishment of separate Yearly Meetings for each ethnic group to address their medical care needs. Throughout the 1980s and 1990s, politicians supported church leaders in their efforts to form Yearly Meetings based on ethnic identity. Consequently, many Yearly Meetings emerged, each driven by self-interest. With every new Yearly Meeting came demands for a share of Kaimosi Friends Hospital's property, resulting in vandalism of the hospital assets and financial mismanagement. Ultimately, this led the hospital to shut down in 1996.

6.1 Recommendations

The paper concludes that Kaimosi Friends Hospital's history can be viewed through two lenses: success and failure. Based on this conclusion, the paper makes the following recommendations. First, the leadership of the Friends Church in Kenya must resolve their differences to promote unity within the church. To do this, the study calls for an overarching governing body to oversee and unite the Friends in Kenya. Once united, the church should focus its energy on revival and effective management of the church's assets including hospitals and clinics. Thus, the study recommends further research on how the hospital can be revitalised to regain its former status. Once revived, church leaders should allow professionals to manage the hospital without undue interference. The church should also develop policy frameworks to enable effective hospital administration

Secondly, the Friends church is known for peacemaking. Peacemaking should start internally within the Yearly Meetings leadership. Church leaders need to be selfless by letting go of personal desires for wealth through the church. They should embrace servant leadership by spearheading the elimination of corruption and promotion of transparency and accountability in the management of church property. Thirdly, the study recommends that the Friends Church in Kenya improves its record-keeping practices at the EAYM archives in Kaimosi. Records should be preserved more professionally in the archives for future use.

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