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**CHURCH AND MEDICINE:
THE ROLE OF MEDICAL MISSIONARIES
IN MALAWI
1875-1914**

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ABSTRACT

This is the first systematic account of early mission medical activities in the Malawi Region (comprising present day Malawi, north eastern Zambia and the eastern shore of Lake Malawi). It compares the policies and practices of three missions – Livingstonia, Blantyre and the UMCA – between 1875 and 1914, from pioneering medical provision through to the establishment of hospitals and participation in large-scale public health campaigns.

The study acknowledges Megan Vaughan's important analysis of the discourse of missionary medicineⁱ, but suggests the need to reflect the different religious and professional influences informing the practice of individual mission doctors. The study further suggests that the organisation and professionalising of medicine within the three missions, from 1900, was dependent upon the activities of those doctors who prioritised their professional rather than their evangelising roles.

The study also considers the important contribution of missionary nursing personnel and African medical assistants in delivering both hospital and out-patient services, and identifies the professional, gender and racial factors which influenced their status and roles.

The study also considers, as far as sources allow, the African patient's experience of missionary medical services. In particular, it identifies the key role of referring agents, such as African medical assistants and European employers, in directing African patients to mission medical services. It suggests that, in contrast to the

ⁱ M. Vaughan, *Curing Their Ills*, (Cambridge, 1991)

conflict in belief systems presented by the mission medical discourse, Western medicine was incorporated alongside indigenous treatments within a plurality of healing systems.

Finally, the study assesses the impact of missionary medical provision within the Malawi region up to 1914. It demonstrates that, during the period of this study, the Blantyre, UMCA and Livingstonia missions remained the principal sources of both curative and palliative Western medicine for the African sick, contributing towards the wider development of the missions and the European settler economy.

DECLARATION

This is to certify that, except where specific reference is made, the work described in this thesis is that of the candidate. Neither the thesis, nor any part of it, has been presented, or is currently submitted, in candidature for any degree at any other university.

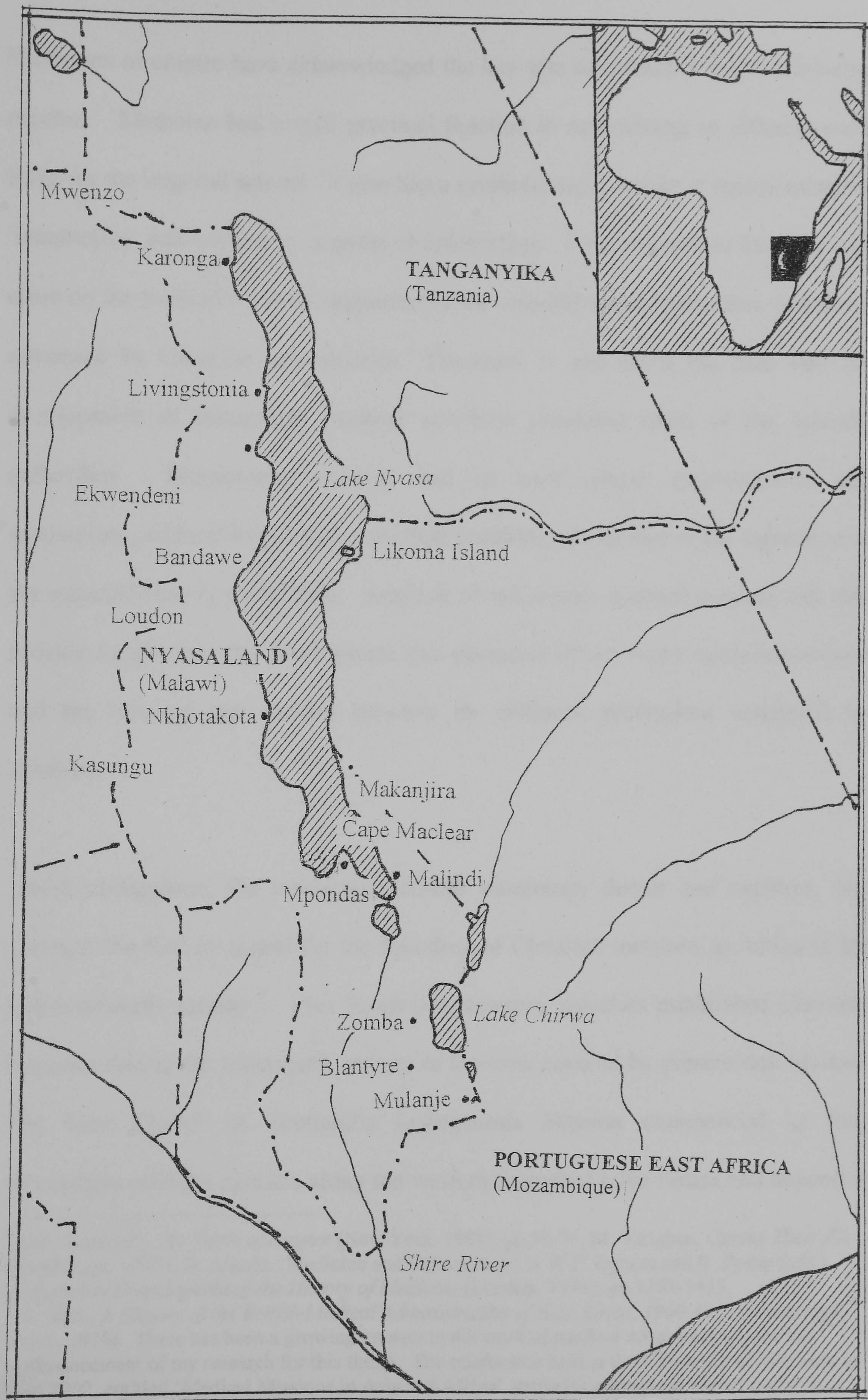
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This work is dedicated to the memory of James Patrick Green.

ABBREVIATIONS

A.L.C.	African Lakes Company
B.C.A.	British Central Africa
B.S.A.C.	British South African Company
C.A.T.	Central African Times
E.U.L.	Edinburgh University Library
F.C.S.M.R.	Free Church of Scotland Monthly Record
F.M.C.	Foreign Mission Committee
J.A.H.	Journal of African History
J.S.A.S.	Journal of Southern African Studies
L.M.S.	London Missionary Society
M.N.A.	National Archives of Malawi
N.L.S.	National Library of Scotland
R.H.L.	Rhodes House Library, Oxford
U.M.C.A.	Universities' Mission to Central Africa



INTRODUCTION

Historians of empire have acknowledged the key role of medicine in the colonising process.¹ Medicine had a vital practical function in maintaining an efficient work force for the imperial project. It also had a symbolic significance in representing the ‘benevolent’ and ‘civilising’ aspects of colonialism. Previous studies have focused more on the medical services supported by the colonial authorities rather than those advanced by Christian missionaries.² However, it was often the case that the development of missionary medical activities pre-dated those of the colonial authorities. Missionary medicine had its own unique characteristics and motivations, distinct from secular medical facilities, yet its role in the expansion of the imperial state is undeniable. Analysis of missionary medical services can also provide insight into the development and operation of the wider mission activities and the tensions that existed between the different professions employed by missions.

David Livingstone, the renowned Scottish missionary doctor and explorer, was amongst the first to appeal for the founding of Christian missions in Africa in the mid-nineteenth century.³ Two Scottish missionary societies established Christian missions during the nineteenth century in the area covered by present day Malawi. The Free Church of Scotland’s Livingstonia Mission commenced its long association with the districts along the western littoral of Lake Nyasa and beyond in

¹ D.R. Headrick, *The Tools of Empire* (New York, 1981), pp.58-79; M. Vaughan, *Curing Their Ills* (Cambridge, 1991); D. Arnold, ‘Medicine and Colonialism’ in W.F. Bynum and R. Porter (eds.), *Companion Encyclopedia of the History of Medicine* (London, 1993), pp.1393-1415.

² A. Beck, *A History of the British Medical Administration of East Africa, 1900-1950* (Cambridge, Mass., 1970). There has been a growing interest in the work of medical missionaries since the commencement of my research for this thesis. The conference held at the University of Warwick in May 2002, entitled ‘Medical Missions in Asia and Africa’, provides example of recent research in this field.

³ O. Chadwick, *Mackenzie’s Grave* (London, 1959), pp.9-26

1875. The Established Church of Scotland's Blantyre Mission was founded in the Shire Highlands the following year. Although the impact upon traditional society of the educational and social policies advocated by these missions has been reviewed in detail by John McCracken and Andrew Ross respectively, the influence of the medical work promoted by these missions has been largely neglected, as McCracken noted in a brief survey published in 1973.⁴ A number of biographies and personal memoirs of mission staff also exist, but while these touch on the missions' medical work, they do not provide detailed or critical analysis.⁵

The Anglo-Catholic mission, known as the Universities Mission to Central Africa (UMCA) was established on Likoma Island on Lake Nyasa and in the regions around the lake from 1885. The UMCA published a number of predominantly narrative descriptions of its work, including its medical activities.⁶ More recently, Ranger's accounts of the UMCA's medical policies provide a new, pathbreaking approach to the study of medicine and mission. However, his observations are

⁴ J. McCracken, *Politics and Christianity in Malawi 1875-1940* (Blantyre, 2000); A. Ross, *Blantyre Mission and the Making of Modern Malawi* (Blantyre, 1996); J. McCracken, 'Scottish Medical Missionaries in Central Africa', *Scottish Society of the History of Medicine*, 17, 2 (1973), pp.188-91. For work in progress see M. Hokkanen, 'Doctors of Body, Soul and Society. Scottish Medical Missionaries of the Livingstonia Mission in Nyasaland, 1875-1914' (2000); A. Rennick, 'Mission Nurses in Nyasaland, 1890-1916', in J. McCracken, T. Lovering and F. Chalamanda (eds.), *Twentieth Century Malawi: Perspectives on History and Culture* (Stirling, 2001). For detailed accounts of the UMCA Mission to the Shire Highlands in the 1860's and of the White Fathers Mission to the Upper Shire Valley see, L. White, *Magomero. Portrait of an African Village* (Cambridge, 1987); I. Linden, *Catholics, Peasants and Chewa Resistance in Nyasaland, 1889-1939* (London, 1974).

⁵ See, for example, W. Robertson, *The Martyrs of Blantyre* (London, 1892); W.H. Rankine, *A Hero of the Dark Continent* (Edinburgh, 1896); D. MacDonald, *Africana: Or the Heart of Heathen Africa. Native Customs and Beliefs*, Vol.1 and 2 (London, 1969); W.P. Livingstone, *A Prince of Missionaries. Alexander Hetherwick* (London, 1931); R. Laws, *Reminiscences of Livingstonia* (London, 1934); W.P. Livingstone, *Laws of Livingstonia* (London, 1921); A.R. Fraser, *Donald Fraser of Livingstonia* (London, 1934); W. Scott, 'Central African Experiences', *The Society of Malawi Journal*, 38, 2, 1985; A.R. Fraser, 'A Missionary's Wife Among African Women', *International Review of Missions*, 111, 1914; J.W. Jack, *Daybreak in Livingstonia* (Edinburgh, 1901); H. McIntosh, *Robert Laws. Servant of Africa* (Galashiels, 1993)

⁶ See, for example, A.E.M. Anderson-Morhead, *The History of the Universities' Mission to Central Africa* (London, 1955); A.G. Blood, *The History of the Universities' Mission to Central Africa*, Vol.2 (London, 1957); G.H. Wilson, *A History of the Universities' Mission to Central Africa* (London, 1936); D. Yarnton Mills, *What We Do In Nyasaland* (London, 1911).

based entirely on material relating to the mission at Masasi in southeastern Tanzania rather than in Malawi. Vaughan, by contrast, does make use of some Malawi material in developing her important and influential thesis but without attempting any systematic account of the UMCA's activities.⁷

This study, therefore, attempts to address the need for detailed analysis of the role of medical missionaries in the Malawi region in the late nineteenth and early twentieth centuries. By focusing on three separate missions within Nyasaland, it is possible to analyse and compare the impact which varying forces, including the agency of the African patient, creed, mission management, professional influences and wider socio/political factors within the Protectorate, exerted upon the practice of missionary medicine. The time frame of the study, 1875-1914, is inclusive of the pioneering phase of the missions through to when the wartime emergency seriously curtailed, and in some instances permanently altered, the activities of the three missions under review.

Historiography

In the late 1950's and early 1960's, historians of empire described the penetration of western medicine into Africa in terms of a positive progression. The scientific knowledge that underpinned medical theory was considered a benevolent, yet

⁷ T. Ranger, 'Godly Medicine: The Ambiguities of Medical Mission in Southeastern Tanzania, 1900-1945', in S. Feierman and J.M. Janzen (eds.), *The Social Basis of Health and Healing in Africa* (Oxford, 1992), pp.256-282; T. Ranger, 'Medical Science and Pentecost: The Dilemma of Anglicanism in Africa', in W.J. Sheils (ed.), *The Church and Healing* (Oxford, 1982), pp.333-365; T. Ranger, 'Missionary Adaptation of African Religious Institutions. The Masasi Case', in T. Ranger and I.N. Kimambo (eds.), *The Historical Study of African Religion* (London, 1972) pp.221-251; Vaughan, *Curing Their Ills*, pp.55-76

politically neutral force, whilst the benefits bestowed upon Africa by western medicine were deemed indisputable.⁸

Historians of empire argued that scientific medicine's contribution towards the elimination of epidemic diseases within tropical regions was significant. For example, the vaccination programme launched against smallpox resulted in the eradication of the disease by 1980, whilst a vaccine for the prevention of yellow fever had been devised by 1937.⁹ Furthermore, the use of quinine in the treatment and prevention of malaria was celebrated within imperial medical discourse as the essential means through which the white man triumphed over the most significant natural barrier to the penetration of western influence into the 'dark continent'.¹⁰ By the initiation of decolonisation in Central Africa in the 1960's, effective therapies were available for many conditions including yaws, while the aetiology of such diseases as sleeping sickness and bilharzia, which had once mystified, were understood. Even critics of empire acknowledged western medicine as one positive legacy of imperialism.¹¹

Corresponding with the continuing process of decolonisation, theories of imperial medicine increasingly positioned the history of disease and the practice of western

⁸The classic study in this genre with reference to Malawi is M. Gelfand, *Lakeside Pioneers. Socio-medical Study of Nyasaland, 1875-1920* (Oxford, 1964); R. Macleod, 'Introduction', in R. Macleod and M. Lewis (eds.), *Disease, Medicine and Empire. Perspectives On Western Medicine and the Experience of European Expansion* (London, 1988), pp.1-8; Arnold in Bynum and Porter (eds.), *Companion Encyclopedia of the History of Medicine*, pp.1393-1395.

⁹ M. Worboys, 'Tropical Diseases', in Bynum and Porter (eds.), *Companion Encyclopedia of the History of Medicine*, pp.526-527.

¹⁰ P.D. Curtin, "'The White Man's Grave': Image and Reality, 1780-1850", *Journal of British Studies*, 1, 1961, pp. 94-110; Headrick, *The Tools of Empire*, pp.58-79. Arnold, however, suggests that Headrick exaggerates the effectiveness of quinine as a prophylaxis against malaria. See, D. Arnold, 'Introduction: Disease, Medicine and Empire', in D. Arnold (ed.), *Imperial Medicine and Indigenous Societies* (Manchester, 1988), pp.10-11.

¹¹ Arnold in Bynum and Porter (eds.), *Companion Encyclopedia of the History of Medicine*, pp.1393-1395.

medicine within their political and social context. Curtin's analysis of the use of quinine in the prevention of malaria provides an example of this trend. Curtin traces the relationship between the representation of West Africa as the 'white man's grave' and the development by the mid-nineteenth century of what he terms 'psuedo-scientific racism'.¹² He suggests that the optimism generated throughout the west by the successful use of quinine as a prophylaxis against malaria contributed to increased European intervention in West Africa in the 1850's and 1860's, and thus reinforced the contemporary view that the practical application of 'rationalism' and 'civilisation' could surmount the most formidable natural impediments.¹³

By the 1970's, western medicine was represented less as a benevolent good and more as a tool of colonial authority and domination.¹⁴ This reflected a prevailing disenchantment with the process of decolonisation and the continued economic dependence of many former colonies on the West.¹⁵ Hospitals, dispensaries and the clinical practice of European doctors and nurses were therefore marked as devices of social control. By the 1980's, the once perceived neutrality of western medicine and medical science had been challenged. Analysis of the history of colonial medicine emphasised the social and political influences on the perception and transmission of infectious disease.¹⁶ Studies that had been written from a

¹² Curtin, "The White Man's Grave", p.104.

¹³ Curtin, "The White Man's Grave", p.110.

¹⁴ Headrick, *The Tools of Empire*, pp.58-79.

¹⁵ Macleod in Macleod and Lewis (eds.), *Disease, Medicine and Empire*, pp.4-5.

¹⁶ P. Wright and A. Treacher (eds.), *The Problem of Medical Knowledge: Examining the Social Construction of Medicine* (Edinburgh, 1982); M. Vaughan, 'Syphilis in Colonial East and Central Africa: The Social Construction of an Epidemic', in T. Ranger and P. Slack (eds.), *Epidemics and Ideas* (Cambridge, 1992), pp.269-302; M. Lyons, *The Colonial Disease. A Social History of Sleeping Sickness in Northern Zaire, 1900-1940* (Cambridge, 1992); P.D. Curtin, 'Medical Knowledge and Urban Planning in Colonial Tropical Africa', in Feierman and Janzen (eds.), *The Social Basis of Health and Healing*, pp.235-255. M. Swanson suggests that sanitation and public

materialist perspective of disease causation therefore developed a political economy of sickness in Africa.¹⁷ It was also appreciated that maladies that had once been labelled as 'tropical' were, in many cases, a consequence of poverty.¹⁸

More recently, interpretations of the dominance of western medicine in Africa have been modified. It is now acknowledged that the numbers of indigenous peoples who experienced western medicine within the hospital or dispensary were a fraction of the total population of any one country. It is also accepted that biomedicine did not eliminate traditional systems of healing. Recent literature on the history of imperial medicine therefore cites the practice of western medicine within a more general African plurality of healing systems.¹⁹

Development of Western Medicine in Africa

There are established studies of the development of Western medical provision in Africa. Between the seventeenth and early nineteenth century medical thought centred upon humoral theory. This supposition emphasised the importance of maintaining equilibrium between the intake of the key elements of water, air and

health measures instigated in Cape Town and Port Elizabeth at the turn of the century in response to the bubonic plague epidemic provided the rationale for the establishment of permanent urban segregation: M. Swanson, 'The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900-09', *Journal of African History*, 18, 3, 1979.

¹⁷ R. Packard, *White Plague, Black Labour: Tuberculosis and the Political Economy of Health and Disease in South Africa* (London, 1989); R. Packard, 'The Invention of the "Tropical Worker". Medical Research and the Quest for Central African Labor on the South African Gold Mines 1903-36', *Journal of African History*, 34, 1993; R. Packard, 'Tuberculosis and the Development of Industrial Health Policies on the Witwatersrand, 1902-32', *Journal of Southern African Studies*, 13, 2, 1987.

¹⁸ Macleod in Macleod and Lewis (eds.), *Disease, Medicine and Empire*, pp.4-6; Worboys in Bynum and Porter, *Companion Encyclopedia of the History of Medicine*, pp.512-513.

¹⁹ J.M. Janzen, *The Quest for Therapy in Lower Zaire* (London, 1978); G. Prins, 'But What Was The Disease? The Present State of Health And Healing in African Studies', *Past and Present*, 124, 1989, pp.159-79; Ranger, in Sheils (ed.), *The Church and Healing*, pp.333-365.

food and the balanced output of respiration, perspiration and excretion.²⁰ Illness resulted from an imbalance of these natural elements within the body. Some diseases were perceived as infectious with the ability to spread between human hosts. This was known as contagion. Treatment of disease focused on the re-establishment of the body's natural equilibrium through measures such as bleeding and purging.²¹

Environmental factors, including climate, were thought to influence the body's liquid balance. It was believed that the soil in certain areas emitted dangerous miasmas that the body absorbed. More generally, it was considered that disease was precipitated by filth and stench.²² Miasmatic theories of disease causation generated avoidance strategies. For example, Arnold and Curtin describe the relocation of European troops and officials to temporary barracks in the hills of colonial India in an attempt to avoid contact with dangerous infectious miasmas, which were thought to emanate from nearby Indian villages.²³ The importance of ventilation in preventing the build up of contagions in the air from infected people was particularly emphasised.

Climatic extremes were blamed for the high death rate amongst European personnel in tropical areas. Medical and botanical studies, such as those undertaken by Livingstone's expedition to the Zambezi, sought to assess the relative suitability of tropical environments for healthy European habitation. Livingstone, therefore, promoted the favourable conditions of the Shire Highlands of present day Malawi

²⁰ R. Porter, *Disease, Medicine and Society in England. 1550-1850* (London, 1987), pp.25-26.

²¹ M. Gelfand, *Livingstone. The Doctor* (Oxford, 1957), pp.1-4.

²² P. Slack, 'Introduction' in Ranger and Slack (eds.), *Epidemics and Ideas*, pp.3-5.

²³ Arnold in Bynum and Porter (eds.), *Companion Encyclopedia of the History of Medicine*, pp.1398-1399; Curtin, in Feierman and Janzen (eds.), *The Social Basis of Health and Healing*, pp.235-236.

over the marsh miasma of the valley below as a site for the first mission to Central Africa.²⁴

Environmental theories of disease causation remained prevalent in colonial medicine up until the turn of the century. Vaughan quotes the medical research undertaken by Dr. Stannus of the Nyasaland Colonial Medical Division as an example of the late nineteenth century's preoccupation with the classification of nature and indigenous people.²⁵ Vaughan suggests that although such research was influenced by the social Darwinian theories promoted by the educated classes, which advanced the concepts of social degeneration and regeneration, racial differences were presumed to result from environmental conditions rather than from inherent biological or social traits.²⁶

The emergence of biomedicine in the late eighteenth and early nineteenth century had, however, advanced medical theories of disease emanating from within as opposed to outwith the body. In keeping with discoveries made during post mortem examinations, scientific medicine increasingly associated the signs and symptoms of disease with pathology. The practice of biomedicine therefore centred upon the physical examination of the body of the patient within the hospital setting.²⁷

The endorsement of germ theory by the medical profession, in the second half of the nineteenth century, further focused the medical gaze upon the body of the patient.

²⁴ D. and C. Livingstone, *Narrative of an Expedition to the Zambesi and its Tributaries* (London, 1865), pp.348-64.

²⁵ Vaughan, *Curing Their Ills*, pp.29-33.

²⁶ Vaughan, *Curing Their Ills*, pp.33-36.

²⁷ A. Hardy, *Health and Medicine in Britain Since 1860. Social History in Perspective* (Basingstoke, 2001), p.4.; M. Foucault, *The Birth of the Clinic* (London, 1976).

The discoveries of Pasteur and Koch demonstrated the role of specific bacteria, which precipitated disease on penetrating the body's natural systems of defence.²⁸ Infection was transmitted from direct person-to-person contact or via a specific disease-carrying vector. Germ theory, therefore, focused narrowly on the epidemiology and aetiology of individual diseases as opposed to their social, political and environmental causatory factors.

Germ theory underpinned the new discipline of tropical medicine, from the late nineteenth century, which focused principally on vector-borne parasitic infections. Successes in the new discipline included Patrick Manson's discovery in 1883 of the role of both the filarial worm and the mosquito in the transmission of elephantiasis. Ronald Ross identified the mosquito as the disease-carrying vector in the transmission of malaria in 1898.²⁹ The London and Liverpool Schools of Tropical Medicine, which offered postgraduate diplomas in the speciality, were both founded in 1899.³⁰

Ecological Crisis in East and Central Africa

The development of tropical medicine in the late nineteenth century coincided with a series of natural disasters, including droughts and plagues of locusts, which devastated the regions of East and Central Africa. In addition, as Kjekshus has noted, warfare and violence associated with the establishment of colonial rule and

²⁸ Arnold, in Arnold (ed.), *Imperial Medicine*, pp.10-17.

²⁹ M. Worboys, 'Manson, Ross and Colonial Medical Policy: Tropical Medicine in London and Liverpool, 1899-1914', in Macleod and Lewis (eds.), *Disease, Medicine and Empire*, pp.21, 23; Worboys, in Bynum and Porter (eds.), *Companion Encyclopedia of the History of Medicine*.

³⁰ Worboys in Macleod and Lewis (eds.), *Disease, Medicine and Empire*, pp.21-37.

the opening up of the African continent to international trade, invariably spread infectious diseases at an unprecedented rate.³¹

Pathogens, which were new to Africa were introduced at this time. For example the Italian campaign in Ethiopia has been blamed for inadvertently introducing rinderpest to Africa via infected Asian cattle that had been imported for the purpose of feeding the Italian forces. Spreading rapidly, the disease decimated cattle herds and populations of wild game before reaching the Cape Colony in 1897.³² Rinderpest particularly affected pastoral societies, such as the Maasai, but also left mixed farming communities vulnerable to crop failure. In addition to this, it is also claimed that sand fleas, which caused painful ulcers on the sufferer's hands and feet, were introduced to Africa from Brazil in the late nineteenth century.³³

Kjekshus and Vail further suggest that the development of systems of labour migrancy, which corresponded with the expansion of the settler economy and the implementation by colonial authorities of systems of taxation, had a negative impact on African health. Malnutrition in rural areas, so they argue, was in part a consequence of the loss of essential male labour to the new commercial economy, since plantation work deprived rural societies of male labour during the planting season.³⁴

³¹ H. Kjekshus, *Ecology, Control and Economic Development in East African History* (London, 1977), pp.143-151.

³² Kjekshus, *Ecology, Control and Economic Development* pp.126-132.

³³ Kjekshus, *Ecology, Control and Economic Development* pp.134-136.

³⁴ L. Vail, 'Ecology and History: The Example of Eastern Zambia', *Journal of Southern African Studies*, 3, 2, 1977, pp.129-135.

This trend also resulted in a reduction in the total acreage under cultivation in labour-exporting regions. This further compounded the ecological effect of altered farming and settlement patterns of the mid-nineteenth century where, in response to the slave trade and warfare, previously dispersed societies had concentrated for protection in large, fortified villages.³⁵ The wild bush re-claimed previously cultivated areas and pastures left empty in the wake of the rinderpest epidemic and soon harboured large populations of wild game, whose numbers recovered more quickly than cattle. The bush also supported tsetse fly, the vector which transmitted the trypanosomes parasite from animals to man. Once infected with the parasite, individuals could develop sleeping sickness, a disease which was often fatal. Sleeping sickness spread across the African continent in epidemic form from 1900 and was one of the conditions for which colonial authorities looked to the new medical discipline of tropical medicine for speedy and economic solutions.³⁶

Contagion in The Colonial Environment

By the late nineteenth century, tropical medicine had gained authority over the discipline of public health and environmental theories of disease causation. Epidemic diseases were treated by colonial authorities through various narrowly focused curative campaigns that were directed at eradicating disease-generating pathogens whilst preventive measures that would have addressed the social and political causes of disease were often neglected.

³⁵ Vail, 'Ecology and History', *Journal of Southern African Studies*, 3, 2, 1977, pp.130-133; J. Ford, *The Role of Trypanosomiasis in African Ecology: A Study of the Tsetse Fly Problem* (Oxford, 1971).

³⁶ J. Iliffe, *A Modern History of Tanganyika* (Cambridge, 1979), pp.163-167; Vail, 'Ecology and History', *Journal of Southern African Studies*, 3, 2, 1977, pp.137-142. Tsetse fly and sleeping sickness are discussed in more detail in chapter 6.

Campaigns launched by colonial authorities for the prevention or treatment of individual diseases frequently adopted a militaristic approach and, when required, were supported by new legislative measures, which authorised specific related medical interventions. Prior to 1920, the threat of epidemic disease generated the most interventionist period of colonial government, as was exemplified in campaigns launched against such diseases as plague, sleeping sickness and Spanish flu.³⁷

Arnold has argued that the fear of epidemic disease was an important motivation underpinning the expansion of government-provided medical facilities for Africans in the early colonial period.³⁸ However, social constructionist theories of imperial medicine suggest that the criteria of what was considered an epidemic was at times manipulated by colonial authorities in order to limit the requirement for the implementation of expensive government-sponsored measures in response. It is therefore suggested that diseases precipitated by endemic poverty generated less government concern than those infections from which all of society, including European settlers, was at risk.³⁹

The selective nature of colonial health policies is evident in John Farley's study of bilharzia. This disease, which was originally identified in Egypt, was transferred between potential human hosts via infected water. It was also presumed that

³⁷ R. Chandavarkar, 'Plague Panic and Epidemic Politics in India, 1896-1914', in Ranger and Slack (eds.), *Epidemics and Ideas*, pp.203-240; Lyons, *The Colonial Disease*; H. Phillips, 'The Local State and Public Health Reform in South Africa: Bloemfontein and the Consequences of the Spanish Flu Epidemic of 1918', *Journal of Southern African Studies*, 13, 2, 1987; D. Arnold, 'Smallpox and Colonial Medicine in Nineteenth-Century India', in Arnold (ed.), *Imperial Medicine*, pp.45-65. Callahan suggests that Africans were not passive recipients of colonial medical discourse: B. Callahan, "'Veni, VD, Vici?' Reassessing the Ila Syphilis Epidemic', *Journal of Southern African Studies*, 23, 3, 1997.

³⁸ Arnold in Bynum and Porter, *Companion Encyclopedia of the History of Medicine*, pp.1401-1403.

³⁹ Slack, in Ranger and Slack (eds.), *Epidemics and Ideas*, pp.5-8.

individuals could be infected by the disease through contact with very small amounts of contaminated water. Farley explains the problem this posed for colonial authorities:

a parasite passed directly from man to man in this way would be as potentially dangerous to the white man as to the Egyptian peasant. But it would be particularly threatening to British troops stationed in Egypt and along the Suez Canal. Every puddle in every army camp would be a potential source of the disease. Artillery men, returning home from Egypt, could be responsible for an epidemic of bilharzia in Woolwich barracks!⁴⁰

British authorities responded immediately to this health threat by commissioning research on the aetiology of the disease in 1913. It was soon discovered that bilharzia was not transmitted from man to man through water but instead via fresh water snails which acted as disease-carrying vectors. These scientific findings therefore negated the threat of epidemic disease. Once military personnel had been instructed to avoid snail infested water, no further action was deemed necessary by colonial officials, despite the fact that bilharzia continued to infect and debilitate significant numbers of Africans. Farley suggests that “The disease had become, ‘one of those diseases for which the individual is mainly, if not entirely, personally responsible.’... The disease could be safely ignored.”⁴¹

Megan Vaughan further develops the critique of colonial medicine. She contends that, by the 1930’s, the emphasis on the epidemiology and aetiology of disease was increasingly underpinned by theories of cultural difference. Vaughan suggests that:

This focus displaced attention from the larger environmental and economic causes of disease and towards the idea that Africans were differentially

⁴⁰ J. Farley, ‘Bilharzia: A Problem of “Native Health”, 1900-1950’, in Arnold (ed.), *Imperial Medicine*, p.191.

⁴¹ Farley in Arnold (ed.), *Imperial Medicine*, pp.192-193.

susceptible to certain diseases on account of their cultural practices. It tended towards the attribution of blame.⁴²

Packard has described how theories of cultural difference were utilised by South African mining authorities in explanation for the high mortality rates amongst Central African labour migrants.⁴³ These ideologies enabled the mining industry to fund medical research towards producing a vaccine against pneumonia, the principal cause of death amongst these workers. By accounting for African ill health in terms of their cultural or biological predisposition, mining officials avoided funding the more expensive environmental improvements within the mining complexes, including providing higher salaries, more spacious accommodation and more nutritious diets for miners.

Case studies of the histories of individual epidemics further reveal how racial prejudice, on occasions, lead to a rejection of scientific evidence where it contradicted theories of cultural difference. Chandavarkar contends that during the epidemic of bubonic plague in India at the turn of the century, the Indian Plague Commission rejected the rat flea theory of the transmission of the disease. They instead supported claims that Indians were infected by contaminated rat excreta via cuts and abrasions on their bare feet. Chandavarkar suggests:

The rat flea theory provoked such vigorous scepticism primarily because it undermined the assumptions connecting hypotheses about the nature of the disease to notions of social behaviour and cultural characteristics in India, upon which epidemiological research had been proceeding.⁴⁴

⁴² Vaughan, *Curing Their Ills*, p.46.

⁴³ Packard, 'The Invention of the Tropical Worker', *Journal of African History*, 34, 2, 1993.

⁴⁴ R. Chandavarkar in Ranger and Slack (eds.), *Epidemics and Ideas*, p.216.

It is possible to contrast the campaigns launched by colonial authorities in the curtailment and prevention of epidemic disease with their limited provision of general health facilities for the African sick. In the initial years of imperial rule, colonial regimes confined their provision of health and education services to white settlers and African military personnel. Their restricted numbers of European medical staff and resources rendered any wider provision of service impractical. However, the increasing prevalence of infectious disease, from the turn of the century, highlighted the reality that diseases suffered by Africans could be transmitted to Europeans. In response to this, colonial authorities provided increasing levels of medical attendance for Africans in the first half of the twentieth century.

There existed considerable disparities in the availability of the Administration's health services. African military personnel had greater access to colonial medicine than African civilians. African townspeople were perceived by settlers as sources of infection. They were more likely, therefore, to experience municipal or administration-led public health measures than rural populations that were distant from Europeans. Where possible, European residential areas were located away from 'native' quarters. 'Sanitary cordons' were imposed around some urban areas inhabited by non-whites.⁴⁵

As well as location, employment was an important factor in determining access to medical services. African male labourers, on occasions, experienced western

⁴⁵ Arnold, in Bynum and Porter, (eds.), *Companion Encyclopedia of the History of Medicine*, pp.1398-1399; R. Ramasubban, 'Imperial Health in British India, 1857-1900', in Macleod and Lewis (eds.), *Disease, Medicine and Empire*, pp.40-41; Swanson, 'The Sanitation Syndrome'; P. Maylam, 'Explaining the Apartheid City: 20 Years of South African Urban Historiography', *Journal of Southern African Studies*, 21, 1, 1995, pp.24-25.

medical treatments, particularly vaccination for smallpox, under the direction of their European employers. African women and children, who were on the periphery of the new economy, were often neglected by colonial medicine.⁴⁶

Therefore, although secular colonial medicine was influential, up until 1914 only a small percentage of Africans were treated by government doctors within colonial hospitals and dispensaries. Before the First World War, the Administration in Malawi provided only a minimal number of hospitals and dispensaries for Africans. Those who encountered colonial medicine usually did so as part of a medical campaign launched against a specific infectious disease. The majority of women, children and rural dwellers who experienced western medicine were treated by Christian missionary doctors and other mission healthcare personnel.

Missionary Medicine

Megan Vaughan suggests that mission medicine differed from colonial medicine in that its ultimate aim in healing the body was the saving of the soul.⁴⁷ Missionaries theorised that many of the diseases suffered by the African sick were a direct consequence of 'heathenism' and traditional society. They therefore advocated Christian conversion, the Christian nuclear family, moral hygiene, education and commerce in the treatment of specific 'self-inflicted' diseases, including venereal disease and alcohol-related conditions.⁴⁸ However, the malnutrition of children and other infectious conditions were also considered to be, in part, remediable through

⁴⁶ Arnold, in Bynum and Porter, (eds.), *Companion Encyclopedia of the History of Medicine*, pp.1400-1401.

⁴⁷ Vaughan, *Curing Their Ills*, pp.55-76.

⁴⁸ Hokkanen, 'Doctors of Body Soul and Society', pp.93-117.

the introduction of systems of personal and public hygiene and the promotion of self-discipline.

Vaughan details a discourse of missionary medicine through which European Christians were informed of the role of medical missionaries. This discourse related the ultimate evangelising ambitions of missionary doctors and was therefore particularly powerful in constructing the image of Africa and the African as sick. Descriptions of Africa's inherent sickness pervaded missionary medical discourse throughout the nineteenth century and were prevalent in the correspondence of David Livingstone who appealed for the introduction of Christianity and Commerce as a suggested cure for 'heathenism' and the slave trade.⁴⁹

Vaughan suggests that missionary medical discourse described the missionary doctor's role in terms of a continuation of the work of Christ the Healer and further emphasises the process through which specific diseases encountered by missionaries in Africa were associated with influential Christian disease symbolism. She cites leprosy, a disease redolent of biblical traditions, as an example of this process.⁵⁰ The practical application of science-based missionary medicine was described in mission journals in terms of the superiority of post-enlightenment rationalism over and above 'primitive superstition'. The mission's dispensary was portrayed as a most pristine example of practical Christian charity to the African while the hospital's role as a unique environment in which Christian teachings could be provided to a captive audience, was also emphasised.

⁴⁹ Livingstone, *Narrative of an Expedition*, pp. 585-608; Arnold in Arnold (ed.), *Imperial Medicine*, p.3.

⁵⁰ Vaughan, *Curing Their Ills*, pp.77-99.

By 1900, the practical application of mission medicine differed from secular colonial medicine most notably in its general availability and accessibility. Although the provision of missionary medicine was necessarily restricted, through limited funding and medical personnel, most missionary societies advanced a general open door philosophy to all African sick and initiated the training of African medical assistants for the purpose of enabling more Africans to experience western medicine. The training of African medical personnel by missionary societies in Malawi is discussed in detail within chapter 4.

The importance of medicine to the evangelising process had, however, not always been appreciated. In the early nineteenth century, missionaries practised self-taught medicine, developed through costly trial and error.⁵¹ The potential of medicine to attract indigenous populations was often recognised. However, it was considered that, in general, the practice of medicine ought to be limited out of concern that it would distract from the evangelising ambitions of missionary endeavour.⁵²

In addition to this, the manner in which medicine was eventually incorporated within the evangelising mission varied between individual missionary societies.⁵³ The three missions reviewed within this thesis each developed their medical facilities in differing ways. The Free Church of Scotland's Livingstonia Mission appeared to attach considerable importance to medicine and qualified doctors dominated its staffing lists. By comparison, in the pioneering years, the UMCA

⁵¹ See, A.F. Walls, 'The Heavy Artillery of The Missionary Army: The Domestic Importance of the Nineteenth Century Medical Missionary', in Sheils (ed.), *The Church and Healing*, pp.287-297, for an overview of the development of medicine within missions.

⁵² C.P. Williams, 'Healing and Evangelism: The Place of Medicine in Later Victorian Protestant Missionary Thinking', in Sheils (ed.), *The Church and Healing*, pp.271-285.

⁵³ Williams in Sheils (ed.), *The Church and Healing*, pp.271-285.

failed to provide adequate medical care even for its own missionaries. Chapter 2, therefore, provides a detailed account of the gradual evolution of missionary medicine both as a general concept and, more practically within the Livingstonia, Blantyre and UMCA missions between 1875 and 1900.

Chapter 3 further plots the development of medicine within mission from 1900 to 1914. By 1900, the British medical profession had been transformed into a creditable organisation, which exerted increasing influence across British society. The medical missionary was therefore the product of a secular medical education and training, which was underpinned by a science-based knowledge that was developing rapidly. However, the missionary doctor was also influenced by his own upbringing and class status. He was also a religious man whose missionary endeavours were motivated by spiritual and humanitarian concerns. Chapter 3 analyses the varying and often conflicting religious, scientific and professional constraints that affected the medical practice of individual medical missionaries. In addition to this, the influence of factors external to individual missions, such as the development of specialisms within the medical profession and the expansion of the settler economy, on the gradual organising and secularising of mission medicine, will also be considered.

The late nineteenth century also witnessed the organisation of the nursing profession in Britain. By 1900, the new profession had developed a standard education and training, was regulated by a governing body and was controlled by a code of conduct. The nurse gained status across British society as a result of these developments. However, since her relationship with her medical colleagues was

based upon Victorian gendered expectations of the obedient wife and mother, the nurse continued to operate as the inferior assistant of the male-dominated medical profession. Chapter 4 of this thesis describes, with reference to the Blantyre, Livingstonia and UMCA Missions, the process through which the specified gendered binaries, which dictated and controlled the working relations of the doctor and nurse within the metropole, were transported intact to the mission field.

The analysis of the working relationship of the missionary doctor and nurse builds upon the growing literature on gendered relations in the colonial environment and the history of the professions.⁵⁴ A fuller understanding of the relations that developed between European and African healthcare personnel, detailed in chapter 4, requires in-depth analysis of the interaction of European and African gender codes, racial prejudice and professional vested interests.

It has been the intention within this thesis to uncover the African patient's individual experience and opinion of mission medicine. These efforts have, however, been frustrated by the lack of detailed information on this subject within the primary sources. Although medical missionaries did write about their patients, they frequently referred to them as an indiscriminate group or as a medical condition rather than as individuals who suffered from particular ailments. The voice of the African patient has been drawn from a disparate collection of sources, including mission journals and the private letters of individual missionaries. The medical records of the UMCA, located within the Malawi National Archives,

⁵⁴ See for example, C. Midgley (ed.), *Gender and Imperialism* (Manchester, 1998); D. Gaitskell, 'Re-thinking Gender Roles: The Field Experience of Women Missionaries in South Africa', paper presented to the Conference on the Imperial Horizons of British Protestant Missions, 1880-1914: The Interplay of Representation and Experience, Cambridge, April 1998; S. Marks, *Divided Sisterhood: Race, Class and Gender in the Southern African Nursing Profession* (Basingstoke, 1994).

provided valuable information on the patients treated within the UMCA's hospitals. These included details on the duration of in-patient stays and the medical treatments provided for individual patients.

Although limited by the lack of detailed information, this study has attempted to counteract the contemporary images of the African patient as either the passive and grateful recipient of care, the innocent victim of superstition or the ignorant adversary of 'rationalism' and 'civilisation'. Chapter 5 attempts to more accurately detail the negotiated interaction between mission medical personnel and their African patients within the mission hospital.

Finally, although mission medicine treated significant numbers of Africans, both as in and out-patients, its practical effectiveness is doubtful. Chapter 6 evaluates the impact of missionary medicine between 1875 and 1914.

This study is based upon a variety of published and unpublished sources. I have made extensive use of published mission journals including the UMCA's, *Central Africa*, *The Nyasa News* 1893-4 and the *Nyasaland Diocesan Quarterly Paper*. The Church of Scotland's, *Life and Work in British Central Africa* provided invaluable information on the Blantyre Mission. The Church of Scotland's *Home and Foreign Missionary Record*, 1876-1900 was also utilised. Various published journals of the Free Church of Scotland have also informed this study, including *Aurora*, 1897-1902, *The Livingstonia News*, 1909-12 and *The Free Church of Scotland Monthly Record* (continued as, *The Missionary Record of the United Free Church of Scotland*)

I have also made extensive use of the records of the Livingstonia and Blantyre Missions held in the National Library of Scotland and the Malawi National Archives. The unpublished records of the UMCA, held in Rhodes House Library, Oxford have also been utilised.

The mission histories and biographies published by individual missionary societies have provided supplementary detail. Additional information on the prevailing health of the populations within the Protectorate has been obtained from government documents, including Annual Medical Reports, Blue Books and other official sources. The settlers' newspaper, *The Central African Times* and the private diary of Frederick Morrison, an employee of the African Lakes Company, held in Edinburgh University Library have also proved useful.

CHAPTER 1

THE MALAWI REGION: 1850-1914

Present day Malawi, bordered on the north and northeast by Tanzania, on the west by Zambia and on the east and southwest by Mozambique, is a long narrow country, which forms the southern extension of the Rift Valley. Its most significant natural feature is Lake Malawi, which extends along the country's eastern border and ranges from between ten and fifty miles in width along its 355 mile length.⁵⁵

The country of Malawi has only existed since 1964 when it gained independence from the British Protectorate, which had operated since 1891. However, the influence of the UMCA, Livingstonia and Blantyre Missions extended beyond these modern borders into present day Zambia and Tanzania. This study will, therefore, refer to the 'Malawi Region', incorporating these cross border spheres of missionary influence, as well as present day Malawi.

The Malawi Region can be divided into geographical zones of missionary influence. Although there was some overlap between the missions, it is possible to discuss the Shire Highlands as the Blantyre Mission's principal area of missionary endeavour. Similarly, the western side of the lake and northeastern Zambia was the zone of the Free Church of Scotland, while Likoma Island and the eastern mainland comprised the UMCA's sphere of influence. Since it is not possible to provide a comprehensive history of each of these regions within this study, the following account will focus principally upon the area of the former Nyasaland Protectorate.

⁵⁵ *Malawi Yearbook*, 1973; J.G. Pike and G.T. Rimmington, *Malawi, A Geographical Study* (London, 1965); McCracken, *Politics and Christianity*, pp.29-30.

Pre-Colonial Populations of the Malawi Region

The peoples of the southern and central Malawi Region were at one point under the authority of the Maravi States, which were established in the sixteenth century. By the following century, two major kingdoms existed: that of Undi, which extended westwards from Central Malawi over large areas of eastern Zambia and north-western Mozambique, and that of Lundi in the south east, which included the Shire Highlands and lower Shire Valley. These kingdoms had decentralised by the nineteenth century into groups of culturally related people of whom the Chewa of Central Malawi were the most numerous.⁵⁶

The Chewa and the related Manganja, who were largely based in central and southern regions, were principally agriculturalists. Their social order was structured at village level under the authority of the headman. The village was further subdivided into *mbumbas* or households of matrilineal kin groupings through which rights of landownership descended down the female lineage. The senior male member of each mbumba, usually a brother or uncle, acted as guardian of its female members; his sisters and nieces. Such matrilineal clans were exogamous, although marriage was matrilocal. The Chewa shared the language chichewa with some dialectical differences. They also celebrated female initiation rites. Those of central regions maintained a strong sense of Chewa identity through their *Vinyau* masked male secret societies.⁵⁷

⁵⁶ K. Phiri, 'Cultural and Political Change: the Pre-colonial History of Malawi', *Society of Malawi Journal*, 30,2, 1977, pp.6-10.

⁵⁷ R. G. Stuart, 'Anglican Missionaries and a Chewa Dini Conversion and Rejection in Central Malawi', *Journal of Religion in Africa*, 10, 1979, pp.46-69; K. Phiri, 'Some Changes in the Matrilineal Family System Among the Chewa of Malawi Since the Nineteenth Century', *Journal of African History*, 24, 1983, pp.257-274.

In northern regions, the agricultural Tumbuka and Tonga of the western lake and lakeshore respectively, reflected more varied cultural influences. For example, the Tonga practised both matrilineal and patrilineal systems of descent, while the Ngonde of the northwest plain were related to the patrilineal peoples of western Tanzania.⁵⁸

The Malawi Region had long established trading routes through which it linked up with the east coast ports of Kilwa, Zanzibar and Quelimane. By the mid-nineteenth century, Arab and Swahili Arabs were increasingly penetrating the areas west of Lake Malawi (Nyasa) in search of ivory and the growing commodity of slaves and establishing fortified villages along these routes. Nkhotakota (Kota Kota) on the western shore of the lake became a principal Arab trading post from which ivory and slaves were transported across the lake. It is thought that the first Jumbe of Nkhotakota travelled from Zanzibar and seized political authority over the people in the surrounding area, who sought protection from Ngoni attackers, in the mid 1840's. The Jumbe had grown wealthy from his participation in trade and was in possession of firearms. He was perceived by the troubled people of the region as a suitable patron.⁵⁹ As his following increased, the Jumbe initiated a system of indirect rule.

Successive Jumbes continued to develop the wealth and power of the lineage whilst maintaining allegiance to the Sultans of Zanzibar. An observer described Nkhotakota in the nineteenth century as extending:

⁵⁸ McCracken, *Politics and Christianity*, pp.31-32; L. Vail, 'Suggestions Towards a Reinterpreted Tumbuka History', in B. Pachai (ed.), *The Early History of Malawi* (London, 1972), pp.148-167.

⁵⁹ G. Shepperson, 'The Jumbe of Kota Kota and Some Aspects of the History of Islam in British Central Africa', in I. M. Lewis (ed.), *Islam in Tropical Africa* (London, 1966)

a considerable length along the shore. Many square houses, so closely packed one can scarcely make one's way through the place ... Many oil palms ... Jumbe has the red flag (of the Sultan of Zanzibar) flying over his house.⁶⁰

The Jumbe dynasty at Nkhotakota continued until the fourth ruler, Mwinyi Kheiri failed in his attempt to overthrow the new British Administration, which had established its Protectorate in 1891. He was subsequently deposed and deported to Zanzibar in May 1895, by which times Nkhotakota had become a principal mission station of the UMCA.⁶¹

The Arab slave traders who operated around the regions of Lake Nyasa were widely condemned by European witnesses. In 1888, the African Lakes Company and the Livingstonia missionaries were involved in a war against the Swahili Arabs at the north end of the lake. There were, however, other slave traders in Malawi at this time who contributed to the sense of fear and violence throughout the region.

The Yao people had entered Malawi around the middle of the nineteenth century. Oral testimony suggests that this multi-ethnic society, known as Yao, originated in northern Mozambique.⁶² The original Yao had been agriculturalists, but also hunted, fished and made salt.⁶³ During the sixteenth and seventeenth centuries they had incorporated into their group, through intermarriage, Lomwe-speaking people and members of the Nyanja community who had migrated into the area in response

⁶⁰ As quoted by Shepperson in Lewis (ed.), *Islam in Tropical Africa*, p.197.

⁶¹ Shepperson, in Lewis (ed.), *Islam in Tropical Africa*, pp.200-201

⁶² M. Vaughan, 'Social and Economic Change in Southern Malawi: A Study of Rural Communities in the Shire Highlands and Upper Shire Valley', PhD thesis (London, 1981) pp.60-64; M. Vaughan, *The Story of an African Famine* (Cambridge, 1987), pp.56-59.

⁶³ Vaughan, 'Social and Economic Change', p.61; E. A. Alpers, 'Trade, State and Society Among the Yao in the Nineteenth Century', *Journal of African History*, 10, 1969, p.406.

to the expansion of the Maravi State.⁶⁴ Therefore, while the ethnic and cultural ties that defined the Yao were wide-ranging, rivalries and divisions within Yao groups provided an inherent destabilising influence.

By the early seventeenth century, the Yao were well-established traders, initially exchanging tobacco, hoes and animal skins at the coast for salt, cloth and beads.⁶⁵ By the end of the century, the Yao were the principal ivory traders at Kilwa. However, during the late eighteenth century, Yao society was afflicted by drought, famine and warfare, which precipitated their waves of migration into southern Malawi. The Yao of Nyanja origin first settled amongst Manganja communities. Since the Yao were matrilineal and matrilocal, they were easily absorbed into the decentralised Manganja society through intermarriage. However, fundamental differences in culture, including diet and language, remained. For example, initiation ceremonies were always held separately.⁶⁶

Yao trading traditions generated distinct attitudes towards the status of agricultural labour, since the caravans that travelled to the coast took large numbers of Yao men from their homesteads, often for up to a year at a time. Evidence suggests that Yao society in the eighteenth century, similar to that of the Manganja, was structured around the *mbumba*. Given the long absences of Yao men on trading expeditions, agricultural duties became principally the responsibility of women. This was in contrast to the Manganja for whom the household was the principal unit of production.⁶⁷ The assimilated Yao soon re-established their trading connections and

⁶⁴ Vaughan, 'Social and Economic Change', pp.60-61.

⁶⁵ Alpers, 'Trade, State and Society', *Journal of African History*, 10, 1969, pp.405-407.

⁶⁶ Vaughan, 'Social and Economic Change', p.72.

⁶⁷ Vaughan, 'Social and Economic Change', pp.68-69.

participated in the ivory and the growing slave trade, whilst the Manganja continued to supply the caravans that passed through their region with provisions of food and other supplies. Difficulties are reported to have arisen when the Manganja failed to adequately supply Yao traders with food. Ultimately this escalated into violent warfare.⁶⁸

As Yao migrations into Malawi continued through the nineteenth century, the more militarised Masaniga and Machinga Yao settled around the southern aspect of the lake.⁶⁹ These Yao-speaking immigrant groups were headed by powerful commercial and military leaders, whose influence was underpinned by the firearms and wealth they had obtained through the slave trade. Mponda and Makanjila on the south and southeast of Lake Malawi were amongst the most influential of these new rulers.⁷⁰

The slave trade not only enhanced the wealth of these territorial chiefs but also enabled them to develop huge dynasties. In Yao matrilineal society, the children produced by a marriage belonged to the wife's family as opposed to that of the husband. By taking many slave wives who, with their children, belonged solely to their master, Yao chiefs initiated systems of patrilineal descent which multiplied the numbers of their followers and commensurately their influence within the region. By the nineteenth century, it had become commonplace for Yao chiefs to attempt to acquire female slaves by trading or raiding. Indeed, the chief Mponda was reported

⁶⁸ Livingstone, *Narrative of an Expedition*, pp.348-64.

⁶⁹ Alpers, 'Trade, State and Society'; Vaughan, *The Story of an African Famine*, pp.56-57.

⁷⁰ McCracken, *Politics and Christianity*, pp.70-71; Alpers, 'Trade, State and Society'.

to have had seventy or eighty wives by the 1870's.⁷¹ Furthermore, Mponda's and Makanjila's townships reportedly accommodated up to 8,000 inhabitants.⁷²

The Shire Highlands experienced continual warfare and violence from the mid-nineteenth century as these Yao intruders gradually attained supremacy over the weaker Manganja. This regional violence was compounded by an escalation in raiding for slaves. David Livingstone provided some of the first observations of the effects of the slave trade on the region in the early 1860's and prescribed legitimate commerce and Christianity as the principal means of ending such uncivilized trading and depopulation of the African continent.⁷³ Early European activity in Malawi, from the mid-nineteenth century, detailed the manner in which male slaves, who were more valuable to the export, rather than domestic, slave trade, were transported from west to east across the lake or Shire River as part of their journey towards the east coast. Frederick Morrison, an employee of the ALC observed at Mponda's in 1883:

As we left we saw at a little distance from the village, a great number of slaves seated on the bank of the River waiting to be taken over to the other side. Each slave had on a slave stick & the lot were guarded by a great number of fellows with guns. Further up the River on the other side there was another lot, waiting for the others to come over.⁷⁴

The influx of the Yao was accompanied from the 1820's by the arrival of a militarised group of intruders, known as Ngoni who were originally from South Africa. Under Zwangendaba, their leader, this group had moved progressively northwards continually raiding and incorporating captives within its state as it went.

⁷¹ McCracken, *Politics and Christianity*, p.72; Alpers, 'Trade, State and Society', pp.410-413.

⁷² McCracken, *Politics and Christianity*, p.34.

⁷³ Livingstone, *Narrative of an Expedition*.

⁷⁴ Diary of Frederick Morrison, Jan. 23 1883. GEN. 1804. Edinburgh University Library (hereafter E.U.L.)

The succession dispute, which followed Zwangendaba's death around 1848, resulted in the fragmentation of this moving state into several smaller groups, which thereafter proceeded in separate directions.⁷⁵ Four Ngoni kingdoms and several smaller groups were established in Malawi by the 1870's. Mbelwa's Jere Ngoni were situated in the highlands of the northern region overlooking the Tonga and Tumbuka societies. Ngoni were also located to the west of Nkhotakota and the eastern Zambian plateau. Finally, the Maseko Ngoni were founded in the south-central regions from which they frequently raided into the Shire Highlands.

In contrast to the Yao, the Ngoni had limited contacts with the east coast. They were a centralised people who practised cattle keeping. They exacerbated the violence and insecurity of the region by conducting raiding sorties against neighbours, seizing cattle, grain and people. In 1861, Livingstone observed that the "Mazite or Mazitu live on the highlands, and make sudden swoops on the villages of the plains...All the villages north of Mankambira's (lat. 11°. 44' south) had been recently destroyed by these terrible marauders."⁷⁶

Throughout the nineteenth century, the prevalence of violence and fear in the region directly affected the political, and social organisation of weaker populations. These societies, which had previously practised dispersed settlement were forced to seek protection against attack on mountain or marsh locations or within larger fortified villages. Morrison described one such village in 1882.

⁷⁵ B. Pachai, *Malawi: The History of the Nation* (London, 1973), pp.22-24.

⁷⁶ Livingstone, *Narrative of an Expedition*, p.381.

The fear which continually (sic) haunt them of the Wangone coming has caused them to built (sic) their houses as close together as possible, in fact they are so close that when amongst them on (sic) seems as if he were into a trap from which there was no getting out.⁷⁷

Others entered into tribute systems as a means of ensuring protection. For example, by 1885, Mponda was paying Chikuse, the Maseko paramount, an annual tribute in cloth and salt.⁷⁸

Early Missionary Activity.

The first British mission in Malawi, the Universities' Mission to Central Africa (UMCA), was directly motivated by David Livingstone, who appealed to graduates of Oxford and Cambridge in 1857 to continue his work in Africa. The mission was composed of graduates of Oxford, Cambridge, Belfast and Durham Universities. It was High Anglican and, in being influenced by the Oxford Tractarianism Movement, was highly catholic in its ideology and method of worship.⁷⁹ The mission, which was established at Magomero in the Shire Highlands in 1861, failed after just two and a half years as a result of the political instability of the region at the time. The missionaries, led by Bishop Mackenzie, a Cambridge mathematics tutor, became embroiled in active warfare on the part of the Manganja against their Yao foes, an act which contributed to their Christian missionary role in the region becoming untenable. The decision for the mission to relocate to Zanzibar was made in the wake of an unusually severe famine, which affected the Shire Highlands and the lower Shire Valley in 1862.⁸⁰

⁷⁷ Diary of Frederick Morrison, Dec. 8 1882. GEN. 1803. E.U.L.

⁷⁸ McCracken, *Politics and Christianity*, p.72.

⁷⁹ N. Yates, *The Oxford Movement and Anglican Ritualism* (London, 1983).

⁸⁰ White, *Magomero*, pp.3-70; Chadwick, *Mackenzie's Grave*; Anderson-Morsehead, *The History of the Universities' Mission to Central Africa*, Vol. 1, pp.1-34.

By 1875 and the arrival of the Scottish Protestant missions, the regions of Malawi were becoming more politically stable. Yao chiefs had established political dominance over many of the Nyanja and Manganja inhabitants of the Upper Shire Valley and Shire Highlands. Meanwhile, the more northerly Tonga and Tumbuka and the Chewa of the central districts preserved precarious and varying degrees of cultural independence despite repeated Ngoni raids. The more isolated Ngonde remained unaffected by the new invaders.⁸¹

Scottish churches were moved to create a suitable memorial to David Livingstone in 1874 following his funeral at Westminster Abbey. A mission established in the regions of Malawi, an area which he himself had identified as suitable for Christian evangelising, was presented as the most appropriate celebration of all that Livingstone had attempted to achieve for Africa. The Free Church's Livingstonia Mission was founded at Cape Maclear in 1875, whilst the Established Church's Blantyre Mission, named after Livingstone's Scottish birth town, was centred in the Shire Highlands the following year. Improvements in global communications at that time must have influenced the decision to form an African mission. For example, the opening of the Suez Canal in 1869 had facilitated communications with East Africa and India, whilst in 1872, a monthly mail service between Aden and Durban via Zanzibar, run by the British India Steam Navigation Company, was initiated.⁸²

⁸¹ White, *Magomero*, pp.3-70; Vaughan, *The Story of an African Famine*, pp.56-59.

⁸² McCracken, *Politics and Christianity*, pp.56-57.

The Livingstonia Mission was principally funded by Glaswegian industrialists including, James White of Overtoun and James Stevenson, who were chemical manufacturers and James Young, who owned the Young Paraffin Light and Mineral Oil Company.⁸³ These men, motivated by a desire to pay dividends towards a heavenly reward and by the need to open up new markets, made a commitment to finance the mission on a long-term basis. While clerical authorities managed the majority of missions at this time, the Livingstonia Mission was administered separately from the Free Church's ecclesiastical hierarchy by a committee of these businessmen who held the ultimate sanction over plans for major expenditure. Furthermore, since the new mission was committed to the introduction of commerce and Christianity on the Livingstone model, its pioneering party was predominantly composed of artisans rather than clerics. The Reverend Dr. Laws was the only ordained missionary appointed along with five artisans.⁸⁴

Since the Established Church of Scotland mission had failed to enlist an ordained minister as its clerical leader, its pioneering party was headed by a physician, Thomas Macklin and included five other artisans. Its first minister, Duff MacDonald, did not arrive at Blantyre until 1878. The Church of Scotland missionaries were at all times under the command of its Foreign Mission Committee (FMC). The financial funding of the mission was precarious as it was principally supported by church donations and individual gifts or legacies. Small fundraising groups were also established. That of Dr. Archibald Scott of St. George's Parish Edinburgh raised considerable sums and by 1890 was supporting the salaries of four

⁸³ McCracken, *Politics and Christianity*, pp.59-63.

⁸⁴ McCracken, *Politics and Christianity*, pp.63-64.

out of ten staff at the Blantyre Mission.⁸⁵ Such systems of funding were unreliable and suffered from the fluctuations in popular interest in foreign missions.⁸⁶

The Blantyre Mission was established in the Shire Highlands amongst weaker Yao societies who suffered continual Ngoni raiding and who identified the mission as a source of protection. Groups of villages, composed of runaway slaves and the disaffected of traditional society, gathered around the vicinity of the mission. The pioneer missionaries, therefore, assumed civil authority over these people, and on occasions resorted to the use of floggings and other cruelties as a means of imposing law and order. This policy was left unchanged by the mission's new ordained leader. MacDonald focused his efforts on practical missionary work, such as teaching and studying the Yao language and thus allowed judicial responsibilities to remain in the hands of his non-ordained colleagues. These artisans were later deemed highly unsuitable for missionary work.⁸⁷ This unsatisfactory situation further deteriorated in 1879 when the missionaries executed a convicted murderer, whilst an accused thief was flogged with such extreme vigour that he subsequently died of his injuries.

News of these atrocities reached the British public through a pamphlet written by Andrew Chirnside, a traveller who had visited the mission in 1879.⁸⁸ In the wake of the public outcry that followed the publication of Chirnside's account, MacDonald and the artisans implicated in the incident were dismissed from the mission's services. A new mission policy was then formulated. The missionaries were

⁸⁵ Ross, *Blantyre Mission*, p.37.

⁸⁶ Ross, *Blantyre Mission*, pp.17-38; A. Ross, 'Scottish Missionary Concern 1874-1914: A Golden Era?', *Scottish Historical Review*, 51, 151, 1971.

⁸⁷ Ross, *Blantyre Mission*, pp.19-21.

⁸⁸ A. Chirnside, *The Blantyre Missionaries: Discreditable Disclosures* (London, 1880).

instructed to leave all jurisdiction in the hands of traditional chiefly authority, while runaway slaves were to be handed back to their rightful owners. From 1881, the mission commenced a more fruitful period of its history under the leadership of David Clement Scott.⁸⁹

The Livingstonia Mission, which was established in Mponda's sphere of influence, was also unsuccessful in its pioneering years. By the 1870's, Mponda was relatively secure from Ngoni attack and although succession disputes occurred on his death, his chiefdom did not suffer from internal dissent. Mponda, therefore, did not require the mission's protection. However, he preferred the mission to settle within his domain rather than those of his rivals. He therefore permitted the missionaries to settle at Cape Maclear although he discouraged his people from attending mission services. Indeed, given the importance of the slave trade to the organisation of Yao political and social power, it is unsurprising to discover that Mponda did not support the missionaries' dual aims of establishing Christianity and legitimate commerce within the region.⁹⁰ Early mission recruits at Cape Maclear were overwhelmingly refugees who, in escaping from the influence of surrounding Yao chiefs and sub-chiefs, attempted to build villages of their own under the mission's protection.⁹¹

The Livingstonia missionaries soon found themselves isolated from the surrounding Yao who resented the numbers of people gathered under the mission's influence. In addition to this, the prevalence of Islam amongst the lakeside Yao created a more

⁸⁹ Ross, *Blantyre Mission*, pp.54-61.

⁹⁰ McCracken, *Politics and Christianity*, pp.72-73; Linden, *Catholics, Peasants and Chewa Resistance*; I. Linden (ed.), 'Mponda Mission Diary, 1889-1891', *The International Journal of African Historical Studies*, 7,2, 1974; 7,4, 1974 and 8,1, 1975.

⁹¹ McCracken, *Politics and Christianity*, pp.81-83.

general unresponsiveness to the Christian message. Not one baptism occurred within the first six years of the missionaries' presence in the region.⁹² More practical problems also emerged. For example, although Cape Maclear was in possession of an excellent natural harbour, which ensured the protection of the mission's steamer, the *Ilala*, the area lacked fertile soil, experienced severe sanitation problems and, since it was surrounded by hills and mountains, left little potential for expansion outwards from the mission's central base.⁹³ In response to these accumulating problems, the missionaries moved northwards to Bandawe in 1881, where they commenced work amongst the more receptive lakeside Tonga who welcomed the missionaries as a source of protection from the attacks of Mbelwa's Ngoni.

Following the public outcry over the atrocities at Blantyre, Laws used the relocation of the mission as a means of initiating a non-interventionist policy to which he adhered strictly.⁹⁴ Between 1881 and 1894, the mission established its influence amongst the Ngoni, the Ngonde and the peoples of Northern Zambia.

The founding of the Overtoun Institution at Khondowe in 1894, however, was arguably the singular most important development in the mission's history. In providing a principal focus for mission expenditure, this centre of education influenced all subsequent mission policy. The institution, which drew its scholars from the most gifted students of all the mission's schools, aimed to provide a

⁹² Jack, *Daybreak in Livingstonia*, p.115.

⁹³ McCracken, *Politics and Christianity*, p.85.

⁹⁴ McCracken, *Politics and Christianity*, pp.97-103.

substantial post-basic education for African pastors and teachers and also acted as an important centre of industrial education.⁹⁵

The UMCA returned to the Malawi Region in 1882 and centred its mission on Likoma Island, only four miles from the eastern shore of the lake. From there it gained influence over the Nyanja-speaking people on the eastern coastline, who had been subjected to Yao and Ngoni attacks. By 1900, the UMCA operated in a virtual political vacuum, since its sphere of influence formed the most distant aspect of both the British Protectorate and Portuguese East Africa.

The Chewa of the central and northern areas of the eastern littoral had been subjected to attacks from the Ngoni and Yao and, to a lesser extent, Tonga from the west.⁹⁶ By the 1880's, certain Chewa chiefs, who had not yet succumbed to these external forces, sought an association with the UMCA. The mission was therefore granted permission by Chitesi to settle on Likoma Island where it established itself quickly amongst the population, many of whom had become detached and dislocated from their lineage during the disruptive years from the mid-nineteenth century onwards.

In the pioneering years, conversions were achieved more quickly amongst those outwith the lineage system. Chewa society centred on the matrilineage. An individual interacted with the *Mzimu*, deceased members of the matrilineage, through the lineage system. The funeral rite, the most important ceremony in

⁹⁵ McCracken, *Politics and Christianity*, pp.171-196; J. McCracken, 'Underdevelopment in Malawi: The Missionary Contribution', *African Affairs*, 76, 303, 1977.

⁹⁶ Stuart, 'Christianity and the Chewa', pp.13-17. Chipembere believes that many of the inhabitants of the eastern mainland were 'Nyasa' or 'Malawi' rather than Chewa: H. Chipembere, *My Malawian Ancestors* (Dar es Salaam, 1969).

Chewa tradition which marked the transition of the deceased to *Mzimu* status, was denied to those outwith the lineage, principally freed slaves and other displaced people.⁹⁷ Christianity and mission provided an alternative community system and identity for such people. The UMCA therefore achieved rapid conversions on the island of Likoma on which resided significant numbers of ex-slaves and people of Tonga-Chewa origin who were less attached to the fiercely guarded Chewa traditions held by those of the Chewa heartland on the west.

Stuart contends that as the threat of Ngoni raids reduced in conjunction with a growing awareness of the economic benefits of association with the missions, principally through education and paid labouring, the Chewa of the eastern littoral became more receptive to missionary advances. Young men and boys, who had the least to gain from the traditional lineage system, proved willing converts. Therefore, while there were only five lakeside schools in 1892, this number had risen to twenty-two by 1896.⁹⁸ In contrast, older men and women who held traditional authority only gradually accepted the Christian message.

The UMCA's history at Nkhotakota was more troubled than at Likoma. In comparison to the weaker commitment to tradition demonstrated by societies on Likoma and the eastern mainland, the central Chewa of the surrounding Ntchisi region strongly adhered to their matrilineal system and other traditions of Chewa culture. Despite encountering continual attack from Ngoni adversaries from the 1850's onwards, who succeeded in establishing petty states over them, the central

⁹⁷ Stuart, 'Christianity and the Chewa', pp.45-61; R. Stuart, 'Anglican Missionaries and a Chewa *Dini* Conversion and Rejection in Central Malawi', *Journal of Religion in Africa*, 10, 1979.

⁹⁸ Stuart, 'Christianity and the Chewa', pp.89-98.

Chewa did not lose their cultural identity. Ultimately, it was the Ngoni themselves who were absorbed into the strong Chewa culture of their subjects.⁹⁹

By contrast, the Nkhotakota area had been overseen by the Jumbe, who had established a system of indirect rule over the local Chewa, and with his apparent wealth and firepower, had subsequently offered protection for many people fleeing the Ngoni. The Chewa of Nkhotakota were therefore dislocated people who lacked the cultural identity held by the Chewa of Ntchisi.¹⁰⁰ The mission had initially targeted Nkhotakota's Muslim community with its Christian evangelism. However, from 1895, the year in which Jumbe IV was deposed and direct rule by a British resident was established, the mission abandoned this campaign and instead focused its efforts on the community of freed slaves around Nkhotakota.

The mission would also establish stations at Mponda's and Malindi in Nyasaland at the south end of the lake and at Unangu, high in the Yao hills of Mozambique, south east of the lake. Within ten years of the UMCA's arrival, 2,000 people living near its mission stations had come under its influence. Of these, 651 were baptized Christians.¹⁰¹

The country soon became a focal point for considerable mission activity. The Dutch Reformed Church from the Cape was founded at Mvera on the west side of the lake in 1889, whilst in 1892, Joseph Booth's Zambesi Industrial Mission

⁹⁹ Stuart, 'Christianity and the Chewa', pp.17-22; Stuart, 'Anglican Missionaries', *Journal of Religion in Africa*, 10, 1979.

¹⁰⁰ Stuart, 'Christianity and the Chewa', pp.24-25.

¹⁰¹ Stuart, 'Christianity and the Chewa', p.74. For the Mozambican dimension to UMCA activities see Chipembere, *My Malawian Ancestors* and J. Paul, *Mozambique. Memoirs of a Revolution* (Harmondsworth, 1975), pp.17-21.

commenced work. In 1895, Baptist missionaries from Glasgow settled at Ncheu, whilst in 1900, the South African General Mission was established. The Seventh-day Adventists established a mission in 1901.¹⁰²

European Commerce and the British Protectorate

Certain of the Glasgow businessmen who funded the Livingstonia Mission attempted to introduce legitimate commerce into Malawi in 1878 in the form of their own transport company. The Livingstonia Central African Company, later known as the The African Lakes Company (ALC), was initially managed by two brothers, John and Frederick Moir. In its pioneer years, the company attempted to buy up supplies of ivory, which would be transported via steamer ship to the coast. It also endeavoured to provide an essential carrying service to and from the coast. By the late 1880's the company employed considerable amounts of African labour, including the first labour migrants who travelled from the lake.¹⁰³

Settler cultivation also developed rapidly from the 1890's as Europeans bought up large areas of land that had been depopulated in the nineteenth century.¹⁰⁴ John Buchanan, an ex-missionary of Blantyre, set up coffee plantations in the Zomba region of the Shire Highlands in 1881. The number of European settlers in the country rose from 314 in 1901 to 766 in 1911,¹⁰⁵ whilst between 1891 and 1896,

¹⁰² Linden, *Catholics Peasants and Chewa Resistance*, p.43.

¹⁰³ McCracken, *Politics and Christianity*, pp.150-151; F. L. M. Moir, *After Livingstone: An African Trade Romance* (London, 1923).

¹⁰⁴ See Introduction.

¹⁰⁵ R. Palmer, 'White Farmers in Malawi: Before and After the Depression', *African Affairs*, 84, 1985, p.215.

land under settler cultivation increased from 1600 to 5700 acres.¹⁰⁶ Following the failure of the coffee plantations, the trade in slaves and ivory was replaced by commercial farming of cotton and tobacco.¹⁰⁷ The majority of Europeans settled in the more favourable conditions of the Shire Highlands, with Blantyre becoming the principal commercial centre. Zomba, which from 1889 accommodated the Protectorate Government of the first Commissioner, Harry Johnstone, was the political centre of the region.

The development of settler commerce; carrying firms, plantation companies and by 1903, the railway construction programme, brought increasing demands for African labour. The creation of a monetary system and the penetration into the area of desirable European goods and clothing provided considerable incentives for Africans to participate in the new economy, either as paid labourers, skilled workers (for those who had been in receipt of a missionary education) or as peasant cultivators.

The settler economy's demand for cheap African labour appeared almost insatiable. The introduction of a hut tax by the new Protectorate Government was used as a means of enforcing labour migration from rural parts of the country. However, the three-shilling hut tax, which was introduced in the Southern Province in 1892, did not force local Africans into wage labour but rather stimulated the production of food crops by peasant farmers, who were supplying the needs of the new market

¹⁰⁶ McCracken, *Politics and Christianity*, p.150.

¹⁰⁷ Palmer, 'White Farmers', *African Affairs*, 84, 1985.

created by European settlers.¹⁰⁸ The influence of Protectorate rule and the new economy was initially disparate across different regions. British rule was only very gradually enforced throughout the Protectorate, between 1891 and 1898, by the signing of treaties and small, contained warfare. The northern Ngoni were not incorporated into the Protectorate until 1904, whilst hut tax was not enforced on the Tonga and Ngoni until 1897 and 1906 respectively.

Despite the incentives to participate in the monetary economy, various groups reacted to labour migration in different ways. For example, the Tonga around the Livingstonia Mission at Bandawe appeared to welcome the western influence. They eagerly utilised all the mission's services and particularly valued its education facilities, such that by 1894, approximately 1,000 pupils regularly attended eighteen mission schools.¹⁰⁹

McCracken has highlighted the influence of Laws of Livingstonia in promoting labour migration amongst the Tonga. The doctor recruited labourers on six monthly contracts for the ALC through his own labour bureau. The first Tonga migrants were sent south as early as 1885. In March 1886, 30 male Tonga reportedly departed from Bandawe on the steamer, *The Ilala*, bound for the ALC's headquarters at Mandala in the Shire Highlands.¹¹⁰ By 1894, Laws estimated that

¹⁰⁸ J. McCracken, "Marginal Men": the Colonial Experience in Malawi,' *Journal of Southern African Studies*, 15, 4, 1989; E.C. Mandala, *Work and Control in a Peasant Economy: A History of the Lower Tchiri Valley in Malawi 1859-1960* (Wisconsin, 1990), pp.108-118.

¹⁰⁹ McCracken, *Politics and Christianity*, pp.106-119.

¹¹⁰ Bandawe Mission Station Journal. March 16 1886, MS. 7911. National Library of Scotland (hereafter N.L.S.)

1,400 Tonga were in the ALC's employment with another 4,000 under that of the settlers of the Shire Highlands.¹¹¹

Labour migrancy provided an opportunity for the northern Ngoni to update and adapt an economy, which, following the end of raiding and the rinderpest epidemic of 1892, was in a state of collapse. Elmslie, of the Livingstonia Mission, described the new situation facing the Ngoni. He noted that before "the cattle plague the herds were numerous and large, but now there are only tens where before there were hundreds. The cessation of war raids also accounts to some extent for the decrease in the number of cattle owned, as cattle-lifting was a constant occupation in the dry season."¹¹² The Chewa and Ngoni of Central Malawi also began to seek employment on the plantations of the Shire Highlands from the early 1890's.¹¹³ By contrast, the Ngonde in the far north of the territory recovered more rapidly from the impact of rinderpest and successfully established themselves as cash crop producers.

As the export economy evolved from trading in ivory and slaves to cash crops, the recruitment of African labour was frequently underscored with violence. Following the defeat of Gomani's Maseko Ngoni in 1895, labour recruiters armed with guns invaded the region and brutally press-ganged labour.¹¹⁴

Immigrants from Portuguese East Africa, popularly known as 'Nguru', began to immigrate into the Southern Province of Malawi from around 1895. The first

¹¹¹ McCracken, *Politics and Christianity*, p.116.

¹¹² W.A. Elmslie, *Among the Wild Ngoni* (Edinburgh 1899, reprinted 1970), p.50.

¹¹³ F.E. Sanderson, 'The Development of Labour', *Journal of African History*, 11,2, 1961.

¹¹⁴ McCracken, "Marginal Men", *Journal of African Studies*, 15,4, 1989, pp.548-549.

reports of Nguru working for Europeans in the Shire Highlands occurred around 1892.¹¹⁵ By 1899, the immigration of these people was accelerated by a Portuguese expedition against Mataka and certain numbers of his sub-chiefs. The forced labour system subsequently imposed by chartered companies in Mozambique contributed to the continual immigration of Nguru into Nyasaland, such that by the first twenty years of the century, there were approximately 100,000 Nguru settlers in the Southern Province.¹¹⁶

The numbers of Nguru who originally settled in the Southern Province were too small to address the labour requirements of the plantations. Nevertheless, it is suggested that the rise in the estimates of African population levels between 1905-1906 and 1907-1908 resulted from the immigration of Nguru who were principally employed in agriculture and transport.¹¹⁷ Galligan, however, contends that the Nguru's contribution towards the labour requirements of the Protectorate was unrecognised by planters and other officials who were campaigning against the recruitment of Malawians for the South African and Rhodesian mines.¹¹⁸

The influx of the Nguru added to the growing problem of land congestion in the Shire Highlands, where significant amounts of land had been alienated by European settlers. Other areas that were not farmed by African cash croppers became crown estates. Such estates were intended to accommodate the populations who dispersed

¹¹⁵ T. Galligan, 'The Nguru Penetration into Nyasaland 1892-1914', in R. J. MacDonald, *From Nyasaland to Malawi: Studies in Colonial History* (Nairobi, 1975), p.108-109. Galligan notes that the terms; 'Nguru', 'Lomwe' or 'Makua' were used interchangeably.

¹¹⁶ Galligan in MacDonald, *From Nyasaland to Malawi*, pp.113, 115; W. C. Chirwa, 'Alomwe and Mozambican Immigrant Labour in Colonial Malawi, 1890's -1945', *The International Journal of African Historical Studies*, 27, 3, 1994, pp.525-550

¹¹⁷ Galligan in MacDonald, *From Nyasaland to Malawi*, pp.112-114; White, *Magomero*, pp.87-90.

¹¹⁸ Galligan, in MacDonald, *From Nyasaland to Malawi*, pp.118-120.

gradually from hill stockades on the ending of the slave trade and inter-tribal violence on the commencement of Protectorate rule. In the first half of the twentieth century, as the African population multiplied, the pressure for land on the overcrowded crown estates intensified.¹¹⁹

Nguru immigrants were initially invited to settle on their employer's estates on condition that they provided a defined amount of labour in return. This arrangement was open to abuse. Moreover, the Native Tenant's (Agreement) Ordinance of 1914, which forced Africans who had defaulted on their labour contracts to vacate the land, exacerbated the growing sense of vulnerability and unease amongst the Nguru.

Despite access to Nguru labour, European commercial agents continued to bemoan the lack of workers for their enterprises. By 1912, the settlers' principal newspaper estimated that the Protectorate was short of 179,000 labourers, although the Administration placed this figure at 107,000.¹²⁰ The growing movement of African labour out of the Protectorate, whether actively recruited by special agents or independently volunteered, caused deep concern. By 1910, it was estimated that 20,000 Nyasaland workers were occupied in Rhodesia alone, whilst by 1913, around 25,000 labourers were thought to be employed outwith the Protectorate.¹²¹ Labourers who remained in Malawi were not only paid lower amounts than they could earn abroad, but frequently faced uncomfortable and inhumane conditions in the various labour encampments of the Southern Province. Confronted with a dearth of labourers, European commercial agents were forced to identify reasons for

¹¹⁹ Vaughan, *The Story of an African Famine*, pp.50-76

¹²⁰ Galligan, in MacDonald, *From Nyasaland to Malawi*, p.118.

¹²¹ Linden, *Catholics, Peasants and Chewa Resistance*, p.74.

their failure to recruit. Conditions of labour could not be overlooked. In 1898, a relatively liberal correspondent to the settlers' newspaper noted:

As one witnesses working on plantations and conveying loads along roads, the skeleton specimens (sic) of black humanity, it cannot but bring saddening reflections if possessed at all with feelings of common justice. Employers of labour ought not to throw aside the care for the physical condition of their men, if they are not moved by the higher dictates of human sympathy and responsibility.... Surely we will not let ourselves drift into that shocking indifference which has so blasted all the efforts of continental nations to colonise, and thus drive our labour supply into a useless, idle good-for-nothing community, but quit ourselves like men and Christians who have ever fought for justice and humanity the world over.¹²²

By the end of the 1890's, settlers were involved in discussions with the Administration and members of the Blantyre Mission, who frequently acted as self-appointed advocates for the African labourer, to achieve improvements in the health of African migrant workers. However, whilst district collectors were advised to prevent sick or elderly men from becoming migrant workers, it was pointed out that other recommendations would raise the cost of labour prohibitively. A planter writing in the settlers' newspaper noted:

Supposing planters were to feed their natives and also to provide them with passages ... it would have the effect of practically doubling the wage of the labourer, doubling the cost of the production of coffee, or other work, and this at a time when prices in the coffee market are abnormally low.¹²³

By 1900, the human effects of labour recruitment and migration were publicly revealed when the company, Walker Bros. & Sinderam, was prosecuted for mistreating Anguru labourers recruited from Portuguese East Africa. It was accused of accommodating several thousand Africans in an unsanitary camp at Ndirande.

¹²² 'Humanity in Business' by A. C. Simpson, *Central African Times* (hereafter *C.A.T.*), July 2, 1898.

¹²³ *C.A.T.*, Nov. 11, 1899.

Many of its acutely ill labourers were treated by the medical staff of the Blantyre Mission Hospital.¹²⁴

The development of the railway system placed additional burdens on the labour reserves of the Protectorate. In the absence of a grant from the British Treasury, the building of the railway was a protracted affair. The line from Blantyre to Port Herald was constructed between 1903 and 1908. The line from Port Herald to Chindio, on the lower Zambesi, was not completed until 1915. The connection to the coast was not established before 1936.¹²⁵

The Shire Highlands Railway Company complained of severe shortages of African construction workers and even unsuccessfully approached Commissioner Sharpe for assistance in recruiting labour in 1903.¹²⁶ It was, however, well known within the Protectorate that the cash-starved company was forced to keep wages low, even by the Protectorate's standards. Furthermore, its labourers allegedly received inadequate food rations, despite the highly physical nature of the work involved. Africans were, therefore, unwilling to work on the railway at a time when the Oceana Cotton Growing Company at Chiromo had satisfactory levels of labour.¹²⁷ The railway company was thus forced to initiate improvements. By 1905, 9,000 men were employed by the company, a figure that would rise to 11,000 the following year. Furthermore, wages were increased to a highly competitive rate of

¹²⁴ C.A.T., July 14, 1900.

¹²⁵ L. Vail, 'The Making of an Imperial Slum: Nyasaland and its Railways, 1895-1935', *Journal of African History*, 16, 1975.

¹²⁶ C. A. Crosby, 'Railway Development in Malawi: The Early Years, 1895-1915', in MacDonald, *From Nyasaland to Malawi*, pp.131-132

¹²⁷ Crosby in MacDonald, *From Nyasaland to Malawi*, pp.131- 132.

six shillings per month.¹²⁸ However, living conditions on the company's labour camps remained poor and its African employees were offered little in the way of medical treatment.

Mission Medicine in the New Protectorate

Within the period under review, mission medicine remained the principal means by which Africans experienced western medical treatments. The Administration's medical service was primarily intended for Government officials and, therefore, its resources were limited. In 1897, there was only one Principal Medical Officer and two Medical Officers. An additional six doctors and seven nurses were appointed in 1901.¹²⁹ The medicine provided was essentially curative. However, the Administration doctors were also involved in smallpox vaccination campaigns and in detecting and controlling the various outbreaks of epidemic diseases, such as beriberi in 1904-1906, plague at Chinde in 1905 and sleeping sickness, which threatened continually throughout the first decade of the new century. These diseases were not only a risk to the workforce of the embryonic settler economy, but also to the survival of the European community. In addition to this, the Government's doctors were also active researchers in the field of tropical medicine. Hugh Stannus conducted research on pellagra, G.M. Sanderson surveyed filariasis along the Ruo River, whilst Eldred studied hookworm at Karonga, Fort Johnston and Zomba.¹³⁰

¹²⁸ Crosby in MacDonald, *From Nyasaland to Malawi*, p.132.

¹²⁹ C. Baker, *The Government Medical Service in Malawi: An Administrative History 1891-1974*, Malawi National Archives, pp.296-301.

¹³⁰ M. and E. King, *The Story of Medicine and Disease in Malawi* (Blantyre, 1992), pp.103-113; Gelfand, *Lakeside Pioneers*, pp.269-288.

Mission medical departments evolved at a time when the country as a whole was in a state of rapid adaptation and modernisation. The establishment and development of mission medical services can be seen to have responded to and facilitated these conditions of change. The Blantyre Mission was confronted with the acute health care needs of the labourers on the plantations, carrying firms and the railway construction programme. By contrast, in their more northerly position, Livingstonia and the UMCA had little direct contact with the European employers of African labour but witnessed the ill health suffered by Africans in consequence of their participation in the migrant labour system. This thesis will analyse and contrast the development of medicine within each individual mission and the manner in which it responded to the health needs of the changing Protectorate.

CHAPTER 2

MISSION MEDICAL WORK: 1875-1900

The Advance of Medical Missionaries Within British Missions.

The concept of the medical missionary, a qualified doctor and missionary, evolved gradually within mission circles throughout Britain in the nineteenth century. Prior to 1850, the formal evangelising role of medicine within missions was generally discounted. There were various reasons for this. Despite the advance of medical education, spearheaded by Scottish universities during the eighteenth century, the practice of medicine, based on humoral theories of physiology, remained largely ineffective.¹³¹ By the end of the nineteenth century, the provision of basic palliative care was replaced by the application of biomedicine. However, in the early nineteenth century, missionary medicine consisted largely of dressing wounds, treating boils and pulling teeth.¹³²

In addition to this, there was also a philosophy maintained within Protestant evangelism, which dictated that the missionary's ultimate focus was the saving of the soul, which would be otherwise damned should the individual die in a state of heathenism. In consequence, it was considered that the provision of medical treatments to indigenous people simply diverted attention from the mission's overriding evangelical intention.¹³³ The early provision of medicine within the missionary field was, therefore, performed by the ordained man, who, equipped

¹³¹ D. Hamilton, 'The Scottish Enlightenment and Clinical Medicine', in D. A. Dow (ed.), *The Influence of Scottish Medicine: An Historical Assessment of its International Impact* (London, 1988), pp.105-111.

¹³² J. and J. Comaroff, *Of Revelation and Revolution*, Vol. 2 (Chicago, 1997), pp.323-364.

¹³³ Williams, 'Healing and Evangelism', in Sheils (ed.), *The Church and Healing*, pp.271- 272; A. Ross, 'The Scottish Missionary Doctor', in Dow (ed.), *The Influence of Scottish Medicine*, pp.89- 90.

with a bag of remedies intended for his personal use, distributed what he had to the sick he encountered on his missionary travels. Hastings has contended that this early medical missionary work was provided in an almost accidental fashion to Africans and was motivated out of humanitarian rather than evangelical concerns. He suggests that the:

amount of medical work performed by the average nineteenth-century missionary was very much more considerable than we tend to imagine, but it was almost always unplanned and had no close connection with conversion. It was a response to human need, often to emergencies, and was pressed on missionaries by Africa rather than deliberately pursued.¹³⁴

From the 1850's, a growing appreciation of the role of qualified medical provision within missions was increasingly perceptible. This coincided with significant practical advances in scientific medicine. These included the development of anaesthesia in the 1840's and the promotion of germ theories through discoveries made by Lister, Jenner, Pasteur and Koch. These innovations augmented significant advances made in human physiology and anatomy, including the discovery of the circulation of the blood and lymphatic systems, the organisation of the nervous system and the physiology of breathing and digestion.

The Medical Act of 1858 had raised the status of doctors within Britain. This statute created a register of qualified doctors who had undertaken specified educational and practical training, and granted the profession the power to remove from the register those deemed unsuitable. The Act, therefore, marginalized the medical practice of the unregistered. By the second half of the nineteenth century, as professional, regulated medical provision became standard, missionary societies

¹³⁴ A. Hastings, *The Church in Africa 1450-1950* (Oxford, 1994), p.276.

were increasingly expected to provide professional attendance for the health of their missionaries. Furthermore, many such calls for the employment of qualified, missionary doctors were actually made by evangelists in the field, who increasingly perceived the practice of medicine as an area of specified competence.¹³⁵

Theories of evangelisation and damnation of the heathen had also advanced by the second half of the nineteenth century. By that time it was increasingly appreciated that the practical relief of physical suffering more effectively cleared the mind and spirit for the receiving and understanding of the Bible.¹³⁶ The concept of missionary medicine, therefore, gradually emerged in holistic terms as the salvation and healing of the whole person, as opposed to the mere attendance on a singular physical malady.

Training institutions for medical missionaries, which promoted medical missionary work in foreign and home mission fields, were established from 1840.¹³⁷ The Edinburgh Medical Missionary Society (EMMS), founded in 1841, was amongst the first organisations in Britain to promote the distinct role of the medical missionary. It was open to students who were committed evangelical Protestants. The society aimed to collect and circulate information on the professional and evangelising potential of the medical missionary within the field. Initially, it offered financial assistance for medical students aspiring to missionary work, however by 1853, it also provided invaluable medical and evangelising training at its Missionary

¹³⁵ Williams in Sheils (ed.), *The Church and Healing*, pp.272-283; Comaroff, *Of Revelation and Revolution*, Vol. 2, pp.323-326.

¹³⁶ Medical Subnote, *Cape Maclear Journal*, MS.7908. N.L.S.

¹³⁷ Ross in Dow (ed.), *The Influence Of Scottish Medicine*, pp.89-95.

Dispensary and Hospital for the Irish Poor.¹³⁸ In the nineteenth century, the principal role of the EMMS and other similar societies, however, remained that of advancing awareness of the unique contribution of the medical missionary.

The Reverend Doctor John Lowe was appointed Superintendent of the Cowgate Dispensary and Medical Institution in 1871. He would also act as the society's secretary until his death in 1892. Lowe maintained that the role of medicine within mission was a direct extension of Christ's work on earth. He wrote:

In reading the New Testament, one cannot fail to be struck with the fact that Our Lord's personal ministry on earth, as well as that of His Apostles, was pre-eminently the work of the medical missionary.¹³⁹

Although emphasising the doctor's potential evangelical contribution within mission, Lowe also reinforced the importance of his medical qualifications and contended that new professionals should not be forced to undertake additional theological studies for ordination, as this would deprive them of necessary practical medical experience.¹⁴⁰ Lowe was in fact opposed to the ordination of medical missionaries as he considered that their clerical duties overwhelmed and marginalized their medical role. He wrote:

We know of several instances where, owing to the want of a due appreciation of this agency on the part of home committees, most accomplished missionary physicians have been sent out as ordained clerical agents, and have had, like other missionaries, pastoral and educational work assigned to them, and, consequently, their usefulness and influence as medical missionaries have been scarcely appreciable.¹⁴¹

¹³⁸ This was reopened in 1858 at the Cowgate in Edinburgh as The Edinburgh Medical Mission Dispensary and Training Institution.

¹³⁹ J.Lowe, *Medical Missions. Their Place and Power* (London, 1886), p.11.

¹⁴⁰ Lowe, *Medical Missions*, p.29.

¹⁴¹ Lowe *Medical Missions*, p.35.

Lowe also condemned the practice of unqualified medicine within missions along with the medical practice of the semi-qualified, suggesting that the limited skills of the amateur physician would ultimately inhibit the development of missionary medicine.¹⁴²

By the second half of the nineteenth century the career of David Livingstone not only influenced the medical ambitions of aspiring missionaries throughout Britain, but also of medical missionary societies, including the EMMS. Prior to the mid-century and the publicity surrounding Livingstone's travels, the concept of the medical missionary was relatively unknown.¹⁴³ Indeed, Livingstone himself had only been made aware of the work of medical missionaries through the activities of Karl Gutzlaff of the Netherlands Missionary Society in the 1830's.¹⁴⁴

Livingstone's work in Central Africa appeared to exemplify all that, in accordance with the EMMS' definition of the term, the medical missionary should represent. He practised as a scientifically trained doctor and was committed to scientific research, having provided detailed studies of the fauna and geology of the tropics. Furthermore, his observations of the aetiology and treatment of malaria culminated in the formulation of his 'rouser' remedy, which was composed of quinine and purgatives. Before the discoveries made in the aetiology of malaria at the end of the century, such pharmaceutical formulations significantly assisted European penetration of tropical regions. Livingstone's recommendation for the introduction of both Christianity and commerce into Africa, as a means of ending the slave trade,

¹⁴² Lowe, *Medical Missions*, p.186.

¹⁴³ J. Wilkinson, *The Coogate Doctors. A History of the Edinburgh Medical Missionary Society 1841-1991* (Edinburgh, 1991), pp.7-8.

¹⁴⁴ T. Jeal, *Livingstone* (London, 1973), p.14. For an assessment of Livingstone's medical work see: Gelfand, *Livingstone the Doctor*.

had a powerful influence upon missions. The role of medicine in healing the body, soul and community was, through Livingstone's example, increasingly perceived as a fundamental and essential component of missionary endeavour. The EMMS, in respect of Livingstone's achievements, named its medical facilities at the Cowgate of Edinburgh, the Livingstone Medical Missionary Training Institution, in 1877 following his death.

The work of the EMMS may have influenced other societies with similar objectives. For example, the Guild of S. Luke, which was closely associated with the Anglican Church, aimed to counterbalance the progressive scientific basis of modern medicine with religion.¹⁴⁵ By 1897, this society even considered establishing a residential college for medical students aspiring to missionary work under the Church of England.¹⁴⁶

The Anglican Church also supported the Guild of S. Barnabas, which, founded in 1876, was open to all trained nurses of good character who were communicants within the Church of England. This fellowship of nurses aimed to achieve a common unity between Anglican nurses through its journal the, *Misericordia*, and monthly meetings. More specifically, it endeavoured to affect a sense of spirituality in the nurse's busy day through its 'Guild Rule of Life', which instructed nurses to practice self-examination in addition to their daily private prayers.¹⁴⁷ The Guild of S. Barnabas ultimately provided considerable degrees of recognition and support for missionary nurses within the UMCA.

¹⁴⁵ *British Medical Journal*, 11, July-Dec. 1896, p.1253.

¹⁴⁶ *British Medical Journal*, 11, July-Dec. 1897.

¹⁴⁷ E.F. Russell, *Lest We Grow Hard. Addresses and Prayers on Spiritual Subjects in the Service of the Guild of S. Barnabas for Nurses* (London, 1913), p.191.

By 1904, in response to the promotion of the role of the medical missionary across the various religious denominations, it was observed that the Church Missionary Society had 63 medical missionaries in its employ who each held British degrees or diplomas. The Free Church of Scotland had 58, the London Missionary Society had 35, the Church of Scotland had 21, the English Presbyterian Church had 20, whilst the Society for the Propagation of the Gospel had 15.¹⁴⁸

Development of Medicine Within the UMCA, Blantyre and Livingstonia Missions

The three missions under review each maintained differing philosophies on the importance of qualified medical provision in the field during their pioneering years. Whilst Blantyre and Livingstonia both appeared to value professional medical attendance on their European employees, only Livingstonia, from the first instance, emphasised the distinct evangelising role of the missionary doctor. By contrast, the UMCA did not regard organised western health provision as essential for either its own staff or for the Africans to whom they ministered.

The UMCA

The mission, which was originally known as, The Oxford and Cambridge Mission to Central Africa, and from 1865, as the Universities' Mission to Central Africa, was High Anglican, having descended from the Oxford Movement of the Church of England. This Anglo-Catholic Movement aimed to reassert the apostolic descent through Episcopal control of the church. Moreover, as a counter to the socio/political image of the clergyman who, with the squire, were perceived as the

¹⁴⁸ *The Church Missionary Record of the United Free Church of Scotland*, Feb. 1904, p.74.

twin sources of temporal authority in rural communities, the Movement instead emphasised the spiritual and vocational aspect of the priestly role.¹⁴⁹ The UMCA was governed by a clerical elite, composed of a bishop, clergy and deacons. The bishop maintained ultimate and supreme authority over all aspects of the mission with the Foreign Mission Committee (FMC) in England acting in a supportive capacity. In dressing differently from lay members, with their adoption of cassocks and stiff collars, the clergy established an aloofness and spiritual isolation from lay missionaries, whilst the practising of ritualistic worship further affirmed the clerical control of the mission. A traveller to Likoma Island described a religious service organised by the UMCA in the early 1890's:

The church is floored with mats, on which the natives squat, prostrating themselves one by one as they come in. A few benches are placed near the altar for the white portion of the audience and for the native choir, who are surpliced in white and cassocked in purple. These enter at the commencement of the service in procession, headed by a large brass cross; the priests bring up the rear, crossing and bowing themselves in front of the altar before taking their places. The service is principally choral.¹⁵⁰

In keeping with their sense of vocation, the clerical members of the UMCA practised celibacy. However, they also expected their lay members to demonstrate a similar sense of missionary calling by living a celibate life under conditions of strict discipline and poverty, which was almost akin to conditions within a religious order. Andrew Porter has observed that the practise of confession and penance promoted within the UMCA fostered adherence to the communal goals of its religious and spiritual philosophies.¹⁵¹ This was demonstrated by Madan, a lay

¹⁴⁹ Yates, *The Oxford Movement*.

¹⁵⁰ J. Johnston, *Reality Versus Romance in South Central Africa* (London, 1893), p.322.

¹⁵¹ A. Porter, 'The Universities' Mission to Central Africa: Anglo-Catholicism and the Colonial Encounter in the Twentieth Century', paper presented to Conference: Missions, Nationalism and the End of Empire, Cambridge, Sept. 2000, pp.10-12

worker within the mission, who described the spirit of communal living within the UMCA as being “organized in such a way that each may tell in its fullest force for the benefit of all the members of one family scattered indeed over hundreds of miles of country, but (under the paternal authority of the Bishop) one family still.”¹⁵²

In 1885, the terms and conditions of employment within the mission were stated as follows:

The Bishop is quite unable to offer any inducements in the way of salary or periodical holiday, ultimate pension, or temporal advantage of any kind; it is necessary that those who join the mission should do so with the single desire to live for, and willingness, if it be so, to die in, their work, because it is Christ's.¹⁵³

Missionary recruits were people from middle-class backgrounds who could afford to self-fund, or who had wealthy benefactors willing to support their missionary endeavours. This was in contrast to the Livingstonia and Blantyre Missions in which all staff were remunerated. Expenses were paid out to UMCA missionaries only on request, with the mission's culture of self-denial limiting the withdrawals made on this fund. The mission's journal enthused in 1893: “A pleasing item in the accounts is the amount of £440 paid for allowances to members of the staff, which would have been £1360 if all had drawn the full amount to which they were entitled.”¹⁵⁴

The work of the mission was governed by an overriding philosophy divergent from that of the industrial mission advocated by Livingstone and followed, in varying degrees, by the Livingstonia and Blantyre Missions. Indeed, the UMCA's

¹⁵² A. C. Madan, *Lay Work in Foreign Missions*, UMCA (London, 1902), p.3.

¹⁵³ *Central Africa*, Jan. 1885.

¹⁵⁴ *Central Africa*, April, 1893.

underpinning philosophy of mission, which aimed to Christianise Africans within an uncontaminated African environment, presented itself almost as a counter-reaction to the excesses of Victorian capitalism and industry. Bishop Smythies described the UMCA's missionary goals in 1882:

Our desire is to distinguish very clearly between Christianising and Europeanising. It is not our wish to make the Africans bad caricatures of the Englishmen. What we want is to Christianise them in their own civil and political conditions; to help them to develop a Christian civilisation, suited to their own climate and to their own circumstances.¹⁵⁵

Mission staff were therefore encouraged to reject contemporary comforts and live in the most basic of conditions, such as in grass and bamboo huts, which ultimately proved a severe hazard to their health. Furthermore, chronic understaffing of the mission often resulted in the physical exhaustion of staff attempting to supervise and evangelise over massive geographical distances. As a result, the death rate of UMCA members was unacceptably high until the late 1890's. For example, between 1892 and 1898, there were 12 deaths amongst UMCA missionaries.¹⁵⁶ Statistics of how many employees there were within the Nyasaland Diocese at any one time are inconclusive; however, in 1898 there were less than ten European missionaries in the field.¹⁵⁷ *The Nyasaland Diocesan Quarterly Paper*, listed the deaths and invalidings of its missionaries in the pioneering years. It observed: "Between 1887 and 1903 there were 22 deaths and 22 invalidings in a staff varying from 12 to 35."¹⁵⁸ By contrast, between 1876 and 1899 there were 11 deaths out of 50 Blantyre staff and their families, including the child of Henry and Mrs

¹⁵⁵ *Central African*, Nov. 1892.

¹⁵⁶ R. Howard, *Five Years' Medical Work on Lake Nyasa* (UMCA, 1904), p.65.

¹⁵⁷ *Central African*, Oct. 1898.

¹⁵⁸ *Nyasaland Diocesan Quarterly Paper*, Oct. 1909, p.618.

Henderson.¹⁵⁹ At Livingstonia there were 19 deaths between 1877 and 1899 out of 70 missionaries and their families.¹⁶⁰

Despite this, heroic feats amongst the staff were celebrated within the UMCA as examples of almost saintly self-mortification. The biography of Bishop Smythies displays these sentiments. An itinerating journey was described:

A waterproof sheet, a blanket, two tins of biscuits, two of milk, one packet of tea, and one of candles – such was the Bishop's outfit – Those who know African travelling will understand what such a journey must have been and what privations the little company must have suffered. Sleeping on the ground often, and having, towards the end, nothing at all to eat except wild bananas, he toiled up and down mountainous country, apparently oblivious to discomforts.¹⁶¹

In relation to other missions, it was unusual that the UMCA did not develop adequate medical provision even for its own European personnel until 1899. It is possible that the mission's neglect of the medical needs of its own staff was simply an extension of the inherent culture within the mission of self-denial and asceticism. Furthermore, the lack of qualified western health care for its African subjects was in keeping with its non-Europeanising philosophy. The activities of research-driven doctors who aimed to tame the wild tropical environment would, after all, only facilitate further European settlement within the region and the distortion of the 'untouched' African. The provision of medicine within the UMCA therefore remained at the level of the missionary simply sharing what remedies and amateur

¹⁵⁹ R.M.W. Shepherd, *A South African Medical Pioneer. The Life of Neil Macvicar* (Lovedale, 1952), p.30; T. Price, 'History of the Blantyre Mission, 1876-1956', unpublished manuscript, Acc.9069, N.L.S. Price notes that no formal list of all the Blantyre Missionaries has survived, his own records being pieced together from various sources.

¹⁶⁰ Jack, *Daybreak in Livingstonia*, pp.357-359.

¹⁶¹ E.F. Russell (ed.), *The Life of Charles Alan Smythies. Bishop of the Universities Mission to Central Africa* (London, 1898), p.202.

knowledge of medicine were in his possession. For example, in 1894, Arthur Sim, a young minister of the UMCA described his medical practice:

I wish you could see some of my patients; they have the most awful sores I can possibly imagine. Poor things, it is little I can do for them except to make them wash them in carbolic acid and water. If ever I return to England I should like, above all things, to go through a medical course.¹⁶²

Throughout the second half of the nineteenth century, the UMCA had instead prioritised the role of education within the mission and, in line with this policy, had favoured the recruitment of clerical staff within its pioneering parties over and above the employment of qualified physicians. Indeed, although a doctor, John Dickinson, a graduate of the University of Durham, had served on the UMCA's first mission to the region between 1861 and 1863, he was the only doctor amongst five priests, a deacon and a lay superintendent. By 1885, and the UMCA's return to the lake, clerical dominance over medicine had become more entrenched. The pioneering party which followed in the footsteps of Rev. W.P. Johnson to the lake was composed of Bishop Smythies, who was permanently based at Zanzibar, Rev. George Swinny, Rev. L.H. Frere, William Bellingham, a lay worker, George Sheriff, a trawler man who headed the crew of the mission's steamer and Charles Alley, a carpenter.

Whilst the Livingstonia and Blantyre Missions had recruited doctors for their pioneering parties, the first doctor in the Nyasaland Diocese, John. E. Hine, did not join the mission until January 1889. Hine had trained as both a doctor and a priest, and had served as a resident medical officer at the Radcliffe Infirmary in the early

¹⁶² Sim to Miss C, Oct. 11, 1894, in A.F. Sim, *The Life and Letters of Arthur Fraser Sim*, 3rd Ed. (London, 1901 first published 1896), p137.

1880's. However, he was quickly affected by the climate and invalided back to England by 1891. Dr Robinson, formerly of Guy's Hospital, did not take over the medical work of the diocese until 1893 and was also invalided home within a year, his small dispensary falling into disrepair. When Hine returned to the district, he undertook pioneering work at Unangu, high in the hills among the Yao, leaving no medical cover for those at the lake. His consecration as Bishop of Nyasaland in 1896 merely formalised the mission's need for a practising doctor.

The UMCA struggled to attract qualified doctors to its mission services. The mission addressed this issue in its journal in 1894. It noted:

Of Medical Missionaries holding British degrees, 27 are working in the C.M.S., 7 under S.P.G., 4 with U.M.C.A., and 1 Church of England Zenana Society. These contrast very feebly with the bodies outside our Church – Presbyterian Churches of Scotland, 48., English Presbyterians, 13., London Missionary Society, 18: other English non conformist societies, 60. Why is this great discrepancy? Why do not more members of the profession, sons of the Church, aspire to this honour?¹⁶³

Gelfand suggests that, unlike the Blantyre and Livingstonia Missions, the UMCA's failure to recruit doctors for its mission was a consequence of there being few medical families amongst its supporters.¹⁶⁴ It is also possible that medical courses within Oxford and Cambridge, the two universities from which the UMCA drew the majority of its graduates, were poorly subscribed in comparison to courses in the arts and theology. An in-depth analysis of the low numbers of qualified doctors in the employment of the Church of England is, however, beyond the parameters of this thesis.

¹⁶³ *Central Africa*, March 1894.

¹⁶⁴ Gelfand, *Lakeside Pioneers*, p.6.

Despite its apparent difficulties in recruiting doctors to its service, the mission continually demonstrated a fundamental lack of appreciation of the work of qualified medical missionaries amongst both Europeans and Africans. Indeed, in 1904, when the only doctor within the mission's vast diocese was about to go off on furlough, the offer of a temporary mission doctor to cover for this absence was rejected by the bishop who preferred to utilise the skills of the doctors of the Livingstonia Mission and of the Administration in the event of a medical emergency.¹⁶⁵

The UMCA, however, readily recruited nurses, its first being Miss Sophia McLaughlin, formerly a matron of Warneford Hospital, Leamington, who was employed in 1888. Despite limited in-patient facilities across the three missions between 1888 and 1895, whilst the Blantyre and Livingstonia Missions had yet to employ their first nurse, the UMCA had recruited four nursing sisters. These included, Nurses Turner and Whitbread who arrived in the diocese between 1890-1892, and Nurse Rees, who was recruited during 1895.

In comparison to the difficulties experienced by the Church of England in attracting qualified doctors to the mission field, the ease with which the UMCA appeared to recruit nurses was possibly a reflection of contemporary social trends, whereby mission services provided an alternative and exciting career for the Victorian spinster outwith the usual realms of teaching or acting as a governess.¹⁶⁶ It might also be suggested that the role of nurses, in providing palliative medical

¹⁶⁵ Trower to Travers, Dec. 29 1904, UMCA Papers A1XV, Rhodes House Library (hereafter R.H.L.).

¹⁶⁶ See chapter 4.

treatments, was more in keeping with the UMCA's non-interventionist philosophy than the more pro-active approach of the medical profession.

Up until 1899 and the arrival of Dr Howard, the demand for medical assistance was greatly felt amongst missionaries. This was exacerbated in 1898 when the mission was temporarily without any nurses, all having been invalidated home or otherwise forced to leave. The mission's staff were therefore required to transport patients to the Livingstonia mission for attendance by Dr Laws and, where this was impossible, were forced to nurse their seriously ill colleagues unassisted. The account of the death of Rev. P.E. Faulkner in the care of a minister and a layman demonstrates this pattern.

3 days after Black Water set in Rev. W.W. Austen & myself were puzzling our Brains what we should do when this great difficulty came face to face with us. We tried our best to keep it from him, shut all the windows & kept the place in darkness so that he should not see what had happened. It was of no use he wanted to know...Poor chap, we could not get the Doctor or Bishop, there being no steamer in, our remedy was to, wait patiently! ¹⁶⁷

By the mid 1890's there was vocal criticism of the UMCA missionaries' ascetic lifestyle from, amongst others, Dr Laws of Livingstonia and notably, H.M Commissioner, Harry Johnston. The Commissioner made a number of recommendations to the mission's committee in 1896, such as advocating the building of brick houses and the relocation of the central station from Likoma, which was considered an unhealthy site. He further called for the missionaries to abandon their frugal lifestyles and to begin to eat well. His criticisms were more explicit in his book, *British Central Africa*, in which he wrote:

¹⁶⁷ Mathews to Viner, Dec. 8 1897, UMCA Papers, E1. R.H.L.

But it cannot be truthfully said that these missionaries keep a good table or care sufficiently for their creature comforts. Their houses are often of poor construction, untidy and unattractive: it is obvious that they are under no care of womankind... On his untidy bureau there will be at one and the same time the newest philosophical treatise from England and an ugly tin teapot of over-stewed tea.¹⁶⁸

Although such censure may be more revealing of the Commissioner's eccentric personality, it would appear that, in the case of the UMCA, his criticisms were not unfounded. Dr Wordsworth Poole of the Administration described Likoma in the mid 1890's as "a wretched crumble, ... The mission has been there about 15 years I believe & has about a year's work to shew in the way of buildings. There is no order or cleanliness - They have nearly sunk to the level of native in fact their huts are not much better than native ones".¹⁶⁹

Towards the end of 1895 there were further deaths within the UMCA including the accidental drowning of the newly consecrated bishop, Chauncy Maples, which precipitated further criticism of missionary self-neglect and recklessness. This gradually effected a change in the mission's culture and non-Europeanising policy, as was demonstrated in an article in *Central Africa* in 1896.

Who shall say this was wrong? if at least he can and cares to enter into the natives' way of looking at things and realises with what feelings they regard the strange white man at first. But those days have gone, and our race is now the governing power in those parts, and the natives *begin* to understand the European, how he lives, and perhaps how he can *not* live.¹⁷⁰

The mission's medical board, based in London, constructed a new health policy in 1894. This aimed to ensure the promotion of health for Europeans in tropical climates. By 1896, the Board had recommended the building of only stone houses

¹⁶⁸ Sir H.H. Johnston, *British Central Africa* (London, 1897), p.201.

¹⁶⁹ Wordsworth Poole to mother, Aug. 20 1896, 13/WPO/1/1. M.N.A.

¹⁷⁰ *Central Africa*, Oct. 1896.

for European personnel and the establishment of hospital facilities. The Board also initiated the process of medically examining all potential recruits as well as those returning from Africa, to gauge their physical suitability for work in difficult climatic conditions. The Board also instigated the collection of data on the health of missionaries. From this period onwards, staff and potential recruits could be refused passage to Africa on health grounds. Furthermore, from 1899, the Board also instigated a 'two years' rule' which stipulated that missionaries must take a furlough after their first two year period in the field rather than after three years, as previously. Scientific medicine was therefore beginning to exert some degree of influence over the UMCA and, indeed, its personnel, on occasions, experienced the full weight of its increasing authority. For example, Doctor Sandwith described his medical examination of a missionary who was home on furlough:

I saw today Miss Nixon Smith, who seems on the whole to have excellent health, but as she has practically lost all her back teeth she should see the dentist as soon as possible in order to have some curious stumps removed and then, after an interval, she should have artificial teeth, ... I have ventured to tell her that the Medical Board will certainly not sanction her return to Africa with her mouth in its present condition.¹⁷¹

The Medical Board's power to label a person 'sick' caused some prospective volunteers to the mission considerable distress. One woman, whose offer to work for the mission was refused on medical grounds, expressed her disbelief at the diagnosis and her powerlessness to have it reversed.

Would you please tell me what is the matter with me that I can't go. I am not at all a nervous person about my health & if you told me I had every complaint under the sun it wouldn't bother me at all...if I knew for certain I had any particular disease or weakness it would make it so much easier for

¹⁷¹ F.M. Sandwith to D. Travers, Nov. 8 1907, A3 UMCA Papers, R.H.L.

me because as things are now it seems so unreasonable to stop my going out when I feel quite well.¹⁷²

The Blantyre and Livingstonia Missions also utilised the services of medical men to ascertain suitability for employment within tropical climates. In 1903, the Church of Scotland's FMC invited Drs, Alex Bruce, Harry Ferguson and Angus McGillivray on to its Board as representatives of the medical profession;¹⁷³ for many years the Livingstonia Committee employed Dr Peden as its medical authority. Furthermore, in 1891, the Livingstonia Committee accepted the recommendations made by Thomas Binnie of the Home Committee and Dr Elmslie, who drafted instructions for the erection of healthier brick dwelling houses for European staff throughout the Livingstonia Mission.¹⁷⁴

By the time of Howard's recruitment, the need to enforce an effective health policy among the UMCA's mission staff was paramount. Educated at Trinity College Oxford, Howard arrived at the mission with the clear intention of bringing the recommendations of the Medical Board into effect. The need to control malaria and blackwater fever was of chief importance. Howard advanced preventative health measures throughout the mission, advocating the use of mosquito nets, the covering of the skin at night when mosquitoes were prevalent and the fumigation of houses.¹⁷⁵ He also attempted to utilise the contemporary discoveries made in the field of tropical medicine to the UMCA's general advantage. He systematically surveyed the site of each mission station, plotted all anopheles breeding grounds and, where relevant, initiated improvements through such measures as draining

¹⁷² Miss J. Blissard to Dr Sandwith, May 15, undated F9 UMCA Papers, R.H.L.

¹⁷³ McMurtrie to Norris, June 26 1903, MS7539. N.L.S.

¹⁷⁴ Jack, *Daybreak in Livingstonia*, p.283.

¹⁷⁵ Howard to Travers, Dec. 19 1900, B2 UMCA Papers, R.H.L.

swamps.¹⁷⁶ His proud announcement in 1903 that no deaths had taken place among mission staff since his arrival in the diocese demonstrates the importance he placed on reducing the death rate at the mission.¹⁷⁷

More importantly, Howard attempted to confront head-on the mission's culture of ascetism and self neglect which was considered to be so detrimental to health. He wrote:

From 1899 onwards it may be said that the old ascetic ideal had been definitely abandoned, and that a real attempt was being made to co-operate with the Medical Board and to recognize the need of precautions and obey the laws of hygiene.¹⁷⁸

Howard, therefore, strongly advocated the use of prophylactic quinine amongst mission staff for the prevention of malaria. However, he faced formidable resistance to such improvements from certain long established missionaries, including the saintly, W.P. Johnson, who were reluctant to support the gradual erosion of the mission's ascetic discipline.¹⁷⁹

Howard also attempted to place the mission's medical provision for Africans on a more organised footing. Within one year of his arrival he had completely renovated the hospitals for both English and African patients and the dispensary on Likoma Island.

¹⁷⁶ Howard, *Five Years' Medical Work on Lake Nyasa*, p.52.

¹⁷⁷ Howard, *Five Years' Medical Work on Lake Nyasa*, p.20. Also see Appendix 1 for UMCA health statistics for the period up until 1914.

¹⁷⁸ Howard, *Five Years' Medical Work on Lake Nyasa*, p.71.

¹⁷⁹ Howard to Browne, Nov.4, 1907, A3 UMCA Papers, R.H.L.; W.P. Johnson, 'On the Doctor's Report', *Nyasaland Diocesan Quarterly Paper*, 8 July 1905.

The Blantyre Mission

In contrast to the UMCA, the Church of Scotland's FMC recognised the essential requirement for a qualified physician for the health of its missionaries within the field. Dr Thomas Macklin served on the pioneering expedition and, in the absence of an ordained minister, provided temporary leadership. By 1881, the FMC appeared to appreciate the evangelical potential of missionary medicine when it instructed in its, *General instructions to the missionaries*:

Doctors remember that they are recognised by the Committee, and must consider themselves as missionaries; and that all they do must bear upon the conversion and edification of souls. The health of the people, the sanitary arrangements of the Mission, the instruction of the natives in the proper observance of the laws of health, and in the expediency of improving their dwellings and modes of life, must all be regarded as religious work. In advocating temperance, in discouraging obnoxious and debasing practices, they will most materially help on the good cause, and prove themselves what they are sent out to be – the associates of the Minister, and servant of the Lord.¹⁸⁰

Furthermore, in recognition of the educational qualifications of doctors, the *General instructions*, confirmed their leadership of the mission in the absence of an ordained minister.¹⁸¹

The Church of Scotland recruited highly qualified physicians for its Blantyre Mission, most of them from middle-class backgrounds and several from medical families. Macklin, a graduate of Glasgow University, was the son of a university professor. George Milne of Aberdeen University, who was employed by the mission between 1885 and 1888, was the grand nephew of Dr. Moir, a lecturer in anatomy at King's College, Aberdeen. Before entering the mission's services, Dr.

¹⁸⁰ *Church of Scotland East African Mission. General Instructions to the Missionaries*, July 13 1881, p.4, MS7606, N.L.S.

¹⁸¹ *Church of Scotland East African Mission. General Instructions*, 1881, p.3, MS7606, N.L.S.

Milne had proved a brilliant student, having gained a medal for pathology and first prize in the practice of medicine. He gained further medical experience in the year before departing for Blantyre on the Isle of Skye. Similarly, Dr. Peden, another graduate of Glasgow, who was employed by the mission between 1880 and 1884, had gained essential experience as house surgeon at Glasgow's Western Infirmary between 1879 and 1880.

It is interesting to note that both the Blantyre and Livingstonia Missions' concept of a medical professional was that of the white male. The Blantyre Mission did not recruit a female physician before 1920 and although Livingstonia employed two female doctors before 1914, they each struggled to achieve recognition for their professional contribution to the mission.¹⁸²

Blantyre and Livingstonia also rejected the medical services of black candidates. In 1885, the notable Dr. Lowe of the EMMS recommended a West Indian medical graduate to the Blantyre Mission. MacLagan of the Committee noted:

Dr. Lowe has just called on me to suggest for Blantyre a Dr. Scholes an African – quite black. His parents were slaves in the West Indies. He has graduated last August and has for three years been doing mission work in the Cowgate. Dr Lowe speaks very highly of him & his power of speaking. He is a Baptist – but anxious for Medical Mission work in connection with any society.¹⁸³

Scholes' application was rejected. MacLagan informed Dr. Lowe that "Dr Scott thinks the Dr you spoke about to me this morning would not do. Both he & Dr

¹⁸² See chapter 4.

¹⁸³ J. MacLagan to A. Scott, 2 Feb 1885, C.O.S. Papers, N.L.S. Reference supplied by J. McCracken.

Peden think he would not command the respect either from the European or Native population that his position should give.”¹⁸⁴

In 1881, the Livingstonia Mission rejected the candidacy of “a coloured medical missionary” from the USA. Although the records do not detail this applicant’s professional qualifications, the Sub Committee presumed that he was an unqualified assistant and minuted that “The Committee were not inclined to look favourably on the application having an ample supply of native assistants from Lovedale. It was agreed to consult Dr. Stewart.”¹⁸⁵

Despite the Blantyre Mission’s acceptance of the essential role of the missionary doctor, in theory at least, up until the mid 1880’s, non-ordained physicians, including Macklin, Peden and Milne, struggled to establish a well-defined role for themselves within the mission. Medical work, which was targeted specifically at African patients, was given far less priority than that of education, which permitted the use of more explicit conversion techniques such as the use of the Bible as a reading book. Non-ordained doctors, therefore, often found that there was not enough specialised medical work available to fully occupy their time. At risk of being considered superfluous to the mission’s requirements, they instead became actively involved in administration, building and educational work.¹⁸⁶ For example, Peden wrote in 1880: “in the absence of much medical work, I am taking a good

¹⁸⁴ MacLagan to Lowe, 2 Feb 1885, C.O.S. Papers, N.L.S. The subsequent career of Dr Theophilus Scholes is not without interest. After training in medicine in Edinburgh and London, Scholes worked in the Congo and Nigeria before returning to London in the late 1890’s. There he wrote three ‘far-sighted, critical studies of British imperialism and racism’, one of them about the experiences of a black medical student in Britain. Peter Fryer, *Staying Power: the History of Black People in Britain* (London, 1984), pp.438-9. Reference provided by J. McCracken.

¹⁸⁵ Minute Book of Sub Committee of Livingstonia Mission, 10 Jan 1881, MS7912, N.L.S.

¹⁸⁶ *The Church of Scotland Home and Foreign Missionary Record* (hereafter *H.F.M.R.*), May 1 1877. This provides example of Doctor Macklin’s non-medical undertakings.

deal of interest in the other secular work. I am beginning now to have a very good idea of native politics, having had to sit through not a few native *mirandus*.”¹⁸⁷

Following the departure from the mission in 1881 of the first ordained missionary, Duff MacDonald, the medical work received new impetus under the leadership of his successor, David Clement Scott, the son of an Edinburgh accountant. Scott brought a new focus and enthusiasm to the mission which enabled it to recover quickly from its years of weak and confused leadership. Scott and the remaining members of the pioneering party, assisted by a group of gifted Africans, including Joseph Bismarck, a teacher and land owner who had been brought up from the Mozambique Coast in the 1870's, implemented the FMC's instructions by ending the mission's magisterial control over the villages of runaway slaves that had gathered under the mission's protection. By paying compensation to chiefs who had claims to the slaves of these villages, and by refusing to accept any more runaways, Scott established firmer relations for the mission with its surrounding Yao neighbours.¹⁸⁸ However, although the headmen of these villages were encouraged to deal with individual instances of complaint, Scott conducted a larger *mlandu* with other headmen where settlement at village level could not be reached.

David.C. Scott maintained that the missionary's role was to impart both the Gospel and modern culture to African societies. He therefore focused his missionary efforts on scholarly and industrial education with such success that on his departure from

¹⁸⁷ H.F.M.R., May 2 1881. A *mlandu* or *mirandu* was a meeting for the discussion of a grievance or a claim. See chapter 3 for a description of Macklin's non-medical responsibilities.

¹⁸⁸ Ross, *Blantyre Mission*, pp.68-70.

Blantyre, in 1898, the mission could boast of a well-established primary school and apprenticeship system, a thriving printing press and a growing African Church.¹⁸⁹

Scott's natural enthusiasm for mission attracted many of his personal friends and relatives to Blantyre where they not only shared his ideological ideals, but also his middle-class background. Amongst this group, his brother Willie Scott, his brother-in-law, John Bowie and his old school friend, Henry Scott formed a core of doctors who concertedly delivered western medicine to the African sick. Dr. Neil Macvicar, a minister's son from Peebles, who joined the mission in 1896, was outwith this familial group, but quickly came to deeply admire Scott and his approach to mission.¹⁹⁰

These men shared a number of characteristics. Almost all studied medicine at Edinburgh University and some performed with high academic distinction. John Bowie, the son of the Secretary of the city's Philosophical Institution, won gold medals at Edinburgh for Physiology, Natural History and the Practice of Medicine and later undertook postgraduate studies in Vienna. He subsequently joined his brother-in-law in a lucrative London practice, only to give it up on his appointment to Blantyre.¹⁹¹ Neil Macvicar graduated with first-class honours in medicine and as "the best student in the year", according to his biographer.¹⁹² Willie Scott and his namesake, Henry Scott, also graduated in medicine from Edinburgh as well as gaining practical experience with the city's poor: Willie with the University Missionary Association; Henry with the Edinburgh Medical Missionary Society,

¹⁸⁹ Ross, *Blantyre Mission*, p.23.

¹⁹⁰ Ross, *Blantyre Mission*, pp.126-170.

¹⁹¹ Robertson, *The Martyrs of Blantyre*, pp.79-80.

¹⁹² R.H.W. Shepherd, *A South African Medical Pioneer* (Lovedale, 1952), pp.13-14.

where he received special training from Dr. John Lowe.¹⁹³ Dr. Samuel Norris, a fellow-student of Macvicar's, worked in a medical practice in Bristol before joining the mission in 1900.

These doctors often possessed a deep evangelical commitment, which underpinned their initial decision to become medical missionaries. Although questioning aspects of his faith, Neil Macvicar was described as giving "promise of being a true missionary."¹⁹⁴ Norris, Macvicar's successor at the Blantyre Mission, wrote of his desire to enter the mission's service. McMurtrie responded to his application to join the mission's service: "The African Sub-Committee were touched by your letter of 2nd July, saying that you would give yourself and your all to that one work until the end of your life."¹⁹⁵

The FMC of the Blantyre Mission did not demand the ordination of its medical missionaries. Among them, only Willie and Henry Scott were ordained, Willie by special licence, as he did not complete his university training in Divinity. However, in the recruitment of doctors, the candidate's educational background, religious conviction and suitability to mission work were deemed to be of greater importance than medical skill. Although Macvicar was an excellent doctor who had performed brilliantly as a medical student, he was eventually dismissed from the mission, in

¹⁹³ Rankine, *Hero of the Dark Continent*, pp.36-55, 68-80, 165-7; *Church of Scotland Home and Foreign Missionary Record*, April 1890, p.389

¹⁹⁴ A. Scott to Hetherwick, 24 Oct. 1895, MS7535 N.L.S.

¹⁹⁵ McMurtrie to Norris, 31 Aug. 1899, MS 7535. N.L.S.

1901, ostensibly because of his misgivings on the Church's teachings on the Resurrection and the Trinity.¹⁹⁶

By the late 1880's, medical work at the Blantyre Mission was both evangelical and philanthropic in intention and, particularly through the activities of John Bowie, focused on a determined programme of expansion. By 1888, Bowie could describe a nascent medical service which incorporated a well attended dispensary and a rudimentary hospital for the treatment and nursing of more seriously ill patients. The March 1888 issue of the Blantyre Mission's journal related that 1,309 cases had been attended on at the dispensary whilst the hospital had treated five in-patients in the preceding month.¹⁹⁷ Willie and Henry Scott had joined the mission by 1890 and although clerical responsibilities dominated their working schedules, they did, in time, oversee the further development of medical facilities, including the initiation of medical work at Domasi under Willie Scott in 1889 and the establishment of a hospital at Zomba in 1903. In addition to this, Dr Robertson, a graduate of Glasgow who had gained medical experience with the EMMS, was recruited to the mission in 1891 and instigated dispensary work at Mulanje.

The mission's medical work, however, was not established on a full professional basis until the arrival of Neil Macvicar. On account of his previously described religious difficulties, Macvicar had been instructed by the FMC not to involve himself in evangelising and therefore was more focused on the mission's medical efforts. In 1896, he designed his own brick hospital, which, by African standards,

¹⁹⁶ Shepherd, *A South African Medical Pioneer*, pp.60-72; Ross, *Blantyre Mission*, pp.169-170. Ross suggests the clash with Hetherwick, the leader of the mission on Scott's departure, was the principal reason behind Macvicar's dismissal.

¹⁹⁷ *Life and Work*, March 1888.

was innovative and substantial.¹⁹⁸ He also initiated the formal training of African medical assistants far earlier than other missions, publishing in 1898 a comprehensive course of medical lectures which would enable the African assistant to perform basic medical work unsupervised. The course included instruction on such topics as, the skin, wound healing, chemistry and dysentery.¹⁹⁹ His first African dispensers qualified in 1898.

However, Macvicar was not the first mission doctor to train African medical assistants. The doctors of the Livingstonia Mission had for many years trained Africans on an individual basis to assist them in their medical work. As early as 1894, Dr Kerr Cross, from his base at Karonga, related how his assistants administered chloroform during operations.²⁰⁰ What is significant about Macvicar is that he was able to visualise, from as early as 1896, a comprehensive health service, largely managed by Africans for Africans. Furthermore, he acknowledged that the achievement of that ultimate goal was reliant upon the provision of medical education for Africans at a level that far surpassed his lecture course of 1898. He wrote of his ultimate ambitions:

Let us look forward to the time when the Blantyre Hospital will be the centre of a great system of stations manned by Native Christian dispensers who will send their serious cases to the centre for treatment and treat the smaller ones themselves. This system has worked magnificently in India. What is there to hinder its growth here? It would be a blessing of no mean sort to the natives of Central Africa.²⁰¹

¹⁹⁸ The architecture of mission hospitals will be discussed in greater detail in chapter 5.

¹⁹⁹ N. Macvicar, *Lectures to Hospital Assistants, Blantyre St. Luke's Hospital* (Blantyre, 1898).

²⁰⁰ Kerr Cross to Smith, Nov. 2 1894, MS7877, N.L.S.

²⁰¹ As quoted in R.W.H. Shepherd, *A South African Medical Pioneer* (1952), p.36.

The Livingstonia Mission

The Livingstonia Mission appreciated the evangelising role of medicine from its pioneering period. Dr Laws, the mission's first doctor, noted as early as 1876:

The good we have been able to do the bodies of the people, they can readily appreciate and they are thus the more ready, while at the station, to listen to the great truths we proclaim, and on returning to their villages they carry with them a good report of our transactions with those coming to us, and open up a way for our reception among them, when itinerating.²⁰²

Six medical missionaries were appointed to the mission between 1875 and 1883. The duration of their employment was short and the demands on them from construction and pioneering duties, militated against them undertaking concerted medical work. Laws was joined at Cape Maclear by Dr Black, a recent graduate of Glasgow University, who succumbed to fever in 1877. Furthermore, the arrival of James Stewart of Lovedale as head of the mission in 1876 did not advance medical work amongst Africans, as throughout his seventeen months' stay he was fully preoccupied, not only with the managerial issues of Livingstonia, but also with those of the Blantyre Mission following their appeals for assistance in the period prior to Duff MacDonald's arrival. Subsequent medical recruits, up until 1885, including Dr Jane Waterston, the first female doctor in Malawi, Robert Hannington and William Scott, either resigned or were invalided home after barely a year's mission service.

Livingstonia, in comparison to other missions, was highly unusual in its recruitment from the earliest days of a significant number of qualified doctors. Sixteen out of

²⁰² Medical sub note, Cape Maclear Journal, MS7908, N.L.S.

70 personnel employed by Livingstonia before 1900 were medically qualified compared to just 9 out of 362 agents recruited by the UMCA to both its Zanzibar and Nyasaland diocese. They included Drs, Dickinson of the pioneer Magomero Mission and Hine, Robertson and Howard, all of whom were employed within Nyasaland. Ten doctors were engaged by the Blantyre Mission in this period out of a total of 50 employees.²⁰³

Prior to 1900, certain of the Livingstonia missionaries had originated from working and lower middle class backgrounds. Many had, in part, financed their own education including Laws, the son of a carpenter and Steele, an orphan who had worked in a drapery establishment and his family's shoe shop whilst preparing for his university education.²⁰⁴ Up until 1894, the majority of Livingstonia's medical missionaries were educated primarily at Glasgow and Aberdeen Universities. In the nineteenth century, meeting the fees of the medical and theological courses in Scottish universities could be challenging for working-class students but was not unfeasible.²⁰⁵ A medical course may have appeared a more practical option for the self-made man in that on graduating, the student was a qualified doctor, fully equipped with both a ready means of earning a living and enhanced social status.

Many of these self-made men undertook concurrent medical and theology courses, having aspired to missionary work from the days of their youth. Many of the Livingstonia recruits had been personally influenced by the Moody and Sankey Mission, which strengthened Christian spirit among the main Protestant

²⁰³ D. Fraser, *Livingstonia* (Edinburgh, 1915), pp.86-87; McCracken, *Politics and Christianity*, p.181; Price, 'History of the Blantyre Mission'.

²⁰⁴ Elmslie, *Among the Wild Ngoni*, pp.254-259.

²⁰⁵ Jeal, *Livingstone*, p.15; H. Dingwall, *A History of Scottish Medicine* (Edinburgh, 2003).

denominations, and by Henry Drummond, Moody's Scottish lieutenant, who initiated a religious movement amongst Scottish students in 1884.²⁰⁶ However, even before 1900, not all of the doctors recruited to Livingstonia were cast in the mould of Livingstone and Robert Laws. William Black was the son of a teacher who originally studied architecture at St. Andrews University before commencing medical studies.²⁰⁷ Jane Waterston was the daughter of a bank manager. Others were the children of established ministers. For example, Frank Innes' father was the minister of Skene United Free Church, Aberdeen.²⁰⁸ This trend towards the employment of middle-class agents became more established from 1900 to 1914

The Livingstonia Committee favoured the recruitment of ordained medical missionaries. Between 1875 and 1899, the mission employed nine physicians who were already ordained ministers out of 16 medical missionaries. This was in comparison to the two ordained doctors employed by the Church of Scotland at Blantyre, with Hine being the only ordained doctor recruited by the UMCA to its Nyasaland Diocese. Despite the activities of societies such as the EMMS, it is possible that the businessmen who principally financed the Livingstonia Mission in the nineteenth century maintained the utilitarian view that a man with two skills was more cost efficient than a man with just one. Duff MacDonald of Blantyre expressed this viewpoint in 1899.

A purely medical man will have little of his proper work – almost nothing; in fact, his presence is only necessary for contingencies of which a non-medical man could not take the responsibility; and being deprived of his proper work, unless he is a very zealous man, he will take but a half-hearted interest in anything else, But a medical minister would be a host in himself. While useful in taking charge of the teaching and evangelising at

²⁰⁶ McCracken, *Politics and Christianity*, pp.159-161; Fraser, *Donald Fraser*, pp. 22-30.

²⁰⁷ Hokkanen, 'Doctors of Body, Soul and Society', p.30.

²⁰⁸ Livingstonia Mission Staff Book, p.17, Acc.7548, D73, N.L.S.

one station, he would give a feeling of safety at all our other stations; for a medical man's presence has always a great moral influence, especially here where attacks of fever have a great effect on the patient's nerves.²⁰⁹

Within the Livingstonia Mission, the placing of an ordained medical man at the headship of individual mission stations was perceived as reducing the cost of supplying each region with both a minister and a physician. The FMC thus actively encouraged its doctors to undertake ordination as a means of enhancing their usefulness to the mission. Dr. Elmslie, who joined the mission in 1884 was ordained in 1897. Dr. Prentice, who was recruited in 1894, was ordained in 1899.²¹⁰

From the late 1880's, medical missionaries took up residence at almost all of the main Livingstonia stations. One of the first to act was Walter Elmslie who took control of Ekwendeni in 1890, turning it by 1895 into the largest station in Ngoniland. David Kerr Cross, recruited in 1885, spent several years in itinerant exploration in the north before moving to the major station of Karonga. Meanwhile, in 1887, George Henry opened a station in the Livlezi Valley near the south end of Lake Nyasa, about 30 miles from the Maseko Ngoni capital. Ten years later, in 1897, George Prentice settled a group of Tonga teachers at Kasungu at the northern extension of the Lilongwe plain, though it was not until 1900 that he moved there permanently. Following Dr. Henry's death from blackwater fever in 1894, the station of Livlezi was transferred to the Dutch Reformed Church, thus permitting a greater concentration of work in the northern region. In that year the Overtoun Institution was opened at Khondowe. Thereafter, dispensary facilities were provided at all stations at which a medical missionary was based. Western medicine

²⁰⁹ *H.F.M.R.*, Nov. 1 1879. Again, confusion remains between missionaries as to medicine's evangelical role. MacDonald appears to only appreciate its purpose in cases of possible European emergency.

²¹⁰ The importance of this trend will be discussed in greater detail in chapter 3.

also began gradually to reach outlying villages through the agency of doctors who provided treatment to patients encountered on their itinerating journeys.

Hastings has suggested that Scottish missionaries were the most interested of all Protestant denominations in medical missionary work.²¹¹ However, despite the high number of doctors on its staff, in-patient accommodation at Livingstonia remained undeveloped and unplanned, thus reflecting the mission's focus on scholarly and industrial training. Shelter was 'found' for the critically ill as required. Steele's first in-patient at Njuju in Ngoniland was accommodated in the old cookhouse,²¹² at Bandawe in 1887, a woman suffering from large ulcers and pressure sores was sheltered in a room at the end of the stable.²¹³ In 1895, proposals were made for the conversion of the old cottage at Bandawe into a dispensary, with two smaller rooms provided for limited in-patient accommodation.²¹⁴ However, Dr. Boxer reported in 1901 that Bandawe had no hospital facilities.²¹⁵ The little hospital, established by Kerr Cross in 1895 at Karonga, was also reduced over time. In 1900, Dr. Innes, serving at Karonga, was forced to send home a man with a broken leg, carried on a door, which acted as a makeshift stretcher.²¹⁶

Between 1875 and 1900, medical provision across the three missions was frequently initiated in individual regions and then, due to changing staffing or other conditions, discontinued. By 1900, the UMCA's temporary hospital at Likoma could accommodate 6 male patients. The girls' dormitory had been renovated and could

²¹¹ Hastings, *The Church in Africa*, pp.276-277.

²¹² Steele to Laws, Jan. 21 1891, MS7895, N.L.S.

²¹³ Bandawe Mission Station Journal, May 10 1887, MS7911, N.L.S.

²¹⁴ Prentice to Smith, June 24 1895, MS7878, N.L.S.

²¹⁵ Annual Report. Livingstonia Mission, 1901, p.18.

²¹⁶ Dewar to Smith, Jan. 1 1900, MS7883, N.L.S.

house 3 female patients. Throughout 1899, 27 patients were attended on in the hospital whilst an average of 23 patients per day were treated at the dispensary.²¹⁷ At Nkhotakota, the dispensary, which was organised under Nurse Minter, attended on approximately 12 patients per day. Despite these efforts, medical personnel within the UMCA remained few in number. In 1899, the diocese had only one practising doctor, Howard, and one nurse. However, Bishop Hine did take charge of the dispensary at Likoma when Howard was absent from the island.

By 1899, the Blantyre central hospital could accommodate 20 beds in its male ward and 10 beds in its Bowie Ward for women and children. There was also separate provision for around six infectious cases.²¹⁸ In 1899, under the attendance of Macvicar and Nurse Farquhar, 236 in-patients were treated with approximately 40 patients per day catered for at the dispensary.²¹⁹ Moreover, medical assistants were active in dispensaries at Domasi, where David Mothela treated 1718 patients in 1899, Mlumbu, under John Gray Kufa, who treated 845 patients and at Pantumbi in Angoniland, where Harry Kambwiri was based. However, Henry Scott's furlough in 1899 curtailed medical provision at Domasi and Zomba.²²⁰

By 1899, despite having no purpose built in-patient facilities, the Livingstonia Mission had dispensaries throughout its vast missionary field. Between 1898 and 1899, 13,314 cases were treated at the dispensary at Livingstonia under the care of Elmslie, who was covering for Laws' furlough.²²¹ Out-patient facilities were also

²¹⁷ This is based on an average of dispensary figures obtained over five months within the year 1899. Dom 10/4/7.M.N.A.

²¹⁸ *Life and Work*, June 1899.

²¹⁹ *Life and Work*, Jan. 1900.

²²⁰ *Life and Work*, Jan. 1900.

²²¹ *Aurora*, Feb 1899.

available at Bandawe under Dr. Scott and later, Prentice, and at Karonga under Innes. By 1899, the mission had also employed two nurses, Margaret McCallum and Maria Jackson, who were based at Bandawe and Livingstonia respectively. In the absence of hospital facilities, these women became heavily involved in the mission's educational work.²²² However, in 1899, the mission council approved plans for the building of hospitals at Karonga and Bandawe in the following year.²²³

Mission Medical Work in the Pioneering Years.

Roy Porter has suggested that throughout the centuries, western clergymen promoted the view of sickness as a symbolic punishment for the sins of mankind and, to a lesser extent, for personal and moral inadequacies or weaknesses.²²⁴ Religion and medicine coexisted since such religious theories were easily superimposed on to contemporary humoral medical theories, which interpreted illness as an imbalance in one or a number of physical and emotional components which determined an individual's well being.

The enlightenment had endorsed the soul/body divide and science-based rationalism, within the western world. However, individual suffering and sickness continued to represent moral inadequacies and disorder within both the individual and the wider society. For example, sexual promiscuity could result in venereal disease and drunkenness in complaints of the liver. Such views of disease causation motivated home missionary movements which, in the nineteenth century, attempted

²²² McCallum to Smith, Aug. 9 1899, MS7882, N.L.S and Jackson to Smith, July 19 1899, MS7882, N.L.S.

²²³ Minutes of the Livingstonia Mission Council. Nov. 8 1899, MS7882, N.L.S.

²²⁴ R. Porter, 'Religion and Medicine', in Bynum and Porter (eds.), *Companion Encyclopedia of the History of Medicine*, pp.1450-1452.

to instigate moral regeneration amongst the urban poor. The moral and social decay effected by the slave trade was cited as a prime motivational factor for the missionary endeavours which sought to heal ‘sick Africa’.

The discovery of the germ, in the second half of the nineteenth century, advanced theories of biomedicine amongst medical missionaries. Despite this, moral theories of disease causation remained and formed a major component of mission medical discourse, which conceptualised a relationship, not only between the sick African and moral degeneration, but also between disease-ridden African society and heathenism. Indeed, Livingstone himself described Africa as the “open sore of the world.” Megan Vaughan has described in detail the nature of this medical missionary discourse, which advocated the healing of the body for the conversion of the soul. She observes:

Each sick person was a potential convert, each had a ‘soul’ as well as a body to be attended to, and the rituals of the missionary hospital reflected this. Healing, for medical missionaries, was part of a programme of social and moral engineering through which ‘Africa’ would be saved.²²⁵

Viewing the doctor’s work as an extension of that of Christ the Healer, the use of analogies between ‘darkness’ and ‘heathenism’ and ‘light’ and ‘Christianity’ would remain dominant themes within this medical discourse. Imperialistic theories of the superiority of Christianity and western medicine over indigenous religion and therapies also underpinned this discourse, which provided additional confirmation to British supporters of mission of medicine’s essential evangelising role.

²²⁵ Vaughan, *Curing Their Ills*, p.74.

Indigenous beliefs on disease aetiology were multifarious. Missionaries relayed how Africans believed in natural and magical causes of illness. The former were minor illnesses or misfortunes, which appeared to be in accordance with the laws of nature, such as a very old person dying. The herbalist, who possessed specialised knowledge of the healing properties of plants and roots, treated these conditions. A few of these medical men were also bone setters.²²⁶ Magic or supernaturally induced diseases were, by contrast, the more serious or unexpected maladies, which resulted from witchcraft, the ill feeling of an angered or jealous neighbour, or from the revenge of an angered spirit (an ancestor who had not received appropriate sacrificial tribute). These conditions required the skills of the sorcerer for the detection of the source of the misfortune.²²⁷

Similar to the ideologies underpinning the missionary medical discourse, indigenous societies also maintained a holistic, if more overt view of disease causation, which incorporated all aspects of a person's social, political and spiritual environment. Imbalances or unease generated by all or any of these components could result not only in sickness, but also in more general ill-fortune. Such views of disease aetiology acted as a powerful means of social control. For example, Fraser has documented how a difficult child birth was indicative of a woman's previous adultery, whilst adultery in general could result in a whole society being affected by epidemic disease.²²⁸ However, it must be remembered that the concept of disease in any society is constantly evolving in response to internal and external influences.

²²⁶ D. Fraser, *Winning a Primitive People* (London, 1914), pp.140-141.

²²⁷ Fraser, *Winning a Primitive People*, pp.142-147; Ranger, in Sheils (ed.), *The Church and Healing*, pp.333-365

²²⁸ Fraser, *Winning a Primitive People*, pp.144, 146; D. Kerr Cross, *The Nyasa News*, No.8, May 1895.

The *muavi* poison ordeal was used by sorcerers as confirmation of a suspected witch's identity. The vomiting of the poisonous drink established the accused's innocence whilst death was the deserved fate of the confirmed witch who did not vomit.²²⁹ Missionaries consistently denounced the negative effects which witchcraft and other traditional beliefs about disease causation were perceived to have upon traditional society. Chauncy Maples of the UMCA wrote:

The ramifications of witchcraft – trial by ordeal, and the like- run through the whole of the social life, such as it is, of these people, creating fear, and suspicion, and mistrust on all sides, breaking up families, severing friendships, and interfering, no one can tell how greatly, with the progress of civilisation and enlightenment.²³⁰

The potential role of western scientific medicine in overthrowing the practice of the witchdoctor was therefore portrayed as a formidable force in breaking down traditional resistance to Christian conversion. Mission societies portrayed their medical work in terms of freeing Africans from the fear generated by traditional views on disease causation. The external symbols of indigenous medicine, the charms and other treatments, were, as a matter of course, regarded as a threat to the penetration of western medicine. Mission healthcare personnel, therefore, insisted that potential patients remove these healing devices prior to receiving treatment with western therapies. More generally, missionary commentaries were disparaging of indigenous therapies. For example, Archdeacon Farler of Magila witnessed the administration of an indigenous treatment, which he subsequently described:

The woman sat with her baby in her arms on a mat, and was first anointed in dabs of a kind of red paint on her face, head, arms, body and legs, and the child as well, although it was not ill. Then he [the traditional healer] stood over her, and mystically waved his arms with downward motion as though

²²⁹ MacDonald, *Africana*, Vol.1, pp.204-205.

²³⁰ E. Maples (ed.), *Journals and Papers of Chauncy Maples* (London, 1899), p.172.

he were mesmerising her, muttering charms all the time ... finally, with a grand downward sweep from her head to her feet, he appeared to catch some invisible thing, which he threw away. He then told me that her illness was caused by a snake inside her, but that now by the power of his medicine he had got it out, and had thrown it away ... Upon my objecting that I had not seen any snake, he said – “No – it was an invisible one.”²³¹

In addition to this, certain of the Livingstonia missionaries, including Laws, were unsuccessful in their attempts to demonstrate to the Tonga that the *Muavi* poison ordeal was open to manipulation by the person administering the trial. On one such occasion at Bandawe, Laws attempted to practically demonstrate this point using two glasses of water, one with added strychnine, the other containing tart emetic.²³²

It must be emphasised that the interaction between traditional and western medicine throughout the pioneering phase of mission and beyond, continually presented difficulties for both the African patient and the European doctor in the interpretation and translation of language and culture. For example, an artisan who sentenced a mission subject to fourteen lashes noted:

The punishment was administered at 12.o.clock in presence of a large crowd...After being flogged I dressed their wounds. At this point some remarks came from those who were looking on to the effect that the English were a curious people they flog a man and then come with a kind hand and bind up his wounds.²³³

Doctors, however, demonstrated awareness of the potential difficulties in these early medical encounters and exhibited a willingness to take things slowly, apparently recognising that early medical failures could inhibit the uptake of western treatments. Robertson of the Blantyre Mission described his early medical practice at Mulanje.

²³¹ W.H. Penney, *Medical Work in East Central Africa*, (1887), F5 R.H.L.

²³² *Bandawe Mission Journal*, May 3 1883, MS7911, N.L.S.

²³³ *Kanangina and Bandawe Journal*, June 23 1879 MS7910, N.L.S.

As yet there has been no regular clinique; but every day there are a few turning up with ulcers, broken toes, bruises and neglected wounds, of one description or another. These do well under the Boracic treatment, and a little care...More complex cases, for want of a reliable interpreter have simply to be left alone, as one does not want to imperil future usefulness, by a wrong prescription.²³⁴

Up until the early 1890's, the uptake of missionary medicine largely depended upon word of mouth, which gradually advertised its successes to increasing numbers of people. The Blantyre Mission noted that: "At first those in and about the mission constituted the bulk of the patients. Now, however, we are having patients coming from a greater distance for treatment."²³⁵

In the pioneering years it was beneficial if a village chief consented to treatment as this often guaranteed his people following suit, although he would sometimes seek additional re-assurance. William Scott, a doctor at Bandawe between 1883 and 1885, observed how village chiefs would request the removal by the physician of some of their slaves' teeth in order that they could observe the operation before personally subjecting to it.²³⁶ In 1893, Dr. Robertson of the Blantyre Mission's Mulanje Station attended to the chief Mkanda. This was described in the missions journal:

Mkanda was found suffering from rheumatism, which hindered his walking about a good deal. I gave him some medicine which I had taken with me, and, after a few directions, asked him to take a doze; but he declined until I had taken one first, when he at once followed the example ... Immediately after this a lot of his people were sick, at least said they were, and of course had to get medicine too.²³⁷

²³⁴ *Life and Work*, April 1892. Language barriers and the problems they posed for patient care will be discussed in greater detail in Chapter 5.

²³⁵ *Life and Work*, March 1891.

²³⁶ Scott, 'Central African Experiences', *The Society of Malawi Journal*, 38, 2, 1985, p.8.

²³⁷ *Life and Work*, Jan. 1893.

As Africans increasingly accepted mission medicine, the view was advanced amongst missionaries that the healing of the body could indeed open the way to spiritual conversion and regeneration. For example, through his treatment of the chief's sick child, Elmslie of Livingstonia advanced the mission's cause amongst the Ngoni at Ekwendeni.²³⁸ However, the welcoming of western medicine did not necessarily guarantee internalisation of the Christian message. Therefore, whilst the Yao chief and slaver, Mponda, accepted the medicine provided by the Livingstonia missionaries, he consistently rebuffed all of their evangelising efforts.²³⁹

It was equally beneficial for the uptake of western medicine if a remarkable treatment could be observed by many. Shang-Jen Li has observed with reference to China how medical missionaries favoured eye surgery, which in many instances effected a dramatic restoration of vision that appeared almost miraculous.²⁴⁰ Steele performed cataract surgery in Ngoniland and wrote: "This I may say is the first operation of the kind done here, and now that one has submitted others will be sure to follow."²⁴¹ Berkeley Robertson, a qualified ophthalmologist, was recruited by the Livingstonia Mission in 1906.

Within the pioneering phase, the most dramatic of all medical treatments administered by missionaries was the effect of chloroform on the patient, a process made all the more spectacular if it was witnessed by many onlookers. The first

²³⁸ Steele to Smith, Aug. 15 1894, MS7877, N.L.S.

²³⁹ See chapter 1 for Mponda's history; Cape Maclear Journal, Nov. 6 1875, MS7908, N.L.S.

²⁴⁰ Shang-Jen, 'To Convert or to Commercialise? A Nineteenth Century Controversy Over the Objective and Meaning of European Medical Mission in China', Paper presented at the Conference: Medical Professionals: Identities, Interests and Ideology, Glasgow, 1999.

²⁴¹ Steele to Smith, Aug. 15 1894, MS7877, N.L.S.

operation under anaesthetic undertaken by Laws in March 1876 involved the excision of a cystic tumour from above a man's eye. Laws described the initial reaction of Africans to the anaesthetic: "The effects of chloroform quite took them by surprise, and as they saw a patient quietly sleeping while the knife was being used, and afterwards heard him declare he felt no pain, they spoke of him as having been dead."²⁴²

Alexander Butchart, advancing the theory of sovereign and disciplinary power promoted by Foucault, suggests that a 'theatre of healing' was needed for the advancement of the pioneer mission and missionary medicine. He writes:

Strange as it may seem, it was with these same mechanisms of sovereign visibility and outward display that the nineteenth-century theatres of missionary healing were built. Only within them it was not the executioner who represented God or the king, but the doctor; not the body of the condemned that swayed above the onlookers on a gibbet, but the body of the infirm African which lay sprawled on the examination table, and not the tools of torture and pain that glinted and bubbled in the sun, but the instruments of healing – the scalpel, the stethoscope and the catheter.²⁴³

This analysis seems extreme and highly theoretical in nature and it is hard to believe that mission medical personnel ever considered their labours in such terms. However, the need for their medical achievements to be appreciated and widely discussed was considered important. Even beyond the pioneering phase of mission, medical treatments performed on itinerating journeys continued to act as a remarkable spectacle, drawing people to the medical missionary. As Berkeley Robertson noted in 1907:

²⁴² Cape Maclear Journal, medical subnote, MS7908, N.L.S.

²⁴³ A. Butchart, *The Anatomy of Power. European Constructions of the African Body* (London, 1998), p.80.

On tour, medical work is done under difficulties. The curiosity of the youth of Africa knows no bounds. If patients are seen in the open air the crowd will, with difficulty, be got to allow elbow-room; if in a school, all windows, innocent as they are of glass, are filled with a mass of black faces hardly to be dispersed by words.²⁴⁴

Despite these advances in the uptake of their medicine, the pioneer mission doctors were wary of being accused of witchcraft and, where possible, selected for treatment only those conditions considered curable. Dr Steele, however, disregarded this policy in 1890 when he attempted to treat a chronic leg condition suffered by the Ngoni chief, Mtwaro. Unfortunately the remedy, which he applied topically to the leg, produced extensive blistering and resulted in a significant deterioration in the chief's condition. Steele wrote anxiously:

It is not so much the case itself I fear as the witchcraft and superstition I have to encounter, for were anything to go wrong with him, while he is in my hands not having any connection with his leg it would be blamed on me and what the result to our work here if not our lives might be would be hard to say.²⁴⁵

Fortunately the blistering resolved. Steele's fears of malicious accusations being made against him, however, were real. Therefore, despite the fact that he considered the chief to be suffering from heart failure, he refused to examine him with his stethoscope, fearing Mtwaro's death would ultimately be blamed on his use of this unusual diagnostic instrument.²⁴⁶

It was not just doctors who risked being charged with witchcraft, all missionaries, particularly during the pioneering stages of mission, were vulnerable to false accusations. Indeed, in the early 1880's, even Mrs Laws, who had touched the face

²⁴⁴ Annual Report, Livingstonia Mission, 1907, p. 47.

²⁴⁵ Steele to Laws, Sept. 9 1890, MS7894, N.L.S.

²⁴⁶ Steele to Laws, Oct. 30 1890, MS7894, N.L.S.

of the Ngoni chief, Mombera's child shortly before it sickened and died, was similarly accused.²⁴⁷

Terence Ranger suggests that western medicine's effectiveness with certain conditions including chronic ulcers, the treatment of animal bites and, by the early 1920's, yaws, was increasingly appreciated by Africans. His salient point, however, is that scientific medicine did not replace its traditional variety but was instead absorbed into a plurality of therapies which, together with the remedies of the indigenous herbalist, were effective in the treatment of 'natural' illnesses. Ailments generated through witchcraft continued to require societal based cures.²⁴⁸ Diseases included within each category of causation were not rigid and fixed. It was possible for a disease to move between these categories, usually as knowledge of its aetiology improved over time. Medical missionaries, however, were often unaware of the complexities of traditional beliefs and how these interacted with European, Christian ideologies.

Ranger has further analysed methods through which Christian converts of the UMCA in Masasi attempted to obtain spiritual and physical healing from certain aspects of the Church, including the sacraments. He highlights the irony that the UMCA discouraged this holistic approach from 1908 – a time when spiritual healing was achieving considerable credence amongst some sectors of the Anglican Church in England.²⁴⁹ The UMCA missionaries, however, were already irked by the accusations that through ritualistic practices of worship "they were leading their

²⁴⁷ Elmslie, *Among the Wild Ngoni*, pp.199-200; Livingstone, *Laws of Livingstonia*, pp.200-201.

²⁴⁸ Ranger, in Shiels (ed.), *The Church and Healing*, pp.337-341.

²⁴⁹ Ranger, in Shiels (ed.), *The Church and Healing*, pp.342-345.

converts into a ‘magical’ view of Christianity.”²⁵⁰ Converts of all missions were encouraged to view healthcare personnel only as possessing the knowledge to heal the sick. The underpinning irony of this situation was that the history of Christianity is the history of a healing religion, which encourages its subjects to pray to an altruistic Father for healing and salvation as well as for more specific temporal benefits. These, within the African situation, included adequate rainfall for crop growth and plentiful harvests.²⁵¹

Privately, however, some members of the UMCA believed in spiritual healing and faced dilemmas when they recognised its relevance in the treatment of individual African patients. Bishop Weston of the Zanzibar diocese firmly believed in demonic possession and readily practised exorcism when required.²⁵² In addition to this, Bishop Hine anguished on the appropriateness of spiritual or allopathic treatments for Africans. He noted:

One case I remember of a Christian youth at Likoma who was said to be ‘possessed with a devil,’ and I hesitated whether to visit him and, as bishop, to exorcise the evil spirit which was believed to have possessed him or, as doctor, to treat his symptoms medically. It seemed better to use natural means before resorting to spiritual means, and I dosed him freely with simple drugs. He soon recovered without any need of other treatment. I should always do this in similar cases.²⁵³

The African patient had to accommodate this dichotomy of both spiritual and scientific approaches to mission healing, alongside the holistic approach of indigenous treatments. This could result in confusion over the considered cause and treatment of disease. However, other aspects of mission, which combined the

²⁵⁰ Ranger, in Sheils (ed.), *The Church and Healing*, p.345.

²⁵¹ Porter in Bynum and Porter (eds.), *Companion Encyclopedia of the History of Medicine*, pp.1449-1465; Elmslie, *Among the Wild Ngoni*, p.176.

²⁵² H. Maynard Smith, *Frank. Bishop of Zanzibar, 1871-1924* (London, 1926), pp.116-117.

²⁵³ As quoted in Maynard Smith, *Frank. Bishop of Zanzibar*, p.127.

spiritual with the rational, may also have confused the missions' African adherents. Similar misunderstandings may have resulted from the charismatic revivalist programmes initiated by Donald Fraser of the Livingstonia Mission, which encouraged Christian converts to receive and be transformed by the Holy Spirit.²⁵⁴ Furthermore, Chanock has questioned the assumptions made by historians that individuals in certain African societies consciously sought a mission education in order that they might receive the material benefits of colonialism. He instead suggests that, in the early stages of Presbyterian missions, education, the ability to read and the Bible itself, were not only perceived by Africans as magical, they were actively promoted by missionaries as supernatural providers of religious, temporal and medical benefits.²⁵⁵ Elmslie wrote of the Livingstonia Mission's pioneering work amongst the Ngoni:

Dr Laws had said that by obeying "the Book" and giving up war and plunder, they would become richer and greater than they were. The spiritual sense in which the statement was made was not perceived by the Ngoni, and from that day many were the theories expressed of how "the Book" was to bring riches and greatness to them.²⁵⁶

Regardless of the concerns of doctors and the clergy, Africans continued to utilise mission medicine within a holistic system of healing. There is also evidence that once understanding of the benefits of scientific medicine provided by the UMCA had been effected, some Africans attempted to employ it as a judicial source of authority within complex social disputes. How willingly the UMCA participated in this process is open to question. The mission's medical reports of 1899 describe certain 'medical *mlandus*'. In one situation a married woman who was separated

²⁵⁴ J. Thompson, *Christianity in Northern Malawi. Donald Fraser's Missionary Methods and Ngoni Culture* (Leiden, 1995), pp.140-147.

²⁵⁵ M. Chanock, 'Development and Change in the History of Malawi', in Pachai. (ed.), *The Early History of Malawi*, pp.434-437; Elmslie, *Among the Wild Ngoni*, p.249.

²⁵⁶ Elmslie, *Among the Wild Ngoni*, pp.119-120.

from her husband died after a sudden illness. The mission deliberated on the claims that she had been poisoned. Howard noted:

Conclusion. No evidence in favour of poisoning. Death might have been due to septic causes or to Pneumonia, or to abdominal trouble... Decision. No Milandu. It was also given out that in all suspected cases of poisoning the doctor must be called in at once.²⁵⁷

In another situation, a woman died after drinking beer suspected of having been laced with poison. It was further claimed that the deceased's sister had also died after consuming the same drink. During the intervening *milandu*, at which Howard served as an assessor, it became apparent that the deceased's brothers had bribed witnesses in order that the hearing would find in their favour.²⁵⁸

Progression of Mission Medicine

The uptake of mission medicine by Africans soon advanced. In 1880, Doctor Laws treated 776 patients.²⁵⁹ Ten years later in 1890, Doctor Henry treated 933 surgical and 1389 medical cases at the Livlezi Mission. Of these conditions, fever, ulcers and other skin ailments, bronchitis and eye afflictions dominated.²⁶⁰ The Blantyre Mission reported similar developments in their medical work, with an average of 38 outpatients attended on daily over three consecutive months in 1896.²⁶¹ By 1898, all three missions under review could report a significant increase in the use of their medical facilities.

²⁵⁷ Medico Legal Cases. (Milandu) B. May 24 1899, 145/Dom/10/4/7, M.N.A.

²⁵⁸ Medico Legal Cases. Case.D. Nov. 1899, 145/Dom/10/4/7, M.N.A.

²⁵⁹ Livingstone, *Laws of Livingstonia*, p.182.

²⁶⁰ Jack, *Daybreak in Livingstonia*, p.324. The treatment of ulcers dominated all mission medical work in the pioneering period. See, *Life and Work*, Feb. 1898.

²⁶¹ *Life and Work*, Jan. 1897.

Table 1: Average Number of Medical Cases Treated Each Month²⁶²

	1898	1899	1900
<i>Dispensaries (Out-Patients)</i>			
Likoma Dispensary	-	712	500
Nkhotakota Dispensary	-	370	470
Livingstonia Dispensary	1,109	-	475
Bandawe Dispensary	916	-	547
Blantyre Dispensary	1,550	1,240	-

Total In-Patient Cases Each Year

	1898	1899	1900
Blantyre	195	236	-
Likoma Native Hospital	-	27	75

N.B. All figures are approximate, based on whole or part-year results. The huge variations and discrepancies in the statistics may be due to differences in the methodology utilised in recording this data, as is explained in more detail below.

Accurate comparison of the level of healthcare provided by each of the missions under review within the pioneering phase is difficult. Between 1895 and 1900, each of the three missions provided highly differing levels of medical support to their African subjects. As has already been discussed, by 1898, the UMCA's Nyasaland Diocese was without either a practising doctor or nurse and, therefore, was unable to record dispensary attendances. Accurate documentation of medical treatments only developed from 1899 under Howard. By contrast, the Blantyre Mission, under Macvicar, provided in-depth analysis of both in and out-patient attendances but focused principally on its centrally located facilities at Blantyre. This reflected the fact that medical provision at Mulanje, Domasi and Zomba was limited and severely affected by changing staffing levels. The Livingstonia Mission, with a few

²⁶² Statistics based on *Life and Work*; Jack, *Daybreak in Livingstonia*, p.326; Livingstonia Annual Reports; Medical and Surgical Reports 1899-1900; UMCA 145 Dom/10/4/7, M.N.A; UMCA Annual Report 1900.

exceptions, focused largely on its dispensary work throughout the pioneering phase and therefore could relate only limited and sporadic accounts of in-patient treatments.

It is important to note when assessing mission medical statistics that such data were produced largely to impress on supporters in Britain the relevance of medical missionaries. The figures themselves remain highly ambiguous and open to debate. For example, in recording attendances at the dispensary, the statistics do not always differentiate between new patients treated and repeated visits for chronic conditions. Whilst Livingstonia, in 1898, recorded 13,314 attendances at its dispensary, 9,283 of these were classed as ‘old cases’.²⁶³

The increased provision and uptake of western medicine proved expensive for mission societies. The doctor of the Blantyre Mission observed in 1890: “For some days we have had an average of over 60 ulcers to dress: this makes a great drain on our very limited stock of medicines.”²⁶⁴ Moreover, further expense was required, not just in financing the building of hospitals, but also in meeting the essential running costs of these institutions. Mission societies were therefore forced to seek out methods of augmenting their financial resources.

Medical missionary discourse was utilised as a fundraising device. The desire to present the religious rather than the scientific aspect of the doctor’s work to the British public at times strayed towards emotional blackmail. A missionary requesting funding for Zomba hospital wrote in *Life and Work*:

²⁶³ *Aurora*, Feb. 1899.

²⁶⁴ *Life and Work*, April 1890.

A Native Hospital, placed along side of the Church, and wrought along with it, is the strongest witness we can set before the eye of the natives as to the nature of the Gospel of Jesus Christ ... Again, putting aside the question of superstition, medical work has a special evangelistic value when combined with preaching, just as the deeds of mercy wrought by Jesus Christ while on earth were a living illustration of what He taught and were the natural complement of His preaching.²⁶⁵

More specific fundraising devices were also utilised by mission medical personnel. For example, in 1902, Howard sent a collection of butterflies to be sold in England for the benefit of the mission.²⁶⁶ Moreover, all of the three missions under review encouraged their supporters to sponsor hospital beds, which they often dedicated to the memory of a deceased relative. In 1902, Howard initiated his 'Bed or Mat Fund', which encouraged the Anglican congregation to subscribe annually towards a hospital bed or mat. The sum of three pounds, he claimed, would cover "all expenses, including repairs, and would be enough to endow a mat".²⁶⁷

As Vaughan has noted, endowment schemes contributed to the creation in mission journals of a familiar type, 'the African patient'.

Regular readers were encouraged to keep track of their favourite patients, to pray for their souls, and to follow their medical and spiritual progress. This was particularly rewarding for those subscribers who had sponsored a hospital sleeping mat and who could keep track of each patient who slept on it.²⁶⁸

The story of Peter Msumba provides a typical example of this process. Peter had been immobilised by a bad leg and a contracted knee, but following treatment at

²⁶⁵ *Life and Work*, July-Sept. 1901.

²⁶⁶ *Central Africa*, Aug. 1902.

²⁶⁷ *Central Africa*, Dec. 1902. Since hospitals were not fully established at the Livingstonia Mission until well into the twentieth century, endowment schemes developed later at this mission than at Blantyre and the UMCA.

²⁶⁸ Vaughan, *Curing Their Ills*, p.61.

Nkhotakota hospital, he managed to get about with the use of crutches. The mission journal described his medical and spiritual advancement.

He was baptized at Msumba last January, and the Bishop confirmed him here some months ago, he had then to be carried into Church. He is very skilful with his hands...His last achievement has been to manufacture little crosses out of some old bits of zinc I gave him, melting them down and pouring them into a mould of his own make.²⁶⁹

It is important to note that appeals for funding, made on such an individual basis, were deeply embedded in mission tradition. Appeals were frequently made by individual missionaries for items ranging from footballs to church bells, which could not be supported out of the general mission fund. Each missionary, had to sell his or her concern to potential contributors. Often, they had to seek to maintain the benefactors' interest and money in the project over a considerable period of time.²⁷⁰

Despite these measures, sources of mission funding, particularly for its medical work, remained precarious. The UMCA continued to rely on the individual donations and legacies, which composed its general fund, whilst its hospitals and dispensaries were supplied with medicines from the 'Sick Comforts Fund' or 'Hospital Fund' to which supporters in Britain annually subscribed. These financial sources ultimately proved inadequate. The mission therefore, experienced pressing and continual financial strain throughout the first decade of the new century, resulting in the resignation of Bishop Trower in 1909.²⁷¹

²⁶⁹ *Central Africa*, March 1904.

²⁷⁰ This phenomenon is prevalent today with the child sponsorship schemes promoted by various charities. The fact remains that the general public, then as now, respond more quickly and generously to individual concerns with which they can identify rather than to general and continuous schemes offering no tangible evidence of how their donations are spent.

²⁷¹ My Apologia Gerard Nyasaland, Oct. 1 1909, AIXV, R.H.L.

Despite its secure funding arrangements provided principally by Glaswegian businessmen, the Livingstonia mission also experienced financial difficulties as the new century progressed. In common with other missions, the expansionist endeavours of its recruits in the field began to outstretch the monetary reserves of the Livingstonia Committee. Furthermore, when benefactors to the mission died, they were often not replaced. The death of Lord Overtoun in 1908, for example, resulted in a loss of nearly £1,000 per year in missionaries' salaries and a similar sum from the building construction budget.²⁷²

Furthermore, the innovative industrialising and educational programmes of the Overtoun Institution drew funds away both from the outstations and also from the mission's medical work.²⁷³ As the new century progressed, newly appointed doctors made repeated demands for an accelerated hospital building programme. However, faced by increased financial pressure, the Livingstonia Committee was slow to respond. In 1902, the Committee did agree to the building of simple hospitals at central stations at an approximate cost of £100 each.²⁷⁴ More generally, however, it insisted that hospital buildings could not be constructed unless the increased operational costs involved were also met.²⁷⁵

Andrew Ross has described how the Blantyre Mission, whose funding levels depended upon church collections and legacies, suffered repeated financial crises in the years prior to 1900. He further suggests that the Church of Scotland FMC was

²⁷² Fairly Daly to Fraser, 16 March 1908, MS7866, N.L.S.

²⁷³ McCracken, *Politics and Christianity*, pp.171-195.

²⁷⁴ Fairly Daly to Elmslie, March 20 1902, MS7864, N.L.S.

²⁷⁵ Fairly Daly to Berkeley Robertson, 9 July 1907, MS7866, N.L.S.

“never in a financially comfortable position during the years 1898 to 1914”²⁷⁶ with calls for the retrenchment of the work being made periodically. As the mission’s medical work became better organised through the development of its central hospital in Blantyre, doctors attempted to supplement the FMC- supplied medical grant whilst at the same time establishing mission medicine on a more professional footing. This process will be analysed in chapter 3.

By 1900, the provision of medicine at the Blantyre, Livingstonia and UMCA missions had developed beyond the pioneering phase. Professional medical support was provided for both the missions’ staff and their African adherents, in dispensaries and temporary and permanent hospitals. This increasing professionalising of missionary medicine both responded to and stimulated increased demand for these services.

Between 1900 and 1914, the provision of medicine at the three missions continued to expand and professionalise. In chapter 3 it will be argued that the secularising of mission medicine, which resulted from these developments, was an inevitable consequence of the advance of mission medicine beyond the pioneering phase and the wider development of medical knowledge and technology in Britain.

²⁷⁶ Ross, *Blantyre Mission*, p.33.

CHAPTER 3

THE PROFESSIONALISING OF MISSION MEDICINE: 1900-1914

Megan Vaughan has attempted to deconstruct the missionary medical discourse, used in mission journals in the nineteenth and early twentieth century. This discourse portrayed the disease and sickness suffered by the African as a direct consequence of his 'primitive', 'uncivilised' lifestyle and held 'heathenism' responsible for the inherent 'evils' in African society.²⁷⁷ The discourse of missionary medicine conveyed meaning crudely in terms of comparison of opposites. Whilst Christianity and western modernity were associated with light, indigenous society and its related 'evils' were perceived as languishing in darkness. Whilst western 'civilisation' was associated with public and individual health, the African continent as a whole, from the writings of David Livingstone onwards, was diagnosed as 'sick', the precipitators of this disease being 'heathenism', the slave trade and Islam.²⁷⁸

Mission medical discourse portrayed the role of the medical missionary in terms of a direct continuation of the work of Christ the Healer. Vaughan writes of this discourse:

For medical missionaries the healing of the body had always to take second place to the winning of the soul and the fight against the 'evils' of African society even if medical missionaries had little time for direct evangelization, the practice of mission medicine remained one to which religious meaning was constantly attached.²⁷⁹

²⁷⁷ Vaughan, *Curing Their Ills*, pp.55-76.

²⁷⁸ Vaughan, *Curing Their Ills*, pp.57-58.

²⁷⁹ Vaughan, *Curing Their Ills*, pp.65-66.

Vaughan identifies important differences between mission medical discourse and the secular medical discourse advanced by colonial doctors. She locates these differences in the perceived causes of Africa's sickness. While secular medical discourse associated the disintegration of traditional society with disease, Vaughan suggests that medical missionaries actively sought the eradication of sources of traditional influence within the matrilineage, and instead attempted to define the individual African subject who was capable of maintaining a personal relationship with a Christian God.²⁸⁰

Vaughan suggests that, motivated by the medical discoveries of the age, government doctors were frequently involved in a race of discovery as a means of gaining a reputation in the new field of tropical medicine.²⁸¹ Furthermore, when not participating in research programmes, these doctors focused their efforts and limited medical resources on directly preventing the spread of epidemic diseases, which threatened the viability of colonial settlement and authority.²⁸² By contrast, Vaughan suggests that medical missionaries internalised aspects of mission medical discourse and therefore viewed their medical practice as a source of conversion rather than as an end in itself.²⁸³

Vaughan acknowledges that the "division between 'missionary' and 'secular' medicine in colonial Africa was never clear cut" and further concedes the difficulty of assessing how medical discourse in general influenced the manner in which

²⁸⁰ Vaughan, *Curing Their Ills*, pp.56-57.

²⁸¹ Vaughan, *Curing Their Ills*, pp.29-33.

²⁸² Vaughan, *Curing Their Ills*, pp.36-54.

²⁸³ Vaughan, *Curing Their Ills*, p.58.

individual doctors practised medicine.²⁸⁴ However, despite these qualifications, it is still possible to suggest that Vaughan's distinction between missionary medicine and the medical attitudes of government doctors is valid only up to a point. The spiritual principles maintained in the discourse of missionary medicine were just one of many influences acting upon mission medical personnel at any one time. Other temporal controlling forces included the scientific medical discourse, which underpinned the practice of western medicine and the social and professional backgrounds of individual doctors. In addition to this, the changing social and political conditions across the colonial field were also significant.

Mission medical personnel were therefore continually being acted upon by a number of spiritual and temporal forces, which were balanced on a personal level by individual missionary doctors. The equilibrium established between these forces by medical missionaries directly influenced each doctor's approach to medicine. Therefore, rather than discussing medical missionaries as members of a homogeneous group, this chapter will instead attempt to demonstrate a range of medicine practised by medical missionaries which reflected their disparate social and educational backgrounds as well as their differing commitment to medicine and religion.

Medical Missionaries and Secular Medicine.

Analysis of the medical practice of the pioneer doctors of the three missions under review demonstrates that, far from internalising the spiritual ideals of the medical missionary discourse, certain of these men were instead personally motivated by

²⁸⁴ Vaughan, *Curing Their Ills*, pp.57, 74.

professional and other temporal influences. The case of Dr Thomas Macklin, who was employed by the Church of Scotland Mission between 1876 and 1879 provides one example. Since the Foreign Mission Committee was unable to recruit a clerical leader for its mission, Macklin, a medical graduate from Glasgow University, was placed nominally in charge of the five artisans including a gardener, blacksmith, carpenter, joiner and seaman, who formed the pioneering party. The essential work of establishing a mission soon absorbed most of Macklin's time. Rather than practising as a doctor, he became heavily involved in such activities as teaching the first school children the alphabet and other administrative duties.²⁸⁵

The arrival of Duff Macdonald as head of the mission in 1878 did not free Macklin to develop his medical role. While MacDonald devoted himself to his studies of linguistics, the doctor continued to oversee a significant amount of the mission's administrative concerns. For example, he was particularly intent upon improving the mission's economic efficiency, aiming for it to become entirely self-supporting. Macklin, therefore, appealed to the home Committee for the introduction of horses and agricultural machinery to the mission.²⁸⁶ By 1879, Macklin admitted that he had yet to develop the mission's medical work. He blamed the apparent good health of Africans for the under utilisation of his medical skills. He wrote:

There is little or no medical practice among the natives, they being exceptionally healthy. What was said of old in "Jugurtha" is still true here; "The race of men is of a healthy body, swift, capable of enduring toil. *Old age* takes away most of them, for not often does disease overcome them".²⁸⁷

²⁸⁵ *H.F.M.R.*, May 1 1877.

²⁸⁶ *H.F.M.R.*, Jan. 1879 and May 1879.

²⁸⁷ *H.F.M.R.*, Feb. 1 1879.

Macklin's overriding missionary ambition was for the curtailment of the slave trade. Under his influence, the mission gained a reputation across the Shire Highlands as a sanctuary for runaway slaves. Macklin noted in 1878: "You thus see that, in a measure, we are succouring the oppressed and setting the captive free. Would that we could as easily set them free from the bondage of sin and the darkness of ignorance!"²⁸⁸

Problems arose when the growing numbers of refugees looked increasingly to the mission as a source of civil jurisdiction. In the absence of clear instructions on this issue from the Home Committee, Macklin ordered a number of severe floggings of petty thieves and the execution of a suspected murderer.²⁸⁹ Andrew Chirnside, a traveller to the region in 1879, exposed these atrocities in a pamphlet published the following year, which attracted widespread coverage in Britain. Under the weight of public and clerical condemnation, Macklin resigned from the mission shortly before his inevitable dismissal. His exploits in later years, as a ship's surgeon on the West African coast and as a doctor on tea estates in Assam, reinforce his image as an essentially secular figure, rejoicing in the freedom that service on the fringes of the empire permitted yet with little or no concern for missionary medicine.²⁹⁰

Dr. David Kerr Cross of the Livingstonia Mission provides another example of a pioneering doctor whose practise of medicine was more in keeping with his government employed counterparts than the traditional medical missionary as described by Vaughan. Rather than practising medicine as a means of converting his

²⁸⁸ *H.F.M.R.*, July 1 1878.

²⁸⁹ Ross, *Blantyre Mission*, pp.39-61.

²⁹⁰ Macklin to Laws, Dec19 1880; May 9 1882; 16 Nov. 1882, Shepperson Papers, EUL. Reference supplied by John McCracken

patients to Christianity, Kerr Cross appeared to view his medical work simply as an end in itself. As a result of this, he organised his medical work at Karonga more quickly than his medical colleagues in other mission stations. He therefore could document that 11,894 cases had been attended on in his dispensary during 1895 and 53 patients had been treated in his hospital.²⁹¹ He further observed in 1897: “there was more actual work, in the medical department done at Karonga than at all the other stations of the mission put together.”²⁹² Furthermore, although his hospital was built ‘native fashion’ it was amongst the first purpose built hospitals of the Livingstonia Mission.²⁹³

Kerr Cross appeared to delight in the challenge of establishing a correct medical diagnosis and treatment regime. He demonstrated his sheer enthusiasm for his medical work in 1895 when he wrote:

The surgical work has been extremely interesting during the past year. Elephantiasis tumours in various parts of the body are wonderfully common here, and I am being forced to make this quite a speciality. I have removed several very large tumours, the largest being 53lbs, with success...I have presently a severe case of tetanus in my hospital. The man has been ill for the last three weeks and I have no very great hope of saving him.²⁹⁴

Similar to his government employed professional peers, Kerr Cross published the results of his research on the tropical environment. He also produced a general travellers’ guide on health in Africa and wrote more generally of the people and natural environment of Nyasaland.²⁹⁵ Although Kerr Cross was employed by the

²⁹¹ Report for Karonga for 1895, MS7879, N.L.S

²⁹² Kerr Cross to Smith, April 25 1897, MS7880, N.L.S.

²⁹³ Kerr Cross to Smith, Oct. 4 1895, MS7878, N.L.S.

²⁹⁴ Kerr Cross to Smith, Jan. 8 1895, MS7878, N.L.S.

²⁹⁵ D. Kerr Cross, *Health in Africa: A Medical Handbook for European Travellers* (London, 1897).
D. Kerr Cross, ‘Notes on the Country Lying Between Lakes Nyassa and Tanganyika’, proceedings of the Royal Geographical Society, 13, 2, Feb. 1891.

mission for twelve years, his medical ambitions surpassed his ministerial calling. More specifically, he resented the controls Laws placed upon his medical work.²⁹⁶ He subsequently resigned from the mission and joined the Administration's medical department in 1896.

Macklin and Kerr Cross provide examples of pioneering medical missionaries who did not internalise the ideals of the practice of medicine as defined in the discourse of missionary medicine. Dr. Fotheringham of the Livingstonia Mission appeared to be the very antithesis of the traditional image of the medical missionary. Recruited to the mission in 1890, the doctor became afraid of the people he was aiming to convert and was convinced that his Bandawe Station would be attacked. As his fears intensified, he attempted to fortify Bandawe. Elmslie informed Laws of his concerns regarding Fotheringham in 1892. He wrote:

He has been training the natives to shoot & has bought in for the mission about a thousand rounds of ammunition... There is nothing but guns in his head. He sleeps with them in bed, eats with them lying on the table loaded & uses them not at but near natives to enforce his words.²⁹⁷

Fotheringham resigned from the mission's service in 1893.

From the 1890's, missionary medicine began to advance beyond its precarious pioneering phase into a more coherent and professional service. The new generation of doctors, recruited from the mid 1890's onwards, exemplified by Howard of the UMCA, Macvicar of Blantyre and Boxer of Livingstonia, had been professionally socialised within an increasingly scientific and organised vocation.

²⁹⁶ Elmslie to Laws, Dec. 31 1890, MS7894, N.L.S.

²⁹⁷ Elmslie to Laws, June 27 1892, MS7896, N.L.S.

By the end of the century, medical specialisms evolved in Britain as ambitious doctors, with limited options for promotion in general hospitals, attempted to create for themselves new medical markets. As a result of this process, increasingly influential medical specialisms, complete with their own hospitals, developed, including ear and eye infirmaries, orthopaedic, rectal, children's and fever hospitals.²⁹⁸ Furthermore, the regulation of medical education required consistent minimum standards across universities, regardless of whether the students' ultimate ambition on qualifying was secular or missionary practice. Each student was registered with the General Medical Council on commencement of his training.

The advance in medical knowledge and education in the second half of the nineteenth century was remarkable, particularly when it is considered that when Livingstone was undertaking his own medical training, the study of chemistry and physics was rudimentary, while the fields of biochemistry and bacteriology were unknown.²⁹⁹ By 1898, the medical curriculum of both Edinburgh and Glasgow Universities involved a five-year course, which included the study of elementary botany, zoology, physics, practical chemistry, practical physiology, pathology and medical jurisprudence. Midwifery, public health awareness, surgical and vaccination skills were also demanded of students.³⁰⁰

Given the predominance of the natural sciences within their university education, it is not surprising to find, certainly up until the turn of the century, that mission doctors were heavily involved in the investigation and categorisation of their

²⁹⁸ L. Granshaw, "Fame and Fortune by Means of Bricks and Mortar": the Medical Profession and Specialist Hospitals in Britain, 1800-1948', in L. Granshaw and R. Porter (eds.), *The Hospital in History* (London 1989), pp.199-220.

²⁹⁹ Gelfand, *Livingstone. The Doctor*, pp.15-26; Jeal, *Livingstone*, pp.16-17.

³⁰⁰ *British Medical Journal* (BMJ), July-Dec. 1898, pp.532-533.

‘strange’ tropical environment. This corresponded with contemporary trends in medicine, which, before the ascent of the germ theory, looked to the natural environment for explanations of disease processes and physical differences between races. For example, Dr. Macklin of the Blantyre Mission documented the precise anatomical features of the unfamiliar African ‘species’ soon after his arrival in the region. He noted:

The features are not at all unpleasant to look upon, and there is great variety; the expression is generally happy and comparatively intelligent. Their stature is very good, and so, too, the physique; in height, on an average of about 5ft.6-8in. The following measurements I have taken, of which I give the average; - The head in circumference, 21 3/4 in. chest, 34 1/4 in. arm, in length, 22 1/2 inc; hand 6 1/4 in.³⁰¹

As environmental theories of medicine began to overlap with those of germ theory in the first decade of the twentieth century, doctors of both the Administration and of the missions acknowledged the importance of the new speciality of tropical medicine.³⁰² From this point, the mysteries of the tropical landscape were each in turn being revealed through the work of such notables as Patrick Manson and Ronald Ross. This was a time when reputations could be made in the new discipline and mission and secular doctors in the region contributed actively to the research process. For example, Howard was awarded the Cragg’s Research Prize in 1907, having produced a pamphlet on malaria that was published through the London School of Tropical Medicine. He also published two articles in the *Journal of Tropical Medicine and Hygiene*, in 1910, in which he revealed to his professional peers his observations on ascites and more general maladies affecting the

³⁰¹ H.F.M.R., July 2 1877.

³⁰² W.F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge, 1994), pp.146-152.

inhabitants of Nyasaland.³⁰³ Dr Innes of Livingstonia researched the ankylostome worm (in 1912).³⁰⁴ David Kerr Cross considered his extensive experience of elephantiasis had made him somewhat of an expert in this field.³⁰⁵ Similarly, Macvicar of Blantyre published his findings on the spread of T.B at Lovedale, South Africa, in 1908.³⁰⁶

Mission doctors were, however, well aware of the difficulties they faced in attempting to keep medically and scientifically up-to-date with a profession that was advancing rapidly. As early as 1877, on receiving a copy of *The Lancet*, Macklin wrote: “ It will compensate in some measure for lack of practice; and it indeed is the only means I have of learning the progress of the medical art, and of the latest discoveries made in pathology and other matters.”³⁰⁷ Doctors also attempted to gain updated practical medical experience whilst home on furlough. For example, prior to the opening of the David Gordon Memorial Hospital, Laws undertook a course of study at Edinburgh University, which incorporated pathological bacteriology, medical entomology, protozoology, public health and tropical diseases.³⁰⁸ The new discipline of tropical medicine was most relevant to missionaries in the field. The majority of mission doctors recruited after 1900, therefore, undertook diplomas in this new specialism. Indeed, five of the eight doctors employed by the Livingstonia Mission from 1899 to 1914 had each obtained the diploma. Similarly, both Macfarlane and Caverhill of Blantyre undertook tropical studies in 1906 and 1908

³⁰³ R. Howard, ‘On Some Cases of Ascites with Enlargement of the Liver, Occurring in Nyasaland’ and ‘General Description of the Diseases Encountered During Ten Years’ Medical Work on the Shores of Lake Nyasa’, *Journal of Tropical Medicine and Hygiene*, 6, 13, 1910.

³⁰⁴ *The Livingstonia News*, April 1912, p.29.

³⁰⁵ Kerr Cross to Smith, Jan. 8 1895, MS7878, N.L.S.

³⁰⁶ N. Macvicar, ‘Tuberculosis Among the South African Natives’, in *South African Medical Record*, 6, 13, 1908.

³⁰⁷ *H.F.M.R.*, May 1877.

³⁰⁸ Livingstone, *Laws of Livingstonia*, p.338.

respectively. Furthermore, Dr Howard of the UMCA expressed his desire to undertake this postgraduate qualification in 1900 and qualified as an MD at Oxford in 1906.³⁰⁹

A study of Dr. Howard is revealing of the ambiguous nature of the medical missionary's role. Howard was a complex character who appeared to support and appreciate scientific developments as a doctor, whilst rejecting specific aspects from a missionary standpoint. His report to the mission's Medical Board demonstrates these ambiguities in his clinical rationale. Howard unreservedly supported the segregation of Europeans from Africans in the interests of health. This was obviously counter to early UMCA traditions of living physically and socially close to Africans. The doctor wrote of the planned Nkwazi sub-station at Likoma:

The native dwellings in connection with such an establishment would be best placed ... on the other side of the stream, as this would reduce the number of stream-bred anopheles that would be likely to reach the European house. It would be better still to build the native dwellings in the village, but this would probably not be practicable on Mission grounds.³¹⁰

In the complex task of aligning segregationist principles with evangelical ambitions, Howard attempted compromise. Whilst appreciating the methods of isolation and segregation in malarial control advocated by the tropical school, he gave greater weight to the regular use of quinine prophylaxis as the most effective malarial protection within a missionary setting. He noted: "Other methods of prophylaxis such as mosquito destruction, segregation of Europeans, mosquito proof houses are much more complicated & difficult of execution, & as I have pointed out elsewhere

³⁰⁹ Howard to Travers, Dec. 3 1900, B2 UMCA Papers, RHL. See Appendix 2,

³¹⁰ Howard, *Five Years' Medical Work on Lake Nyasa*, p.29.

have only a limited application to the conditions of mission life.”³¹¹ However, in the same year he was also seen to recommend, from a medical perspective, the modification of some techniques of missionary evangelism, specifically, the dormitory accommodation for school children. He wrote:

It is to be feared that in the past the moral reasons, which prompted the starting of dormitories, have been too exclusively considered, and the hygiene and other problems, which are a necessary result of collecting together numbers of peoples with primitive ideas and habits, have been hardly regarded...Prayers may be said regularly, and attendance carefully registered, but if Matekenya, Nkufi and Upele are allowed to run riot, the results are sure to be serious, and the dormitory system, instead of doing good may be working actual harm.³¹²

However, Howard was also a deeply religious man who provided insight into his own religious beliefs in a description of Africa’s wet and dry seasons.

It is a striking sight, this struggle to get to the water which is necessary for their existence, and it brings forcibly to one’s mind the reason of one’s presence here in Africa – the object of our Mission to these natives; and one longs and prays that they too may congregate from far and wide with desire to drink of the Water of Life, and that it may satisfy their spiritual needs, and may become in them a spring of water springing up to Life Eternal.³¹³

Furthermore, as McCulloch notes, it was well known throughout the diocese that Howard, despite the fact that he had been sent out to Africa with instructions to terminate extreme ascetic practices thought to be injurious to the health of missionaries, fully supported the UMCA’s policy of discipline and hardship for its recruits. When a missionary sought an exemption from fasting on the grounds that

³¹¹ Howard to the Medical Board, Nov. 1907, A3 UMCA Papers, RHL.

³¹² *Likoma Diocesan Quarterly Paper*, 16 July 1907. The terms Matekenya, Nkufi and Upele refer to problematic insects and parasites common in Nyasaland.

³¹³ *Central Africa*, May 1905.

it gave him a headache, Howard reportedly responded: “Well, it’s meant to, isn’t it?”³¹⁴

There are many examples of Howard practising medicine in the holistic sense detailed within the missionary discourse of medicine. The medical notes, which list the patients treated at the hospital, demonstrate that Howard, on occasions, willingly performed circumcision on young boys for other than medical reasons. The ‘Likoma Native Hospital Reports’ for 1899, describe case. 15, a schoolboy called George, a “patient (who) has always been troubled with nocturnal incontinence of urine. He has a long prepuce but no phimosis. He is a Yao so ought to be circumcised for tribal reasons.”³¹⁵ In addition to this, Howard and the mission’s nurses readily performed clinical baptisms on dying patients in appreciation of their responsibility for both the body and the soul. Furthermore, Howard, who was described by Bishop Trower as “a strong, practical common sense Christian with a true missionary’s heart,”³¹⁶ called on the clergy to authorise prayers for laypersons to use when visiting the sick and terminally ill. The mission’s journal documented that Howard:

especially mentioned four classes for which the need of such provision was especially felt, viz(1) the death-bed of the unbaptized child of Christian parents (11) The death-bed of Christians for which Commendatory prayers and prayers for the relatives were desired. (111) The death-bed of unsatisfactory catechumens. (1V) The death-bed of the absolute outsider who had Christian relatives.³¹⁷

³¹⁴ As quoted in, M. McCulloch, *A Time to Remember. The Story of the Diocese of Nyasaland* (London, 1959), p.73.

³¹⁵ Medical and Surgical Reports, Likoma, 1899-1900, 145/Dom/10/4/7. M.N.A.

³¹⁶ Trower to Travers, Sept. 19 1904, A1XV, UMCA Papers, R.H.L.

³¹⁷ *Likoma Diocesan Quarterly Paper*, No.9, Oct. 1905, p.246.

y the late 1890's, medical missionaries were therefore forced to occupy a complex role. They sought to adhere to the traditional definition of the medical missionary as the Christian healer and saver of souls whilst endeavouring to increase their professional status within the confines of the mission field. Many aspects of missionary medicine obviously militated against its professional development and organisation. For example, supplies of medicines and equipment were precarious. Boxer complained of the lack of medical facilities at Bandawe. "I am sorry to seem to complain, but the fact is that when Dr. Prentice takes away his boxes of instruments to Kasungu I am left with little else but my own pocket case! This should not be at a station like this."³¹⁸

In addition to this, staffing shortages meant that all missionaries, regardless of their training and education, had to undertake general chores in accordance with the exigencies of the service. Mission doctors, in consequence, were over-worked and preoccupied with tasks unrelated to medicine. As Dr. Black of Livingstonia noted in 1877:

The medical work has been assigned to me, but almost all my time is consumed in the general operations of the mission which are very multifarious, such as the construction of roads & building of houses, laying out the grounds, felling trees, cultivating the fields and gardens, making of furniture³¹⁹

This trend had more serious consequences within the UMCA where Howard was the only medical practitioner across its vast diocese. In 1900, he listed his missionary roles as "builder, harbour-master... carpenter, store-keeper,

³¹⁸ Annual Report. Livingstonia Mission, 1900, p.18.

³¹⁹ Black to Smith, March 3 1877, MS7876, N.L.S.

gardener.”³²⁰ At times his frustration at this inefficient use of his skills was palpable. “You know it is perfectly ridiculous for me to run a carpenters’ shop”.³²¹ Conditions would not significantly improve for Wigan, Howard’s successor, who was described in 1915 as “doing all the building work, and is so energetic – just another Dr Howard.”³²²

With mission doctors otherwise engaged in non-medical responsibilities, the practice of amateur medicine by their non-qualified colleagues continued, although increasingly this was performed reluctantly. The new generation of doctors, recruited from the mid 1890’s, attempted to achieve degrees of professional closure in keeping with that obtained by their peers in Britain. In the early 1890’s, the professional staff at Blantyre’s Mulanje station, including Dr. Robertson and the teacher, H.D. Herd, objected to the demands for them to perform more general mission tasks. Andrew Ross has portrayed this episode in terms of a dispute over D.C. Scott’s liberal philosophy of granting status and responsibility to African Christians.³²³ However, professional standing was also an important ingredient in this disagreement. The Mulanje staff complained:

It is no economy to turn clergymen and doctors into bricklayers and joiners. We are certainly very far from thinking ourselves demeaned by having such hard labour to do, but it is disheartening to set aside the work for which one has been especially trained in order to attempt what another man could do so much better and cheaper.³²⁴

The principal means of achieving the desired professional closure was for doctors to practise more advanced medicine, particularly surgery. Not only would this

³²⁰ *Central Africa*, May 1900.

³²¹ *Central Africa*, Sept. 1900.

³²² *Central Africa*, Sept. 1915.

³²³ Ross, *Blantyre Mission*, pp.158-159.

³²⁴ *Life and Work*, July 1893.

distinguish their practice from that of the amateur, but it would also eliminate the boredom experienced by some doctors with the mundane cases principally treated during the initial stages of mission medicine.³²⁵ The early training of African medical attendants created ancillary assistance for doctors in the treatment of ulcers. More challenging conditions were referred to the qualified physician. Boxer of Livingstonia, described the work undertaken by his African assistant: “at the dispensary hour, he saves me much time by disposing of all the silly nothings they bother one with, leaving me but the difficult ones to deal with”.³²⁶ This same doctor could not help but demonstrate his excitement on being presented with a challenging medical case in 1902.

A severe crocodile bite completely beat me. There was an almost severed hand, some seventy odd teeth bites, a crushed backbone; also a double pneumothorax, and both lungs were collapsed; and this medical men will find interesting – a pneumopericardium, probably caused by the collapsed lungs sucking air into the pericardium. And besides all this, the abdomen was opened in three places. The chest was sewn up, and the abdomen, but he died next morning.³²⁷

The practise of more ambitious medicine and surgery demanded in-patient facilities for the provision of effective aftercare. Dr Black of Livingstonia appreciated this fact as early as 1877 when he wrote: “Our medical work has not been organized into any sort of system as we have had so many other things to do, and until we have time to put up an Hospital I fear we will not be able to do much.”³²⁸ By 1900, demands from doctors for the construction of hospitals were increasing. Macvicar’s successors at Blantyre endorsed the view of the essential central role of the hospital within mission medicine. In 1901, when appealing for funding for a second hospital

³²⁵ *Central Africa*, Sept. 1894.

³²⁶ Annual Report, Livingstonia Mission, 1902, p.48.

³²⁷ Annual Report, Livingstonia Mission, 1902, p.47.

³²⁸ Black to Smith, March 3 1877, MS7876, N.L.S.

for the mission in the Zomba district, Norris suggested that a missionary doctor “must have a hospital; for a medical missionary in Africa without a hospital is an artisan without his tools.”³²⁹ He later wrote more emotively:

The development of the hospital is the most important part of a medical man’s work amongst African natives. To attempt to treat cases, except in special instances and under special conditions, by itinerating journeys is to prostitute the profession of medicine.³³⁰

By 1912, these trends had developed to the extent that McLaughlan, the Secretary of the Blantyre Mission FMC, doubted whether the mission would be able to recruit doctors for areas where no hospitals existed.³³¹

Vaughan suggests that the secularisation of mission medicine took place only slowly and did not become fully realised until after the Second World War.³³²

Hastings also believes that mission medicine was gradually secularised; however, he contends that this process was well under way in some locations as early as the 1890’s.³³³ This study sides with Hastings in arguing that the secularising process was well developed by the end of the nineteenth century and further suggests that the creation of hospitals from the mid 1890’s was crucial to this process.

Professionalising of Mission Medicine Within the Blantyre Mission

The Blantyre Mission’s central hospital was increasingly influential within the Shire Highlands in the first decade of the new century. By 1901, it was common practice

³²⁹ *Life and Work*, July-Sept. 1901.

³³⁰ *Life and Work*, Jan.-March 1902.

³³¹ Secretary to Hetherwick, Nov. 22 1912, MS7561.

³³² Vaughan, *Curing Their Ills*, pp.70-71,74-74.

³³³ Hastings, *The Church in Africa*, pp.277-278.

for Europeans to refer their sick workers to the mission's medical facilities for treatment. A correspondent noted in *Life and Work*:

A third thing very noticeable in the Blantyre district, is that the hospital and native medical work is gaining the sympathy of the Europeans, traders, and others in mission work, as no other means can do. There are very few Europeans who have not had, at some time or other, a favourite boy attending as an in-patient or outpatient.³³⁴

The mission charged settlers a certain rate for these services. At the dispensary at Zomba, it was noted: "For convenience sake tickets have been printed each of which entitles the bearer to one visit. The tickets are put up in books of fifteen (price 2/6) and may be had at the Hospital."³³⁵

The Blantyre and Zomba hospitals also catered for the sick workers employed by planting and carrier firms and by the Administration, with the result that by 1903 they had become the principal users of the hospitals' services.³³⁶ Furthermore, although the FMC's annual grant remained of primary importance to the mission's hospital, the endowment of beds by trading and planting companies became increasingly significant.³³⁷ In 1903, commercial agents supported hospital beds for the annual sum of £10 per bed, whilst the employers of African labour were charged two pence per patient for out-patient treatments. It is possible that the mission hospital centred its services on the sick labourers of the new economy in direct response to their apparent need. However, the secularising of the medical department of the Blantyre Mission from 1900 onwards may be indicative of an increasing focus across the mission to servicing the settler economy.

³³⁴ *Life and Work*, July-Sept. 1901.

³³⁵ *Life and Work*, Dec. 1903.

³³⁶ *C.A.T.*, Jan. 3 1903.

³³⁷ *C.A.T.*, Jan. 3 1903

At the turn of the century, the Shire Highlands was an area of sickness and infection. As the numbers of African labourers arriving in the highlands increased, from the 1890's onwards, the region struggled to feed its incumbent population. Doctors at Blantyre commented on the connection between disease and malnutrition in their patients. In 1900, it was noted in *Life and Work*: "Owing to the type of labour now imported into this district, to the scarcity of food and to other causes more or less remediable, there has been more sickness than usual amongst the natives especially amongst the carriers of the large companies."³³⁸ In addition to this, in 1895, plagues of locusts, which destroyed the maturing crops, exacerbated the pressure on food supplies. At various times individual regions were on the brink of starvation, including Domasi, where in 1901 in "many places the men and women have been so greatly reduced by the want of food that they have not strength to give the attention necessary to the cultivation of their next year's food. Large numbers have for some months kept themselves alive by wandering about the woods and digging up edible roots".³³⁹

Blantyre's St. Luke's Hospital was established at the heart of the growing settler economy and township. According to W.P. Livingstone, "More folk than missionaries appeared on the highway in front of the manse. All the life of Central Africa flowed past its doors. Every article, from a keg of paint, or a case of tinned fruit, to machinery weighing many tons, was conveyed along this traffic-way."³⁴⁰

The mission's doctors were well-placed within both the Blantyre and Zomba hospitals to identify diseases precipitated by the new wage economy. In 1907,

³³⁸ *Life and Work*, Aug. 1900.

³³⁹ *Life and Work*, Jan.-March 1901.

³⁴⁰ Livingstone, *A Prince of Missionaries*, p.110.

medical staff at the Livingstone Memorial Hospital observed the prevalence of pneumonia amongst Ngoni labourers employed in the public works and transport departments.³⁴¹ Furthermore, occasional outbreaks of beri-beri were witnessed in migrant workers who fell ill on their return journey from the Transvaal mines.³⁴²

The increasing incidence of pulmonary T.B amongst migrants from 1909 onwards, was associated with working conditions on the Rand.³⁴³ In 1913, the administration's medical department recorded 32 documented cases of the disease mainly from Zomba, Marimba and Blantyre.³⁴⁴ In response, the Blantyre Mission hospital in 1915 made provision for contemporary open-air treatments. A small yard was set aside "for phthisical and tubercular patients where they sleep with open windows at night and have a grass shelter for sleeping out in during the day."³⁴⁵

Letherwick utilised the mission's renown for treating the African sick to pressurise the Administration to reform conditions of labour within the Protectorate. Witnessing at first hand the repercussions for health inherent in the tenga tenga system, the Blantyre Mission called for alternative transport systems to be introduced in the Protectorate. In 1901, the Joint Conference of the medical missionaries of the Blantyre, Livingstonia, and the Dutch Reformed Church, agreed to support the Church of Scotland mission's campaign for the creation of an

³⁴¹ *Life and Work*, Jan.-Feb. 1907. Pneumonia was however prevalent on an annual basis in the months following the wet season. In 1906, approximately 50% of all the deaths in the villages of Nyasaland were precipitated by this single malady. N.H. Pollock, *Nyasaland and North Eastern Rhodesia: Corridor to the North* (Pittsburgh, 1971), p.475.

³⁴² *Life and Work*, April 1907.

³⁴³ Packard, *White Plague, Black Labour*.

³⁴⁴ Medical Department, Annual Report, 1913, p.18.

³⁴⁵ *Life and Work*, Jan.-March, 1915.

effective road system.³⁴⁶ The mission also lobbied for more humanitarian working conditions for African labourers. Hetherwick argued that food rations should be distributed to workers rather than calico, which often was provided in lieu of food. He also called for the construction of shelters, one day's journey apart along tenga tenga routes, as a means of ensuring that workers had warm accommodation during the cold nights of the Shire Highlands. The mission further stipulated that those who recruited migrant workers should ensure that they had reached maturity and were in adequate health.³⁴⁷

The mission also responded to the plight of abandoned migrants who had succumbed to illness on their journey, by sending out teams of carriers to bring them to the hospital for treatment. Through the columns of *Life and Work*, it also attempted to foster European awareness of their responsibilities towards their African employees and of the risks of epidemic disease arising from unsanitary labouring conditions. Hetherwick noted:

Surely if we use the native as a beast of burden, it is our duty to feed and house him. Instead to avoid trouble and lessen the costs, means bigger dividends to the British shareholder, we trade upon his humanity by making him do the work of an ox and then forage for his food in a foodless country. Is this the British justice, and equality which we pretend to uphold and fight for?³⁴⁸

The cost of treating the casualties of the Protectorate's new economy motivated the mission to forge formal contractual arrangements with European employers of labour. Between 1905 and 1907, the estimated annual running costs of the Blantyre Hospital were approximately £250, with more limited medical expenditure at the

³⁴⁶ Ross, *Blantyre Mission*, pp.136-137.

³⁴⁷ *Life and Work*, Aug. 1900.

³⁴⁸ *Life and Work*, Aug. 1900.

Domasi and Mulanje stations. The mission also spent £250, between 1906 and 1907, on the hospital and dispensary at Zomba.³⁴⁹

By 1900, the mission was becoming increasingly involved economically and politically with the growing Blantyre Township, the Administration and the settler economy. Under the leadership of D.C. Scott, the mission had maintained a wary distance from the Protectorate Government, criticising its labour policies, specifically its physical and economic exploitation of African labour. Scott believed that the European role in Africa was that of caretaker and advanced the philosophy of training Africans to rule themselves. He, therefore, was at variance with any measures which entrenched European rule and the subservience of Africans. Indeed, by 1893, Johnstone informed the Colonial Office that his work in the new Protectorate would be easier were it not for the criticisms of Scott and Hetherwick.³⁵⁰

From 1898, under the leadership of Alexander Hetherwick, the son of an Aberdonian farmer, the mission established effective working relations with settlers and the Administration. Ross has highlighted the fundamental difference in the philosophies advanced by Scott and Hetherwick on the development of Africa. Hetherwick accepted as essential the long-term role of the European-led economy and the necessary function of taxation in forcing African labour on to the plantations.³⁵¹ He, therefore, skilfully balanced genuine concern for the interests of European settlers with those of African labourers. As leader of the Chamber of Commerce, an organisation composed of white planters and traders, he lobbied the

³⁴⁹ *Blantyre Mission Council Minutes*, 1904 to 1914, Acc.9069, N.L.S

³⁵⁰ K.N. Mufuka, *Missions and Politics in Malawi* (Kingston, Ontario, 1977), p. 20.

³⁵¹ Ross, *Blantyre Mission*, pp.141-142.

Administration on behalf of white settlers. But he also accepted a chair on the Administration's Legislative Council in 1908 as representative of missionary and African concerns.³⁵²

Under Hetherwick's leadership, the mission encouraged each of its departments to become self-supporting. This led to the gradual servicing of the growing settler market. Sales of work were frequently held and laundry facilities were offered, at a price, to European bachelors. Settlers were offered the opportunity of having their boots repaired in the mission workshops and of purchasing material from the printing press.

From 1901, the medical facilities of the mission were also made available to European employers of labour. For a set charge of two pence a day, paid by the employer, the Blantyre medical department agreed to attend to the health needs, including all necessary medicines and dressings, of African workers in the Shire Highlands. *Life and Work*, noted:

A short time ago, realising that a great many cases of native mortality were due to the sick people lying in their huts without attendance, and that there was no organised method for the medical treatment of the native employees of the companies, we proposed a scheme whereby our hospital attendant daily visited all the encampments in the districts... We thus have the medical control of all the *tengatenga* men in the district.³⁵³

Under this system, sick workers were medically examined as out-patients and their fitness for work established, while more seriously ill cases were referred to the

³⁵² Ross, *Blantyre Mission*, pp.126-130.

³⁵³ *Life and Work*, April-June 1901.

mission's hospital. The B.C.A Chamber of Commerce recorded its appreciation of the service in 1904:

Not only did this system benefit the natives, but it also benefited the employers of labour for it was a common thing for natives to shirk their work under the plea of sickness, and thereby the planter or trader or transport agent lost valuable labour for the time being.³⁵⁴

Mission medicine at Blantyre, therefore, adopted a labour controlling role in response to the needs of European commerce. The Mission's medical expenditure was largely focused on the Blantyre hospital and remained relatively consistent, even during the period from 1912 when the Mission's overall budget was reduced significantly. However, spending on dispensary services at the more remote Domasi and Mulanje stations remained limited, rising from £25 per year in 1899 to £53 by 1914. Significant investment (£250 per year) was made in hospital services at Zomba from 1906. However, after the hospital's transferral to the control of the Administration in 1908, there was no further identified budget for medical provision at Zomba.³⁵⁵

The provision of a medical service for the African employees of Europeans introduced the secular dimension of success rate and efficiency into Blantyre's medical activities in line with the increased practice of curative, hospital-based medicine in Britain. One Blantyre doctor noted:

Therefore, recognising that hospital work is more efficient and more economical, the chief features of our present work at Blantyre is the development and full equipment of the native hospital, and thus the hospital has become the centre of that work and as that work develops will become more and more so.³⁵⁶

³⁵⁴ C.A.T. Oct. 29 1904.

³⁵⁵ *Blantyre Mission Council Minutes*, 1904 to 1914, Acc.9069, N.L.S.

³⁵⁶ *Life and Work*, Nov. 1902.

Whilst a material perspective does not totally explain the development of medicine within the Blantyre Mission, there can be no doubt that it was influential. The increasing numbers of sick migrant labourers in the Shire Highlands also contributed to the gradual change in the type of patient treated at the Blantyre hospital, as chronic ulcerative conditions were replaced with those of a more acute nature. A doctor reported in 1906:

What has been most noticeable this past year has been the great increase in medical cases with a corresponding diminution of cases of ulcers. No less than (sic) 10 per cent of the total were cases of pneumonia, while we have had more cases of dysentery in nine months this year than in the whole of last. The cause of this is to be found in the fact that we are on the main route for natives going and coming from the railway which is being made, so that we get in all those who fall sick on the way.³⁵⁷

The increasing numbers of acute cases treated resulted in changes being made to the hospital's charging system in order that it might reflect the extensive usage of the facilities by the employees of commercial agents. In 1911, it was determined that:

In patients will be charged for, at the rate of 1/6d a day for 14 days, after which no further charge will be made. The old charge was sixpence a day till discharge, which was a little unsatisfactory for acute cases obviously paid too little, while chronic cases run up an account which was often too large to be rendered in full.³⁵⁸

Professionalising of Medicine Within the UMCA

Although from the late 1890's the UMCA was increasingly sensitive to the role of missionary medicine for both the health of its European personnel and within the evangelising process, in many respects the low priority it had originally placed on

³⁵⁷ *Life and Work*, Jan.-Feb. 1906.

³⁵⁸ *Life and Work*, Aug.-Sept. 1911.

the provision of medicine continued. There was never more than one practising doctor within the field at any one time. Even into the second decade of the twentieth century, UMCA missionaries were forced to depend heavily upon their own amateur practice of medicine when trained medical personnel were out of reach. Although the mission experienced problems in recruiting qualified, self-funded medical missionaries, successive bishops considered that adequate medical provision for the mission's European staff and African adherents could be provided by a single doctor with a team of nurses. The UMCA, therefore, did not seek a second doctor to assist Dr. Wigan until 1939.³⁵⁹

By contrast, in the new century, both the Blantyre and Livingstonia missions attempted to consolidate and develop their healthcare provision. In 1906 and 1907 the Blantyre mission attempted to place two doctors, Caverhill and MacFarlane, at its central hospital, with Henry Scott continuing to oversee the Zomba hospital and dispensary.³⁶⁰ Ernest Caverhill, the son of a Church of Scotland elder from Jedburgh, joined the mission in 1903, having gained practical medical experience at a Stirling hospital. Robert Macfarlane obtained his diploma in tropical medicine at Liverpool in 1905 before entering the mission's service the following year. Staffing shortages, however, prevented these doctors from working together at Blantyre. They were therefore located at Blantyre and Zomba/Domasi respectively on Henry Scott's resignation from the mission in 1907 and the subsequent transferral of the Livingstone Memorial Hospital to the control of the Administration. Between 1900 and 1914, thirteen nurses were employed by the mission and were located at the central Blantyre station and at each of the out-

³⁵⁹ King, *The Story of Medicine*, pp.59-66.

³⁶⁰ McMurtrie to Scott, Jan. 26 1906, MS7540, N.L.S.

stations, although staffing shortages occasionally affected the Mulanje station. Similarly, within the same time-span, there were seven doctors employed by the Livingstonia Mission and six nurses.³⁶¹

There are two other reasons for the UMCA’s limited provision of healthcare. First, similar to Livingstonia and Blantyre, the UMCA, with its limited support base amongst the Anglo-Catholic adherents of the Church of England, was financially insecure. All of the missions faced unrelenting financial hardship during the early twentieth century and, as has been discussed previously, the provision of medicine within missions was very expensive. Table 2 demonstrates that the total income for all UMCA dioceses in Tanganyika, Zanzibar, Northern Rhodesia and Nyasaland was close to, or even below, the total remittances to the FMC of the Church of Scotland, which operated missions in Africa, India and Asia.

Table 2: UMCA Receipts and Givings to Church of Scotland F.M.C.

	UMCA Total Receipts	Remitted to Likoma	Total Givings to the F.M.C. of the Church of Scotland
	£	£	£
1904	30,021	11,093	28,619
1905	34,605	10,981	27,970
1908	38,876	16,104	42,868
1910	43,980	10,218	32,227
1914	36,512	12,949	32,700

N.B. Total UMCA expenditure includes remittance to Diocese of Zanzibar, Nyasaland and Northern Rhodesia and support for Home & General Fund.³⁶²

Second, the mission did not encounter the external pressures and expectations on its medical facilities of the kind experienced by the Blantyre Mission from the early

³⁶¹ Dr Agnes Fraser, who joined the mission in 1901 was officially recognised as a missionary’s wife rather than a doctor. Annual Report, Livingstonia Mission, 1901, p.37
³⁶² UMCA Financial Reports; Ross, *Blantyre Mission*, p.38.

1890's. Some UMCA converts were migrant labourers, but the mission itself was not immediately confronted with the detrimental effects which the new economy posed to African health. This is demonstrated by the absence of comments on this issue in *Central Africa* compared with the frequent references in *Life and Work*.

As has been previously described, the land alienated by European planters and commercial companies in the 1890's was largely concentrated in the Shire Highlands. For example, the British Central Africa Company owned 367,000 acres, and the Bruce Estate and the Blantyre and East Africa Company owned 160,000 acres each.³⁶³ The British South Africa Company owned 2.75 million acres, mainly in the northern territories, but the majority of this land was unused.³⁶⁴

In the 1890's and early 1900, Tonga and Ngoni migrant labourers converged at specific times in the agricultural calendar on the Shire Highlands, seeking wage labour. As has been described, the health needs of these workers, many of whom were found destitute around Blantyre, were met by the Church of Scotland Mission.³⁶⁵ By contrast, the UMCA avoided such externally imposed influences to adapt its medical provision from its overwhelmingly palliative provision to a more curative form.

From 1900, the mission added a sense of social and political isolation to its geographical distance from the Administration, settler community and other missionary societies. It was noticeably absent from The United Board of Translators, the Federated Board of Missions and the Joint Missionary Conferences

³⁶³ Vaughan, 'Social and Economic Change', p.115.

³⁶⁴ Vaughan, 'Social and Economic Change', p.115.

³⁶⁵ Vaughan, 'Social and Economic Change', pp.164-165.

of 1900, 1904 and 1910.³⁶⁶ The missionary convention of 1904, attended by all the Protestant missions in the Protectorate, excluding only the UMCA and the London Missionary Society, had in fact lent its support to a paper written by Dr. Innes of Livingstonia. Recognising the health problems generated by changing social and economic circumstances within the new Protectorate, the convention had united behind Innes' appeal to the Administration to establish a public health department that would deal effectively with infectious diseases and sanitation and would provide care for lepers, epileptics, 'imbeciles' and the 'insane'.³⁶⁷

However, from 1910, the UMCA demonstrated a change in its expectation of the role of the medical missionary. Directly corresponding with the further professionalising of medicine in Britain, this change was precipitated by the poor response to the mission's advertisement for a successor to Howard. It was apparent that newly qualified physicians were unwilling to accept the UMCA's terms and conditions of employment.³⁶⁸ In September 1910, therefore, new and unprecedented terms and conditions were devised for this post which even included the payment of a stipend should the new recruit be unable to self-finance his missionary endeavours. These measures, in theory at least, effected a division between the medical and evangelising work of the medical missionary. A note in *Central Africa* detailed the proposed new terms:

The doctor would be regarded as in every way a member of the staff, and no one would be happy in such a position who was not a communicant member of the Church of England, and in general sympathy with the aims and methods of the Mission. His own actual work however would only be the

³⁶⁶ Ross, *Blantyre Mission*, p.180.

³⁶⁷ *C.A.T.* Oct. 29 1904; the minutes of the Blantyre Mission Council, Jan. 25 1905, Acc.9069, N.L.S.

³⁶⁸ Sandwith to Travers, Jan. 31 1911, A3, UMCA Papers, RHL. Also see chapter 2.

medical care of the staff, the superintendence of the hospitals, and the visiting of patients (European as well as natives).³⁶⁹

As their desperation increased, members of the Committee attempted to entice medical recruits into its service by emphasising the potential contribution their research could make to the field of tropical medicine. “The Sleeping Sickness has not as yet extended to the Lake, but there is a great opening for a man of enthusiasm desirous of working in the Master’s service.”³⁷⁰ Dr. Wigan, who had gained practical medical experience at Bart’s Hospital London, subsequently joined the mission in 1911 and served within the Nyasaland Diocese until 1947.

The development of hospitals within the UMCA, run by qualified nurses and supervised by the doctor, raised the status of professional healthcare within the mission, even if this remained principally at a theoretical rather than practical level. Although in the absence of trained staff, amateur medicine continued to be practised, the essential difference by the twentieth century was that it was understood that in ideal circumstances only trained healthcare staff ought to administer medical treatments. A comparison between the biographies of Arthur Sim and Arthur Douglas published in 1896 and 1912 respectively, demonstrates this change of attitude. While Sim actively incorporated amateur medicine into his everyday activities within the mission, Douglas made few references to medical work, seeing it clearly as the nurse’s special area of expertise.³⁷¹ By the second decade of the twentieth century, even the pioneer, W.P. Johnson, was aware of the

³⁶⁹ *Central Africa*, Sept. 1910.

³⁷⁰ *Central Africa*, Oct. 1910.

³⁷¹ Sim, *The Life and Letters of Arthur Sim*; B.W. Randolph, *Arthur Douglas, Missionary on Lake Nyasa* (London, 1912).

professionalising of the practice of medicine which had occurred within the mission. Referring to the early days of mission, he noted:

I was inclined to be free with Epsom Salts and other remedies, just as I was in proclaiming my real message, and I remember being amused at Jansen's taking me to task quite seriously over the harm one might do by too much Epsom Salts. Of the folly of giving away medicine in amateur ignorance I am convinced.³⁷²

Within the UMCA, hospitals initiated the secularising of missionary medicine from as early as the 1890's. This process occurred in a different manner within the Livingstonia Mission.

Secularising of Medicine Within the Livingstonia Mission

It has previously been observed that the Livingstonia mission employed more doctors than did either Blantyre or the UMCA, but had the least in-patient facilities. This lack of hospital provision was an important means of inhibiting the secularising and professionalising of missionary medicine. It is, therefore, important to analyse the influences which effectively delayed the development of organised in-patient provision within the Free Church of Scotland mission.

Up until 1914, the Livingstonia Mission was dominated by its leader, Robert Laws. Laws has been described as a typical medical missionary of the pioneering period.³⁷³ He was educated at Aberdeen University where he undertook studies in both theology and medicine after which he was employed for a year in Glasgow's fever and smallpox hospitals. His youth has been portrayed as a continual

³⁷² W.P. Johnson, *My African Reminiscences* (London, 1924), p.82.

³⁷³ McCracken, 'Scottish Medical Missionaries in Central Africa', in *The Scottish Society Of the History of Medicine*, 17, 2, 1973.

preparation for the foreign mission field.³⁷⁴ However, despite the extensive practical medical experience gained prior to his departure for the mission field, Laws viewed medicine simply as a support to evangelistic missionary endeavour. He elaborated on these opinions in an address to the Edinburgh Medical Missionary Society in 1900:

there was self-denial required even on the part of Medical Missionaries in their own work. A man went through a thorough preparation for doing, it might be, any operation that came in his way, and yet he might be placed in circumstances that even when these were offered to him it was his duty to decline to accept the risk, just for the sake of the future; or it might be his duty to sink his medical training into a very second place, and accept other duties which lay to his hand, and which, all the same, might be the very duties to prepare the way for the future, and to establish the Kingdom of Christ in the district to which he had gone.³⁷⁵

Although Laws recognised that hospitals were necessary within missions, it was enough that they were basic and unsophisticated. The location in which medical tasks were undertaken was unimportant since the example of Christian charity effected through the attendance on the sick would not be diminished if it occurred in the open air, in a schoolroom or even in a well equipped hospital. Under his direction, medical work at the pioneering Overtoun Institution was conducted in temporary buildings prior to the opening of the David Gordon Memorial Hospital in 1911. By 1905 the girls' dormitory had been converted to form a female ward whilst the ladies' sitting room was utilised as a consulting area and dispensary. A veranda acted as a waiting room and provided an area in which religious services could be provided for out-patients.³⁷⁶

³⁷⁴ Livingstone, *Laws of Livingstonia*, pp.14-15.

³⁷⁵ *Aurora*, Aug. 1900.

³⁷⁶ Annual Report, Livingstonia Mission, 1905, p.10.

Laws' views on medical buildings were similar to his approach to the construction of churches. By 1900, despite having been opened for six years, during which an impressive building, educational and industrial training programme had been undertaken, the Institution had yet to construct its own church, worship being conducted within the carpenter's shop or the school.³⁷⁷

The overriding irony of Laws was that his views on medicine clashed abruptly with his opinions on the civilising and industrialising mission. In these, Laws harboured ambitions which far surpassed those of the Blantyre Mission. His Overtoun Institution stands as a gauge of Laws' ambitions for Africa. McCracken has suggested that many of the courses taught within the Institution were initiated in direct response to the needs of the Protectorate Government or the settler economy, in Nyasaland and beyond. For example, the new commercial course of 1904 was introduced in direct response to calls from the BSAC for typists and clerks.³⁷⁸

It is therefore difficult to explain the anomaly of why Laws did not identify a clear and distinct role for organised healthcare within the developing Protectorate. It has to be acknowledged that, from its more northerly position, the Livingstonia Mission did not directly witness the detrimental effects upon African health generated by the new settler economy until well into the new century. Missionaries were therefore slow to recognise the increasing prevalence of such mine-related diseases as T.B, though by 1911, concern for the destructive impact of TB was finally expressed:

³⁷⁷ *Aurora*, Oct. 1900.

³⁷⁸ McCracken, 'Underdevelopment', *African Affairs*, 76, 303, 1977

Many of the natives who have gone south to work in the mines and elsewhere have returned with the disease evident in them. These scattered in different villages with a tendency to remain in dark huts, where they cough and expectorate freely on the floors and walls, become active foci of infection and prove a very serious danger to the community... Separate places for the treatment of such are likely soon to become an unwelcome necessity in the country hitherto remarkably free from this scourge of our home lands.³⁷⁹

The mission was therefore not exposed to the pressures experienced by its Church of Scotland counterpart from the growing numbers of visibly sick and destitute migrants or from demands from European commercial agents to professionalise its provision of healthcare. However, this does not justify the continuing reluctance to organise its medical department.

One explanation might be that Laws' ambition and vision for the mission, and the potential for civilising and commercialising the region, extended beyond immediate concerns about medical provision. This is hinted at in the views of the Livingstonia Committee, which supported Laws' attitude towards the role of medicine within the mission. Members acted in unison in limiting the medical ambitions of certain doctors who, particularly from the 1900's onwards, struggled to professionalise and consequently secularise medicine within the mission. The checking of the construction of hospitals was an essential aspect of this process. In 1911, Binnie of the Home Committee responded to the demands of mission doctors for further organisation and investment in the mission's medical work. He wrote:

It will be soon that they not obscurely hint that the medical staff should be relieved from all educational and evangelistic work... They regard as indispensable an Hospital such as has never entered the minds of any one here... Our medical work has hitherto been regarded as a Handmaid to our Spiritual work.... I am second to no one in admiration of our medical

³⁷⁹ Annual Report, Livingstonia Mission, 1911 p.11.

missionaries and their work as we have known it, but this does not blind me to the exceeding danger of following the advice which – carried away by enthusiasm for their profession – they now offer us.³⁸⁰

One method of curtailing the professional ambitions of doctors was to demand that non-ordained physicians should become ordained during their first furlough. As the Secretary of the Committee wrote in 1903: “It is now the adopted policy of the Foreign Mission Committee that their Medical Men should return after their first term of service as ordained missionaries. This removes many difficulties and solves some serious problems.”³⁸¹ This stipulation effectively incorporated doctors within clerical missionary authority, forcing them to internalise the evangelising ambitions of the mission’s clergy. As a result of this process, ordained physicians were positioned at the head of mission stations where the overwhelming demands of educational and evangelising duties marginalized their medical practice.

Certain ordained doctors within the Livingstonia Mission supported the limited importance the mission placed on professional medical practice. For example, it was reported that Elmslie considered “that unless a station had both an evangelistic and a medical missionary, the medical work should be kept very limited and where possible serious cases requiring time and attention sent to the central station where a larger and more fully equipped hospital could be maintained.”³⁸²

Other mission doctors resented these limitations on their medical practice. Innes, who joined the mission in 1899, was reluctant to undergo ordination. Fairly Daly of the FMC acknowledged the doctor’s views and admitted: “I understand that while

³⁸⁰ Fairly Daly to Laws, May 26 1911, MS7867, N.L.S.

³⁸¹ Fairly Daly to Laws, Sept. 16 1903, MS7864, N.L.S.

³⁸² Fairly Daly to Chisholm, April 22 1904, MS7864, N.L.S.

you felt you could never have asked ordination yourself, yet seeing the Church called you and set you apart to the office of the ministry in order to increase your usefulness, you loyally fell in with the arrangement and appreciated the advantages it would secure you.”³⁸³ In 1904, Innes expressed his frustration with the limitations placed on his medical work. He wrote:

a man is expected to give himself to medico-evangelistic work and at the same time carry on the whole work of a developing station like Karonga. In Livingstonia at this moment our stations are one-manned except the Institution, and the individual missionary’s concern and uneasiness are only a question of degree. After seven months of this miscellany one can appreciate the feeling of duty which has determined the resignation of more than one medical missionary from such circumstances.³⁸⁴

By 1906, Fairly Daly was forced to remind Innes, who had reported record growth in the medical work at Karonga: “you have not seen your way to limit yourself on that side and therefore found you had not the time you would like neither the strength for the ministerial side of the Mission. Dear Dr Innes, take a conjoint view of the whole work and remember now that you are not medical missionary alone.”³⁸⁵ Dr. Prentice shared the frustrations experienced by Innes. He wrote of his work: “It would be a great matter for Kasungu were there someone here who could manage the schools and share the work of the Church, thus setting me free for the medical missionary’s most effective sphere of operations.”³⁸⁶ However, despite the disappointments suffered, he resigned himself to the conflicting pressures of his role, noting in 1913:

A medical missionary in Africa was a machine constructed upon a 3-speed-gear principle long before that mechanism was applied to motor cycles. Sometimes he is running on his medical gear; sometimes there is a long spin

³⁸³ Fairly Daly to Innes, April 12 1906, MS7865, N.L.S.

³⁸⁴ Annual Report, Livingstonia Mission, 1904, p.44.

³⁸⁵ Fairly Daly to Innes, April 12 1906, MS7865, N.L.S.

³⁸⁶ Annual Report, Livingstonia Mission, 1903, p.46.

on the educational gear; sometimes there is a prolonged run on Church gear. Sometimes an attempt had to be made to run an all three gears at once – a feat no Sturme Archer has yet accomplished!³⁸⁷

Other doctors simply resigned on finding their medical ambitions thwarted. Robert Scott, a graduate of Glasgow University left the mission in 1900 after just two years' service. He informed the mission's authorities that this was "in consequence of the medical work not being what I expected and wished when I was appointed."³⁸⁸ Elmslie, however, had no sympathy for Scott's position. He wrote: "There is no reason why any one who means to be a Medical Missionary should be dissatisfied with his work... When I saw him at home I said 'If you want to go out as a mere doctor, I advise you not to go.'"³⁸⁹ Similarly, Dr. Brown, a graduate of Aberdeen who had gained essential medical experience at Caithness prior to joining the mission, resigned in 1912 after seven years service with the mission.³⁹⁰ He subsequently transferred to the Indian Mission. The Home Committee blamed Brown's frustrations at having to perform pioneering missionary work at the new station of Serenje in modern day Zambia for his departure from the mission. Fairly Daly noted: "Dr Elmslie tells us that almost all the medical missionaries in Livingstonia pass through what he calls the medical fever of professional disappointment at the limited amount of medical practice a pioneer missionary experiences."³⁹¹

There is little doubt that by incorporating mission doctors into the realm of clerical authority, the Livingstonia Mission effectively ensured that they fulfilled the

³⁸⁷ Annual Report, Livingstonia Mission. 1913, p.23.

³⁸⁸ Scott to Scott, Oct. 12 1899, MS7882, N.L.S.

³⁸⁹ Elmslie to Smith Nov. 14 1899, MS7882, N.L.S.

³⁹⁰ Fairly Daly to Maitland, Sept. 22 1905, MS7865, N.L.S.

³⁹¹ Fairly Daly to Brown, Feb. 23 1912, MS7867, N.L.S.

ambitions of its clergy. Chisholm's experiences with the mission provide example of this process. He was recruited to the mission in 1900 and was based at the Mwenzo Station in present day northern Zambia. The mission was situated close to the British South African Company's station at Ikawa. Chisholm was called upon to attend on the sick Europeans within its employ. The Livingstonia Mission therefore experienced at Mwenzo externally imposed pressures to organise and ultimately secularise its medical provision. In 1899, Codrington of the BSAC attempted to formalise the company's arrangements with the mission doctor at Mwenzo by agreeing an annual sum to be forwarded to the mission for medical services provided.³⁹² However, the Livingstonia Mission Council terminated these negotiations whilst they were still in their infancy.³⁹³

As Chisholm's attendance on the European employees of the BSAC increased, the medical fees paid to the doctor rose to over £105 in 1901, which was recognised as an unusually large sum.³⁹⁴ By 1902, Fairly Daly was concerned enough with these developments to remind Chisholm of his missionary responsibilities. He warned the doctor: "I trust, however, the demands made upon you by Europeans will not take up so much of your time and exhaust so much of your energy as to hamper you in your Mission work."³⁹⁵ By that year, in response to the external pressures placed upon the doctor at Mwenzo by European commerce, the mission had erected one of its first permanent hospitals for Africans. This hospital had been partly funded from subscriptions from the BSAC, the Flotilla Co. and the ALC.³⁹⁶

³⁹² Laws to Codrington, July 15 1899, MS7882, N.L.S.

³⁹³ *Minutes of the Livingstonia Mission Council*, Nov. 6 1899, MS7882, N.L.S.

³⁹⁴ Fairly Daly to Chisholm, Feb. 21 1902, MS7864, N.L.S.

³⁹⁵ Fairly Daly to Chisholm, Feb. 21 1902, MS7864, N.L.S.

³⁹⁶ Fairly Daly to Chisholm, June 5 1902, MS7864, N.L.S.; *Aurora*, Oct. 1902.

Chisholm was ordained whilst home on furlough in 1905. However, as early as 1903 he had observed that the external pressure from settler commerce for medical services was diminishing. He noted that the European population on the plateau had fallen and also that the trade routes utilised by carrying firms had altered over time: “The number of *native patients* is less this year, as the traffic on the Stevenson Road is now almost *nil*. Any traffic there is has been diverted to the Kasama and Abercorn route.”³⁹⁷

On his return from furlough, complete with his new ministerial status, Chisholm became absorbed in the educational and evangelistic aspects of his role. The arrival of Nurse Ballantyne at Mwenzo, who took over the complete running of the hospital in 1907, merely formalised his limited participation in the mission’s medical work, a situation which he readily acknowledged in 1913.

Though a medical missionary, a very small proportion of my time is spent on medical work. Miss Ballantyne and her native assistants seldom require my help. However, on the station and during itineration, a certain amount is done to relieve suffering or prolong life, which probably justifies the mission policy of having a medical man at each station.³⁹⁸

Medical Missionaries and Mission Doctors

This chapter has attempted to demonstrate a range of secular and spiritual controlling forces that acted continually upon medical missionaries. Doctors were required to balance these forces on a personal level. Certain doctors prioritised medicine over and above the evangelising aspect of their role. I will refer to these missionaries as ‘mission doctors’. Others favoured their spiritual work. These

³⁹⁷ Annual Report, Livingstonia Mission, 1903, p.44.

³⁹⁸ Annual Report, Livingstonia Mission, 1913, p. 46.

doctors were usually ordained. I will refer to these missionaries as ‘medical ministers’. Each doctor balanced these controlling forces along a spectrum of styles of medical practice. Mission doctors and missionary ministers are positioned on the two extremes of this spectrum, with a whole range of practice occurring in between.

This study will describe in detail the differing clinical styles evident amongst the medical missionaries of the three missions under review and will suggest that the term ‘medical missionary’, as utilised in wider studies of missions, does not represent the various ways in which missionary doctors fulfilled their spiritual and professional duties. It must be acknowledged that this argument is necessarily simplistic and is intended merely as a rough guide rather than a statement of absolutes. The spiritual and temporal forces which acted upon missionary doctors were in a continual state of change, therefore the manner in which individual doctors accommodated these varied forces altered over time.

Mission Doctors

Those physicians whom I categorise as mission doctors effectively compartmentalised their medical and evangelical responsibilities, operating as qualified, scientifically trained physicians whilst in their hospitals and dispensaries and as Christian evangelists in their Sunday preaching. I have already demonstrated that by maintaining a unique policy of ordaining medical missionaries during their first furlough, the Livingstonia Mission encouraged its mission doctors to adopt and strive for the educational and evangelising ambitions of its clerical leaders. By contrast, non-ordained ‘mission doctors’, across the three missions, were more

likely to come into conflict with the mission's clergy than those medical missionaries who prioritised the spiritual aspect of their role.

Professional Conflicts Within the Blantyre Mission

The doctors at the Blantyre Mission were paid by the Church of Scotland's FMC and acted under its auspices and that of the mission's leader on the ground. This system of control had profound implications for the nature of the doctor-patient relationship which developed within the mission's medical work. Building on theories of professionalism, Johnson has determined varying historically relevant forms of consumer-producer relationships. For example, he identified situations in which professionals, as a coherent group, defined the needs of the consumer and also, in contrast, those where a consumer or community specified their service requirements.³⁹⁹ He also identified a third system which he termed a 'mediative type', existing where a third party "mediates in the relationship between producer and consumer, defining both the need and the manner in which the needs are met."⁴⁰⁰ Johnson cites the growth in Britain of state welfare policies as an example. However, the FMC of the Church of Scotland and the mission's clerical leader effected a similar mediative role in the relationship between medical missionaries and their patients. As the purchaser of the doctor's medical services, in return for an agreed salary, the FMC of the Church of Scotland stipulated both the manner in which missionary medicine was provided and, with more serious consequences for the mission, attempted to identify the recipients of the service.

³⁹⁹ T. Johnson, *Professions and Power* (London, 1972), pp.45-46.

⁴⁰⁰ Johnson, *Professions and Power*, p.46.

From the commencement of his appointment, Robertson demonstrated that he considered himself, as a professional, to be of equal status with the clergy within the general mission hierarchy. Although Robertson clashed with D.C.Scott over the latter's promotion of ritualistic worship in the early 1890's, his direct challenging of clerical authority in 1895 resulted in the termination of his contract with the mission. As a result of Willie Scott's sudden death, Robertson, being the only doctor left within the district, had presumed that his rightful place ought to be at the central hospital at Blantyre as opposed to Mulanje. Hetherwick, as acting leader of the mission however thought differently. He wrote:

Went up to see Dr. Robertson who said that the medical work of the Blantyre Station was in his hands – that the head of the mission had nothing to do with arranging for it. He as senior medical man had come here – and here he would remain. I told him then that arranging for the proper conduct of the medical work of the station lay in the hands of the Head of the station, that I had arranged with Mr. Sharpe for Dr. Paole's services here. He said that did not matter he was here & he had the arranging of all that was to be done in the medical department of the Blantyre Mission.⁴⁰¹

The FMC, under Hetherwick's instructions, ultimately ordered Robertson back to Mulanje. This clash may have been given additional impetus by the fact that Hetherwick had also undertaken medical training before joining the mission. The *Home and Foreign Missionary Record*, documented in 1885 that "Mr Hetherwick attended a number of medical classes along with his divinity course, intending to take a degree in medicine, and so fit himself for work as a medical missionary. Owing, however, to his services being required in the Mission field, this plan had to be reluctantly abandoned."⁴⁰² Furthermore, before the arrival of Dr. Milne to the

⁴⁰¹ *Blantyre Mission Journal*, April 15, 1895 Acc.9218, N.L.S.

⁴⁰² *H.F.M.R.*, Oct. 1885.

mission in the 1880's, Hetherwick, in response to the shortage of doctors, had been forced to utilise his limited medical skills within the field.⁴⁰³

Whilst Robertson's dispute with the mission was underpinned by issues of professionalism and professional status, a contested issue was his right as a doctor to treat those whom, in accordance with his professional knowledge, he had labelled 'unwell'. Up until the turn of the century, the mission authorities discouraged their medical employees from providing regular medical treatment for the growing settler population of the Shire Highlands. Indeed, in 1896, in a letter to Macvicar, the FMC noted: "You are commissioned to serve the mission and the natives first, the European community only next. I would not take a shilling from any of them for the mission expenses in consideration of your services."⁴⁰⁴

There were many contributing factors in the formation of this policy, the issue of limited medical resources, including personnel, being just one. It is possible that the mission leaders feared that their loss of mediative control in the situation of doctors engaging in a direct doctor-client relationship with European patients, would lead to a more general erosion of their authority over their medical employees. This is speculative, but it is significant that up until 1905, the Blantyre Mission witnessed significant power struggles between ministers and physicians, with three doctors (Robertson, Norris and Walker) leaving the mission under acrimonious circumstances. Walker questioned the authority of the Rev. Anderson in 1904, in a

⁴⁰³ *H.F.M.R.*, Dec. 1885.

⁴⁰⁴ Scott to Macvicar, July 14 1896, MS7536, N.L.S.

dispute which came to a climax in a public fistfight between the two on the veranda of the manse.⁴⁰⁵

On the termination of his contract with the mission, Robertson accepted a position as doctor to the European settlers. As he increasingly empathised with settlers' aims and views, it was widely speculated throughout the mission that he had accepted the post within the newly constructed European hospital before his official dismissal from the mission's services.⁴⁰⁶ The controversy over the mission's responsibility for the medical treatment of the settler community had, however, not been resolved. Moreover, this issue resulted in Norris' resignation in 1903 when he transferred to the services of the Administration without completing his required period of notice. Hetherwick discussed this unfortunate situation with McMurtrie of the FMC. He wrote:

I (sic) more and more justifies the arrangement made in 1896 .. that the Mission Doctor should have nothing to do with European practice. It gives a man a divided interest here and he gets led off his feet. I blame Dr. Norris but I blame the people who have taken advantage of his weakness and got him into an entanglement he could not shake himself free from.⁴⁰⁷

It is interesting to note that the UMCA had no objections to their medical staff attending on the medical needs of Europeans. However, this was more a reflection of the limited medical resources within the Nyasaland Diocese rather than any real philosophical divergence from the Church of Scotland over the treatment of Europeans. The UMCA relied heavily upon the services of the doctors of the Administration when its one doctor was beyond travelling distance within its

⁴⁰⁵ Anderson to Hetherwick, Aug. 2 1904, 50 BMC2/1/59, M.N.A.

⁴⁰⁶ McMurtrie to Robertson, Jan. 3 1896, MS7535, N.L.S.

⁴⁰⁷ Hetherwick to McMurtrie, July 27 1903, 50 BMC2/1/49, M.N.A.

geographically huge diocese. Therefore, in an informal reciprocal arrangement, the mission treated sick Europeans in the district when required.

The Church of Scotland's FMC appeared to modify its stance on the treatment of settlers in 1903 when it confirmed the physician's right to treat those whom he regarded as 'sick', stating that "a Medical Missionary must have full professional liberty, like a doctor at home, to judge when it would be wrong to refuse assistance, and when the poverty of patients makes it right not to exact money."⁴⁰⁸ This obvious U-turn may have been effected by the FMC's three new medical advisors; Drs. Alex Bruce, Harry Ferguson and Angus McGillivray, who represented the views of the medical profession on the home committee. More generally, this change of policy reflected the increased status commanded by the medical profession at this time and the wider recruitment problems being experienced across the range of missionary occupations.⁴⁰⁹

However, despite McMurtrie's intention of giving medical missionaries similar levels of professional autonomy to their counterparts in Britain, in practice, in the first few decades of the twentieth century, missionary medicine remained firmly under the control of the mission leaders. The comments made by Dr. J. Elder Cumming of the China Mission, as early as 1879, regarding possible power struggles between mission clergy and physicians over the treatment of Europeans, were still relevant in the new century.

⁴⁰⁸ McMurtrie to Norris, July 13 1903, MS7539, N.L.S.

⁴⁰⁹ McMurtrie to Hetherwick, Dec. 19 1902, MS7539 N.L.S.

One of the questions rising almost at the beginning is, what is to be done with *European practice*? If there be a doctor in private practice at the station, there need be no difficulty in the medical missionary confining himself to such consultations as he is asked to attend. But in the case of his being the only European physician there, it would be impossible, and certainly not desirable, to prevent him giving the benefit of his services where they may be needed. This, however, may soon open up the questions, whether he has time for both? Whether he is to receive the fees of the private practice in addition to his full salary? And whether he is tempted to neglect the one duty for the other?...Another difficulty...is as to the relations between the two heads of the mission, the clerical and the medical. The latter is, of course, supreme on all medical questions; but there is a margin always sufficiently broad to call for the exercise of mutual discretion and good feeling. The limits of spiritual jurisdiction have, unfortunately, furnished subjects of debate in this as in wider fields.⁴¹⁰

Mission Doctors Within the UMCA

Within the UMCA, the mission doctor operated under the Bishop's unquestioned authority. However, the overseeing minister ruled supreme at each individual mission station. The UMCA clergy also had the ultimate say on the quantity of funds distributed to medical work from the General Fund. This was in contrast to the situation at Blantyre, where doctors were represented on the mission council, usually holding the position of secretary.

The situation was a frustrating one for Howard, particularly since the UMCA clergy continually prioritised education over the provision of healthcare within the mission. During one episode of food shortages at Likoma, Howard noted: "those in authority declared that it was quite impossible to feed any more, and one had the heartrending task of sending away patients who might have been cured could they

⁴¹⁰ *H.F.M.R.*, Oct. 1 1879.

have remained long enough under treatment.”⁴¹¹ He directly addressed the issues as he saw them at an anniversary meeting in 1906:

It has been said that a school is the first thing. But there is something else that must go hand in hand, and has gone hand in hand since Our Lord first preached Christianity. Christ came to preach the Gospel, and to heal the sick. And if in the early centuries those two functions were united, and now in the process of specialization have been divided and apportioned to different individuals, still in a Mission they must be again united. If a Mission is to appeal to the natives of Africa, we must care not only for their souls, but for their bodies.⁴¹²

Despite his calls for a holistic missionary approach, which embraced education and health in equal terms, the reality of his situation forced Howard to strive to secure independent funding for his medical work. By 1902, patients were expected to make a payment towards their treatment either in money or in kind.⁴¹³ The same year also witnessed the inception of Howard’s ‘Bed or Mat’ fund, which encouraged supporters of mission to sponsor a bed or mat within the mission hospitals. He expressed his gratitude to supporters of this scheme in 1906:

Sometimes, when the work looks expensive, and the priest in charge is thinking of his quarterly account, it is a great blessing for the doctor and the nurse to be able to say, “It does not matter if the hospital is twice as full, because it is not costing the General Fund anything.”⁴¹⁴

Despite their relatively isolated and unique position within the mission, UMCA doctors did however become involved in direct power struggles with successive bishops. This was possibly due to the nature of their medical training, which demanded that doctors be methodical, systematic and practical, such that they may have been tempted to apply their organisational skills more generally to the

⁴¹¹ *Central Africa*, Dec. 1902.

⁴¹² *Central Africa*, Aug. 1906.

⁴¹³ *Central Africa*, Dec. 1902.

⁴¹⁴ *Central Africa*, Aug. 1906.

administration of the mission. When Bishop Trower first arrived at the mission in 1902, he immediately experienced difficulties with Howard whom he considered was questioning his authority. Nurse Minter described the situation. She wrote:

I hate to say it, but ever since he came out the Bp has seemed to dislike the Doctor & hasn't treated him at all nicely ... Dear old thing he can't help making plans for everyone, but it doesn't do with the Bishop, & I know he will get into trouble. All the rest of us who know what he is inside don't mind how much he arranges our business for us, but the Bp's favourite remark is, "I am the HEAD of the mission - I arrange".⁴¹⁵

The relationship between Howard and Trower did soon improve; however, Howard's successor also clashed at a professional level with his bishop. It would appear that both Wigan and Bishop Fisher were uncertain of the scope and perimeters of each of their roles within the mission, with conflict and dispute threatening occasionally as each encroached upon the other's considered area of expertise. For example, in 1913 Fisher related how Wigan had frustrated his management plans:

He's sent one nurse who seems perfectly well on a fortnight's holiday and kept another ... to take her place, on the ground that it was a last chance of a holiday for several months. It wasn't: he didn't know it but next month would have been equally possible ... and saved six pounds. Why on earth Wigan would to act as .. bishop I can't see but I think it's getting very clear that either he or I will have to leave this Diocese.⁴¹⁶

Missionary doctors were debarred from the mission's governing administrative power by the professional closure maintained by the dominant clerical elite. Faced with the encroachment of the clergy on their own area of professional expertise, it is possible that mission doctors utilised strategies of closure as a means of attaining

⁴¹⁵ Minter to Travers. April 22 undated, A1XV1, UMCA Papers, RHL Nurse Minter would marry Howard in 1909 and therefore might have been somewhat biased in her future husband's favour.

⁴¹⁶ Fisher to Travers, March 1 1913, A1XX11, UMCA Papers, R.H.L.

and preserving their own specialised and unique sphere of influence and control within the mission.

The hospital may have been deployed within this process as a means by which mission doctors not only achieved degrees of closure from the amateur medical practice of their missionary colleagues, but also from clerical control. In parallel with their professional peers in Britain, mission doctors expected, not only to dictate the intricacies of the health care provided within these institutions, but also to assume control over the nursing, ancillary staff and patients. By the turn of the century, mission doctors increasingly operated within a specialised and closed medical department, separated physically from the mission by the walls of the institution and ideologically by the esoteric terminology, which composed the accounts of their work within the mission journals. Indeed, Hetherwick perhaps unconsciously described this situation when he referred to the “hospital staff” in a letter written in 1908.⁴¹⁷

It is possible to compare and contrast the priorities of mission doctors with those of medical missionaries who more equally balanced the spiritual and temporal aspects of their role. I have previously discussed Dr. Robertson of Blantyre and have demonstrated his rejection of the role of mission ‘odd job’ man. In contrast, Willie Scott appeared to thrive on the variety of tasks he undertook, becoming heavily involved in the building of St. Michael’s Cathedral at Blantyre. He also enjoyed working in the mission’s workshop for which he accepted total responsibility during

⁴¹⁷ Hetherwick to Caverhill, June 23, 1908, 86/Zom /2/5/23, M.N.A.

the carpenter, McIlwain's, furlough.⁴¹⁸ Furthermore, he did not court attendance on the European settlers and instead focused his medicine principally on Africans. A friend subsequently noted that "It was quite common to see him on a shake down and an African patient in his best bed."⁴¹⁹

As has been previously discussed, Norris of Blantyre jealously guarded his professional status and autonomy. It would seem that despite his strong religious convictions, he never fully internalised and fulfilled the evangelical aspects of the medical missionaries' role. His failure to learn Chinyanja was obviously a major contributory factor in this.⁴²⁰ Norris transferred to the administration's medical department in 1903. This secular post enabled him to fully contribute to research in tropical medicine. By 1908, he held the post of Acting Principal Medical Officer and was fully involved in the Administration's campaign against sleeping sickness.

The differences in the missionary careers of Caverhill and Macfarlane, who joined the Blantyre Mission in 1903 and 1905 respectively, are also revealing of the differences in the clinical practice of missionary doctors. Both of these physicians had been socialised in the curative ideals of the British hospital system. Moreover, the speciality of tropical medicine was not a new phenomenon to them and both doctors achieved their postgraduate qualification in tropical medicine. Despite having to respond to similar external pressures, the two doctors operated within the mission in different ways. Caverhill primarily functioned as a 'mission doctor'. He cherished his role as senior missionary doctor and the position within the Blantyre Hospital which this guaranteed. Furthermore, although Caverhill was a religious

⁴¹⁸ Rankine, *A Hero of the Dark Continent*, p.252.

⁴¹⁹ As quoted in King, *The Story of Medicine*, p.86.

⁴²⁰ Hetherwick to McMurtrie, May 13 1903 50.BMC/2/1/48, M.N.A.

man, he participated in evangelical missionary work when it did not interfere with his medical vocation, primarily on a Sunday.⁴²¹

Macfarlane undertook similar medical tasks to Caverhill in his more junior position. However, he was willing to undertake medical duties outwith the hospital's controlling influence. For example, in 1908, he suggested that the mission hospital at Zomba was superfluous to requirements on account of the Administration's increased medical work in that region. He instead recommended the development of medical facilities at Domasi. However, Caverhill was reluctant to relinquish his professional stake at Zomba. Hetherwick wrote to him:

I cannot share your views about Zomba. There is no need now for the Hospital there since Government are taking up the question of Native Medical attendance. During the last year Dr. Norris attended 23,000 cases among natives...this shows the Government are dealing with a large question now at Zomba...Moreover in the Zomba Hospital the proportion of the patients who are sent down by he (sic) Government Medical Officer is a considerable one.⁴²²

Macfarlane, described by the FMC as a "true missionary", operated more in keeping with the traditional role of the 'medical missionary'. He was willing to undertake non-medical as well as medical chores for the benefit of the mission in general. For example, in 1911, he was sent to the under-developed Domasi station where medical work was still in its infancy. Macfarlane noted:

I have been busy with all the little bits of nchito incidental to the taking over of a station, and am really only now beginning to get things into order. I gave a good deal of my attention to begin with to the medical work, for I am anxious to develop it to a reasonable extent and I wanted to make the people understand from the first that there was a medical man in the place who was willing to attend to them if they cared to come to consult him. We had a

⁴²¹ Lorimer to Hetherwick, June 12 1910, 50.BMC2/1/107, M.N.A.

⁴²² Hetherwick to Caverhill, June 4 1908, 50.BMC.2/1/90, M.N.A.

little operation on Saturday last, and the preparation for it involved a little care in a place where there were absolutely no appliances for sterilisation.⁴²³

However, he further reported that “medical work, indeed, has been but a by-product of my duties at Domasi; nine-tenths of my time has been occupied with other things.”⁴²⁴

Macfarlane also pioneered mission work in Portuguese East Africa in 1913, describing in his medical report the prevalence of chronic tropical ulcers amongst the conditions he regularly encountered.⁴²⁵ One year later, Caverhill’s departure from the mission necessitated Macfarlane’s return to the Blantyre hospital where he was forced to practice curative medicine in the treatment of largely acute conditions.

Adapting to such extreme changes in their working environment could be stressful for those medical missionaries who focused more on the spiritual aspect of their role. By 1910, missionary medicine, particularly at Blantyre, had significantly changed from the days of Willie Scott and John Bowie. I have previously described the changing effects created under the influence of the hospital system, the settler economy and the gradual evolution of the administration’s medical service. It is, however, important to note that, in response to these trends, the mission’s expectations of its doctors had also altered. Rather than tolerating the quasi free-lance approach to medicine adopted by the early medical men in the pre-hospital days, the mission doctor was now expected to focus on his medical responsibilities. The expectations held by the doctor’s African patients had also risen. Macfarlane

⁴²³ Macfarlane to Reid, April 19, 1911, 50.BMC.2/2/2, ‘M’ Series, M.N.A.

⁴²⁴ *Life and Work*, Jan.-Feb. 1912.

⁴²⁵ Medical Report for Lomweland, 1914, 86/Zom/2/8/1, M.N.A.

described the growing demands on mission medicine made by African patients. He wrote:

One is struck year by year with the progressive decrease in the number of ulcer cases who come to us, and the corresponding increase in the number of other cases, both surgical and medical...The increased number of general cases...we must regard as evidence of the growing confidence of the people in the Mission hospital...The willingness to submit to anaesthesia and operations, the growing demands upon us of classes of cases which we formerly saw but rarely...these and other less tangible evidences show us that the people are coming to understand the difference between native ways of treatment and methods informed by real knowledge.⁴²⁶

External influences increasingly forced the medical missionary to practise as a more secular mission doctor. Dr. Wilfrid Macfarlane, a medical missionary formerly of the London Missionary Society, who contemplated joining the Blantyre Mission in 1914, expressed the changing nature of his position.

In September my time will be taken up with the Post-Graduate Surgical Course and then I am anxious to have as much time as possible for tropical bacteriology and hospital practice, before again returning to the field. I need this badly, as I was alone at Mpolokoso for the last two years and medical work was very largely replaced by Education and Itinerating...I feel it is only fair to myself and...the work I am going to, to rub up my medical knowledge.⁴²⁷

Hetherwick generally regretted the perceptible mutation of the medical missionaries' role. He clearly believed in the traditional heroic, selfless image of the medical missionary and may have had Willie Scott in mind when he listed the qualities he hoped to find in Caverhill's successor:

he must be a missionary first and then his medical skill will be for the good of the missionary and the kingdom of God in this land...his work should be to develop the medical missionary idea in the fields that lie untouched all round, by visiting the outstations and district dispensaries regularly and

⁴²⁶ *Life and Work*, Jan.-Feb. 1913.

⁴²⁷ W. McFarlane to Hetherwick, July 9 1914, 50.BMC.2/1/133, M.N.A.

bringing these districts into touch, when necessary with the work of the central hospital.⁴²⁸

Hetherwick in part blamed the hospital system for eroding the evangelising spirit of the medical missionary. He wrote:

I know the desire for a hospital that lies in the heart of every medical man, but the existence of the hospital with its various appendices not infrequently has the effect of confining the attention of the medical man in charge to the spot and the extension of the work to the fields that lie around is lost sight of.⁴²⁹

In reality, the secularising of the medical missionary was a convoluted process with multiple contributory factors, which in the case of the Blantyre Mission, was associated with the growth of the settler economy. For many years Hetherwick had harboured suspicions of the possible contaminating influence of the growing settler community upon missionary ideals. He wrote wistfully to Trower of the UMCA: “One sometimes envies the ‘ungetatableness’ of Likoma...here the ‘world is too much with us’, and we have to face problems that our more remote friends are happily free from.”⁴³⁰ By 1915, although failing to acknowledge his own contribution to this process, Hetherwick had resigned himself to a more general change in missionary attitude of which the replacement of medical missionaries with mission doctors was but a single component. He wrote:

I do not think you realise how much the mission is changing these past ten or twelve years...becoming more and more assimilated to the outside (sic) commercial and Government concerns in the country. The old missionary spirit which led the mission life and policy at the beginning is fast disappearing...men are here to fill posts, more than to see how much or what best can be done to further the Kingdom of God. I had hoped something to counteract this might come out of our new Mission into the wilds of

⁴²⁸ Hetherwick to McLachlan, Jan. 2 1913, 50.BMC.2/1/124, M.N.A.

⁴²⁹ Hetherwick to McLachlan, Jan. 2 1913, 50.BMC.2/1/124, M.N.A.

⁴³⁰ Hetherwick to Trower, Feb 1. 1904, 86.Zom./2/5/15, M.N.A.

Portuguese East Africa...but there is no enthusiasm for this at all apparent in the mission. It has failed of one of the ends in view in its founding.⁴³¹

At the other end of the spectrum of medical practice were those ordained doctors who balanced their medical and ministerial duties firmly in favour of the latter. Bishop Hine of the UMCA and Henry Scott of Blantyre provide examples.

Case Studies: Bishop Hine of the UMCA and Henry Scott of Blantyre

Doctor Hine first arrived at Likoma in 1889, having undertaken medical and theological studies at University College, London and Oxford University. Hine clearly demonstrated in his private letters to Travers of the FMC that he considered himself to be first and foremost a minister. He therefore objected to interference in his evangelising and ministerial duties, and despite being a qualified doctor, provided only grudging attendance on the sick. For example, he wrote of his proposed journey to Unangu:

No more sick people for 3 wks...I hate sick people with their sweatings & shiverings & vomitings & groanings & yet never anything else in this lively country.⁴³²

He further noted in an additional letter: "I Loathe sick people & they are always with us!!"⁴³³

Hine went out of his way in order to avoid having to medically treat his fellow missionaries. In 1895, following the deaths of three of his colleagues in close succession, the remaining personnel were required to move to different stations in

⁴³¹ Hetherwick to McCallum, Oct. 11 1915, 50.BMC.2/1/140, M.N.A.

⁴³² Hine to Travers, June 25 1897, A1X1, UMCA Papers, R.H.L.

⁴³³ Hine to Travers, Sept. 7 1897, A1X1, UMCA Papers, R.H.L.

order to ensure that the fall in the number of missionaries did not unduly retard the work of the mission. It was suggested that Hine, as the mission's only doctor, should be transferred from Unangu to the more accessible location of Nkhotakota. Hine declared his opposition to this scheme.

They thought that as a doctor in case of illness at Likoma I shd be more accessible at Kota. K. than at Unangu... The really important que[stion] in many eyes is the fact that I am a doctor & people at home may think it strange that I don't make my headquarters somewhere when I can be got at in case of need... An efficient nurse has come & is resident in Likoma: & nursing is really as important as doctoring in bad illness... Bandawe has a doctor who is accessible (more so) than Kota Kota...⁴³⁴

Hine identified in his autobiography the point at which he, in his own mind, gave up medicine. Significantly, this was even before he commenced his medical missionary work. He wrote:

A notable event for me was the serious illness of Dr Burdon Sanderson, who knowing me as an old pupil of University College, London, insisted on my attending him. It kept me in a state of anxiety for weeks. It was not an ordinary case, and presented some features of an unusual character, and various complications arose as the weeks went on. He looked on himself as a sort of experiment, and I had to undergo a perpetual viva-voce examination in all the symptoms... I think it helped to end my medical career... It was those weeks of anxiety and responsibility which first led me to reconsider my calling in life, and to begin to look to the missionary vocation as more fitting for me than the life of a medical practitioner in Oxford.⁴³⁵

Hine, therefore, went on to read for Holy Orders at Lincoln before joining the UMCA.

Like Hine, Henry Scott, at certain times in his missionary career, identified more with his ministerial than with his medical role. Although he practised medicine

⁴³⁴ Hine to Travers, Nov 13 1895, A1X1, UMCA Papers, R.H.L.

⁴³⁵ J.E.Hine, *Days Gone By: Being Some Account of Past Years Chiefly in Central Africa* (London, 1924), pp.58-59.

within the mission, he preferred to leave what medical tasks he could to an efficient nurse, thus allowing himself more time for educational and administrative tasks. He also resented those times when staffing shortages compelled him to practise more medicine than he would have otherwise wished. Scott, thus, proved non-cooperative when personnel shortages in 1903 compelled Hetherwick to suggest retaining at Blantyre the nurse allocated for his Zomba station. Hetherwick noted, “he would not hear of it.”⁴³⁶ Furthermore, it was considered that Scott’s transferral to the Kikuyu Mission in 1907 was largely motivated by a desire to avoid his medical responsibilities at Zomba. Hetherwick wrote: “He gives no reason for the change .. but I hear privately that it was the fact of his having to do medical work at Zomba and of having Mr. Anderson at Domasi that led to his decision.”⁴³⁷

The Expansion of Mission Medicine: 1900-1914

Up until 1914, it was the actions of those medical missionaries who prioritised the professional rather than the spiritual aspect of their role that moulded mission medicine into the comprehensive system it was to become by the 1930’s. Shang-Jen Li describes a similar process in his study of European missionaries in China. He observed that these missionaries employed lay doctors for temporal medical work, and saved evangelical activities for themselves.⁴³⁸

Although the ambitions of mission doctors within Livingstonia were somewhat thwarted by that mission’s views on the role of medicine within the evangelising process, their combined efforts did, to some extent, professionalise missionary

⁴³⁶ Hetherwick to Robertson, April 6 1903, 50BMC. 2/1/47, M.N.A.

⁴³⁷ Hetherwick to Christie, Dec. 19 1907, 50BMC. 2/1/85, M.N.A.

⁴³⁸ Shang-Jen, ‘To Convert or to Commercialize’.

medicine. Laws and Elmslie practised very little medicine in the new century, but through the efforts of Boxer, Prentice, Turner and Innes, hospitals were established at Bandawe and Kasungu and improvements were made to the medical programme at the Institution.

Innes transferred to the Institution in 1911, where, despite Laws' continued leadership of the Livingstonia Station, he took command of the new David Gordon Memorial Hospital and the training programme for African medical assistants. Fairly Daly considered Innes to be highly suited to this work. He wrote to the doctor: "The work will be congenial to you as being more medical than clerical".⁴³⁹ In addition to this, Prentice provided the necessary driving force behind the funding and construction of the hospital at Kasungu in 1911, countering clerical resistance to this project by calling upon the donational giving of his friends.⁴⁴⁰ By 1910, Prentice could write of his new hospital: "It has been my aim to finance the building without drawing upon the funds of the Home Committee, and I am hopeful that that aim will be attained before I leave on furlough."⁴⁴¹

The medical doctors of the Livingstonia Mission were also increasingly involved in public health campaigns in 1911, with both Innes and Brown assisting the Administration in examining Africans for signs of sleeping sickness infection.⁴⁴²

Sam Norris made a significant contribution to the advance of the medical work in the Blantyre Mission. Under his influence, the bed capacity of the hospital at

⁴³⁹ Fairly Daly to Innes, March 15 1911, MS7867, N.L.S.

⁴⁴⁰ Fairly Daly to Prentice, Oct. 5 1907, MS7866, N.L.S.

⁴⁴¹ Annual Report, Livingstonia Mission, 1910, p.30.

⁴⁴² See chapter 6.

Blantyre was extended. By May of 1903, the hospital was treating an unprecedented number of patients. It was documented in *Life and Work* that “The number of patients at present in Hospital exceeds anything we have ever seen before in the history of the Medical Work of the Mission.”⁴⁴³ Norris also attempted to apply the anti-malarial recommendations of tropical medical research within the mission environment and endeavoured to improve general sanitary conditions. He was the first to recommend that the stream, that supplied the mission should be covered over as a preventive measure against malaria and typhoid.⁴⁴⁴ In addition to this, as already described, Norris was the driving force behind the introduction of the system which enabled European commercial agents to purchase medical care for their sick employees. Latterly, in the role of government doctor, Norris advised and encouraged Hetherwick to hand-over the management of the Livingstone Memorial Hospital in Zomba to the Administration on Henry Scott’s transfer to the Kikuyu Mission in Kenya.⁴⁴⁵

Caverhill, Norris’ successor, initiated in 1905 arrangements whereby the mission treated sick labour migrants. He reported in the mission’s journal: “we decided to keep a team of men employed on the Chiromo-Blantyre road to go out and bring in such cases, and a great number of people have been succoured in this way.”⁴⁴⁶ He also established targets for increasing the general uptake of scientific medicine and identified the potential contribution of schoolteachers to this process. He reported: “In the course of time it is to be expected that all teachers in charge of out-stations will be able to do dressings and dole out stock medicines, which will be an

⁴⁴³ *Life and Work*, May 1903.

⁴⁴⁴ *Life and Work*, July 1902.

⁴⁴⁵ Norris to Hetherwick, Nov. 26 1907, 86/Zom/ 2/5/21, M.N.A.

⁴⁴⁶ *Life and Work*, Nov. 1905.

important advance in overtaking the medical needs of this district.”⁴⁴⁷ He also planned medical services on a strategic and geographic basis in addition to further developing medical training. He described this process:

Several new out-dispensaries were started during the year, and they now number ten forming a complete ring round Blantyre at a distance of about 10 miles. Nothing much can be done to further the work of these dispensaries until regular visitation can be undertaken by trained boys, which the new apprenticeship system will bring to pass for the additional fourth year to be spent at their profession will enable this part of the work to be systematically undertaken.⁴⁴⁸

Caverhill also further developed the mission’s hospital facilities. This included planning for new medical and female wards and the development of a maternity wing.⁴⁴⁹ By 1914 he could also boast that the training of female nurses had at last become a reality within the Blantyre Mission.⁴⁵⁰

Whilst it is possible to explain the advances of mission medicine simply in terms of increased African confidence in western therapies, it must be emphasised that the efforts and determination of mission doctors, in setting and attaining medical goals, underpinned this growing trust in mission medicine. Caverhill appears to have viewed the practice of medicine in secular terms and particularly associated its purpose with national efficiency. In 1914, he called on the Government to acknowledge its responsibility for the health of the Protectorate. He wrote:

The labour of the country is one of its great assets and by preventing excessive infantile mortality by the free distribution of quinine, by the healing of disabling tropical ulcers, by the protection of adult life by improved sanitation, by the prevention of the spread of contagious disease by rapid treatment, they will not only be giving the native a little more in

⁴⁴⁷ *Life and Work*, Jan. 1905.

⁴⁴⁸ *Life and Work*, Jan.-Feb. 1912.

⁴⁴⁹ See Appendix 3 for a review of the protectorate Government list of mission medical facilities.

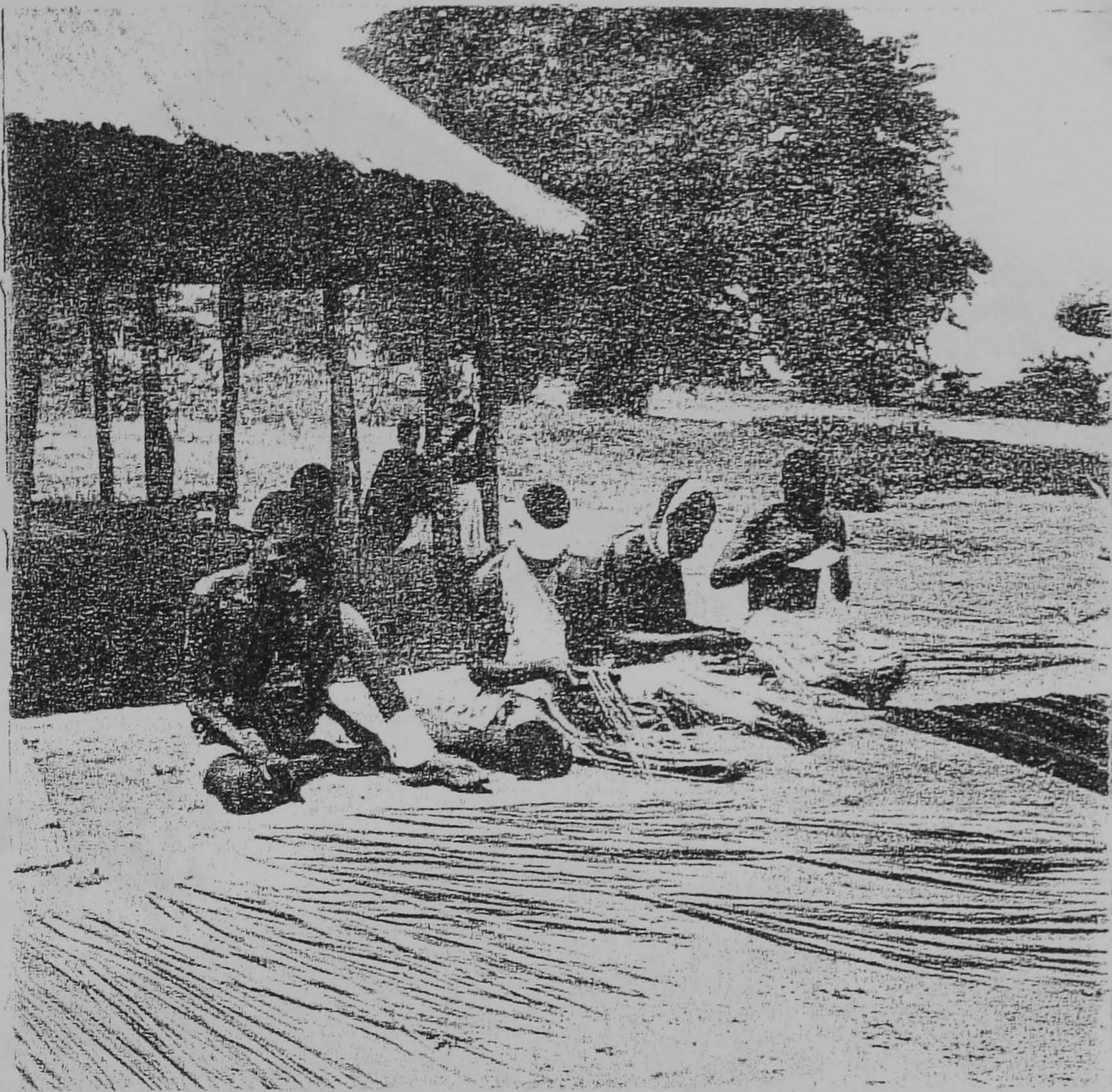
⁴⁵⁰ *Life and Work*, Jan.-Feb. 1914.

return for his hut tax, but the expense will eventually be met by the return in labour and hut-taxes that a larger number of healthy lives will afford.⁴⁵¹

In contrast to mission doctors, those physicians who prioritised the spiritual aspect of their role were more focused, in the case of medical ministers almost exclusively, on other spiritual and managerial commitments within the mission. They had neither the time nor the inclination required to co-ordinate and motivate the development of medical services to the same extent as mission doctors. However, it would appear to have been this willingness to accept a broader role, alongside their medical work, that mission leaders such as Hetherwick sought in their ideal of the ‘true’ medical missionary. Howard of the UMCA proved the exception to this trend. In being the only practising doctor within the mission, the organising of the medical work remained entirely within his domain.

Megan Vaughan has confirmed the importance of the discourse of missionary medicine, distinct from secular medical services, in the presentation of mission activities in central Africa in the late nineteenth century. However, in deconstructing the term ‘medical missionary’, this chapter has identified a diversity of approaches adopted by mission medical personnel in their interaction with patients and in how they influenced the medical work within the wider mission activities. This confirms a far more complex set of motivations than suggested by a superficial acceptance of missionary medical discourse. The distinction between the rhetoric and reality of missionary medical activities is vital in understanding the development of these services and how this differed between the various missions.

⁴⁵¹ *Life and Work*, Jan.-Feb. 1914.



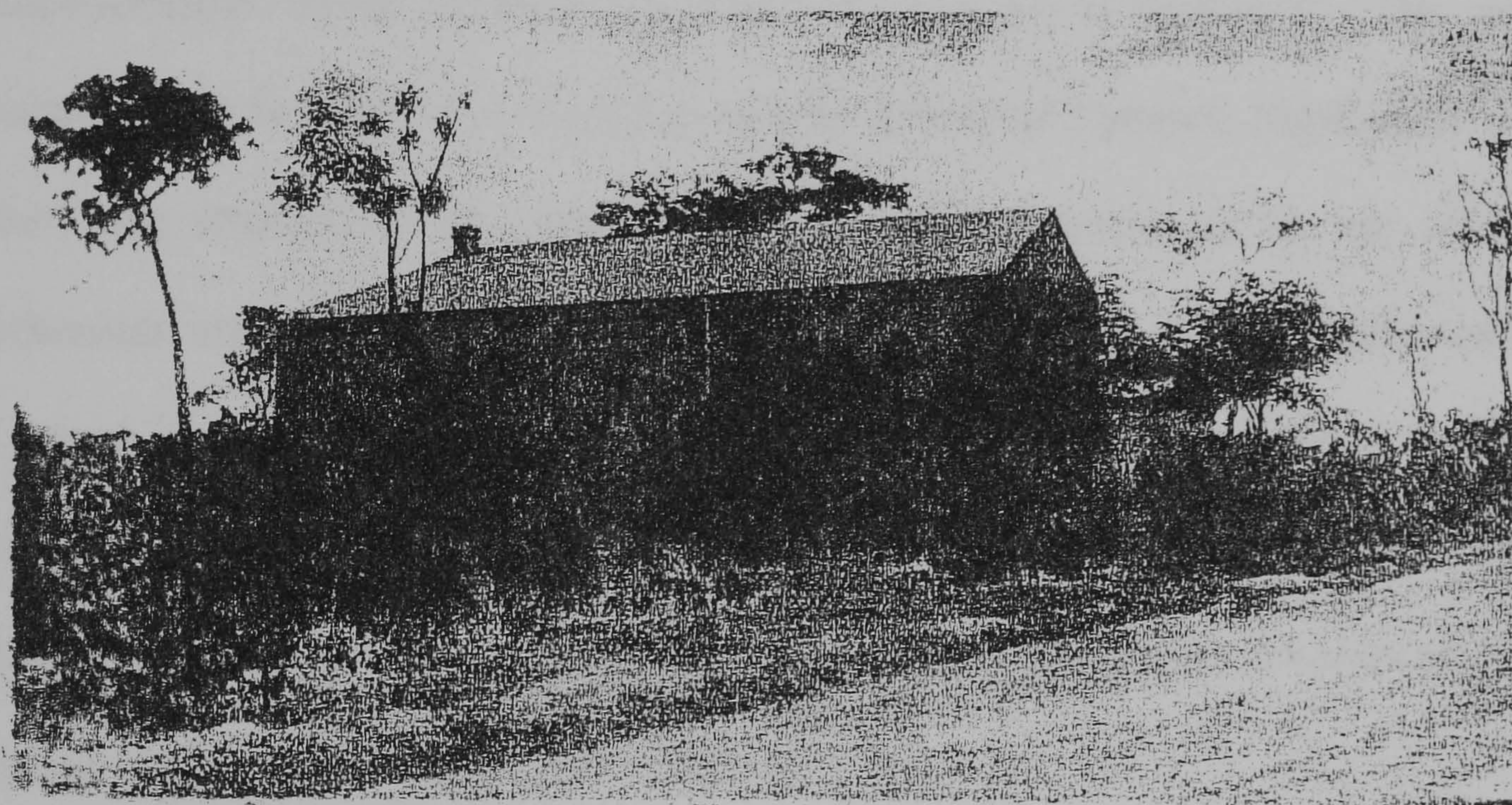
Patients of the UMCA at work.
D. Yarnton Mills, *What We do in Nyasaland*, p.115



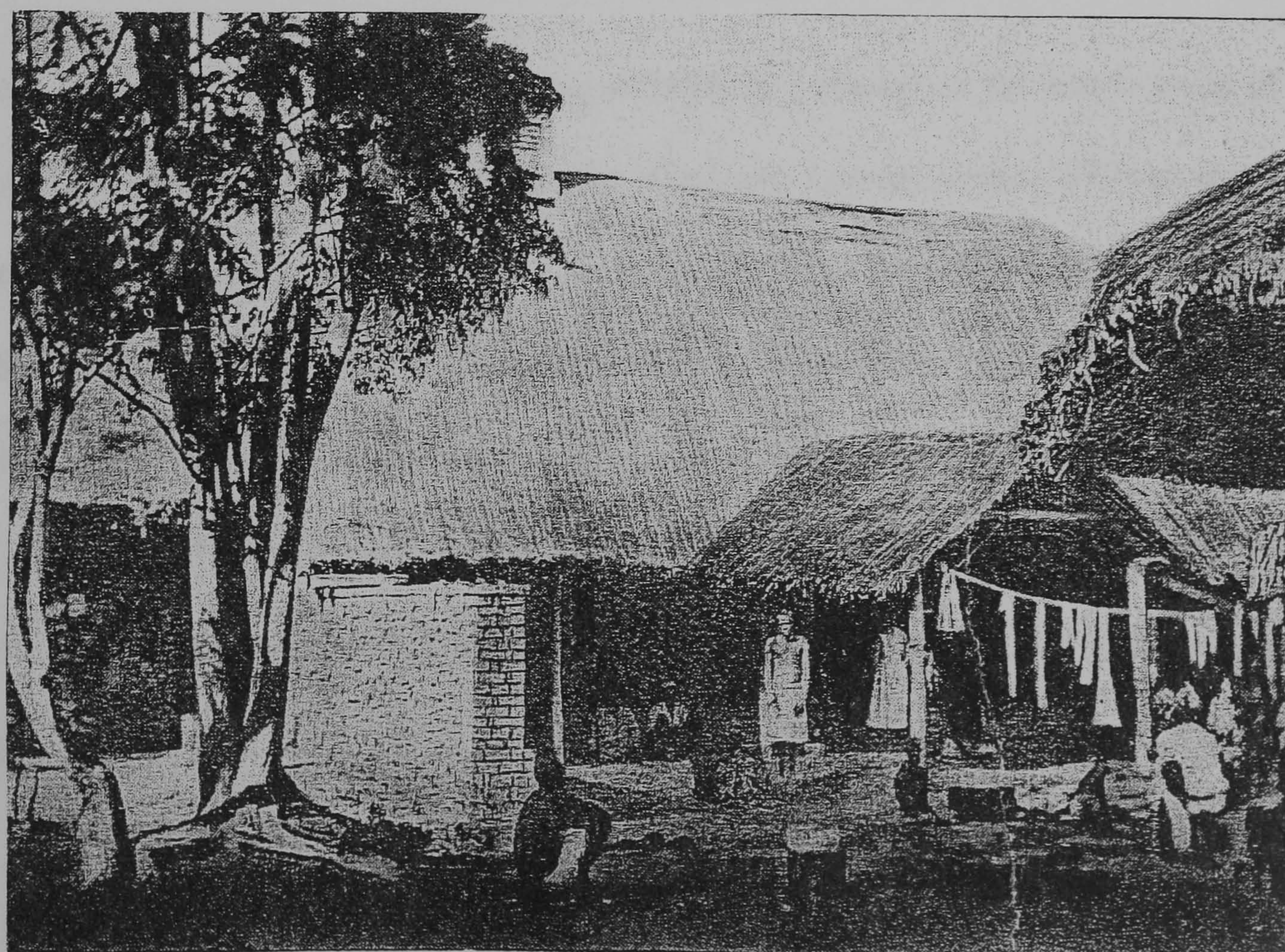
Eye patients with Dr. Fraser, 1910.
M. E. King, *The Story of Medicine and Disease in Malawi*, p.49



David Gordon Memorial Hospital



Blantyre Hospital (Ward II)



Likoma Hospital

CHAPTER 4

MISSION MEDICAL PERSONNEL: 1890-1914

In her pioneering study of the South African nursing profession, Shula Marks highlights the relative lack of studies of the history of nursing in Africa. Drawing on literature on the development of nursing in Britain and America, Marks emphasises that any review of colonial nurses must grapple with the paramount issues of race and imperialism, in addition to those of class, gender and professionalism which underpin the history of nursing in Britain.⁴⁵² The mid-nineteenth century had witnessed, through the efforts of Florence Nightingale and others, the attempts of an embryonic British nursing profession to cast off the Dickensian image of Sairey Gamp. By focusing on both the character and training of nurses, it was Nightingale's intention for nursing to become a moral profession. The early nursing service in Nyasaland from the 1890's onwards had inherited from its British counterpart the vulnerabilities of an emerging profession, acquiescent, yet separate from a dominant medical hierarchy.⁴⁵³

Early studies of the history of nursing principally focused on the justification of its claims to professional status. However, feminist theories in the 1970's questioned for the first time the ever-changing division of labour between doctors and nurses. They suggested that the reform of the nursing profession did not and indeed had never intended to threaten the superior influence of medicine. The potential success of the emerging profession in fact depended upon its acceptance of the dominant medical profession's dictated sexual division of labour. Indeed, it is often suggested

⁴⁵² Marks, *Divided Sisterhood*, pp.1-14.

⁴⁵³ B.A. Abel-Smith, *A History of the Nursing Profession* (London, 1960).

that the division of labour within health care was based upon the ideal of the patriarchal family. The doctor - nurse - patient relationship mirrored that of the father - mother and child.⁴⁵⁴

The organisation of nursing adopted the nineteenth-century pseudo-scientific belief in the 'natural' or biological inferiority of women to men. To this was superimposed the Victorian definition of femininity. Florence Nightingale frequently defined the 'good nurse' as the 'good woman', possessing such virtues as patience, humility, obedience, gentleness, calmness, sobriety and cleanliness. Consequently in its earlier years, the new organisation of nursing placed greater value on the character of the nurse, as opposed to her skills and experience. By the turn of the century, the patriarchal sexual division of labour within healthcare stressed the nurse as the good mother and housemaid, who naturally excelled in nurturing and cleaning chores: euphemistically labelled as the 'science of hygiene'. By contrast, the doctor, as the principal proponent of the dominant scientific discourse, exclusively practised medicine and surgery.⁴⁵⁵

It has however been contended that feminist approaches to the history of nursing, which overly emphasise the social construction of gender and women's subservience to systems of male power, in effect portray nurses as an "undifferentiated bloc of subordinated women."⁴⁵⁶ Nurses' role of agency in the maintenance of their own subordination, or their achievements in the creation of a separate area of expertise, distinct in its knowledge and administration from medicine, have not been

⁴⁵⁴ E. Gamarnikow, 'Sexual Division of Labour: The Case of Nursing' in A. Kuhn and A.M. Wolpe (eds.), *Feminism and Materialism* (London, 1978), pp. 96-123.

⁴⁵⁵ Gamarnikow in Kuhn and Wolpe (eds.), *Feminism and Materialism*, pp.116-117.

⁴⁵⁶ D. Wicks, *Nurses and Doctors at Work. Rethinking Professional Boundaries* (Buckingham, 1998), p.6.

emphasised. Feminist analysis stemming from the sociology of the professions has recently initiated this necessary review of the active agency of the nurse.⁴⁵⁷

Working in this tradition, Deirdre Wicks has stressed the need for an approach to the analysis of nursing which:

is capable of holding on to a sense of the power of social structure, at the same time as acknowledging that nurses also have power in their daily work, in the knowledge base that underpins their work and through their professional organisations and unions to resist, evade and confront that power.⁴⁵⁸

Wicks has further probed nursing's relationship with medicine, contending that the rise of the dominant scientific medical discourse in the eighteenth and nineteenth centuries did not completely eliminate the previous discourse of holistic healing and bedside care. She claims that this healing discourse continues to exist within the practice and knowledge base of organised nursing. Indeed Wicks has defined a contradictory 'duality of focus' in the role of the nurse, as handmaiden of scientific medicine and holistic practitioner in her own right.⁴⁵⁹ This duality resulted in an uneasy relationship for the nurse with her medical superiors, which continues to have contemporary relevance.

It is possible to explore the power relations between white mission doctors and nurses which had been transported out to Africa from the British teaching hospital. It is suggested that, despite the deviations and distortions inflicted on their relationship by the pioneering environment, the powerful socialisation of doctors and nurses into their gender-specified professional roles preserved male medical power intact.

⁴⁵⁷ See A. Witz, *Professions and Patriarchy* (London, 1992); C. Davies, *Gender and the Professional Predicament in Nursing* (Buckingham, 1995).

⁴⁵⁸ Wicks, *Nurses and Doctors at Work*, p.27.

⁴⁵⁹ Wicks, *Nurses and Doctors at Work*, pp.171-173.

Mission Nurses

Deborah Gaitskell has suggested that the wives of missionaries first conceptualised in the nineteenth century the separate sphere of women's missionary work.⁴⁶⁰ Despite the fact that their unpaid endeavours were considered only as an extension of their husbands' efforts, these early missionary women succeeded in establishing girls' schools, sewing classes and other forms of industrial work, specifically targeting the African female with their own message and example of Christian enlightenment. They sought to create civilised Christian brides for male missionary converts. In time, the expansion and further development of this 'women's work' necessitated its formal organisation. By the turn of the century, these new vacancies were being filled by single women. The professionalising of female missionary work directly clashed with Victorian patriarchal ideologies which revered the femininity of the 'good woman' as a wife, positioning her at the heart of the household, her husband at its head. This anomaly was however justified in terms of religious duty. These women were "helping to plant the 'home of God's church' in foreign lands."⁴⁶¹

The UMCA

Principally motivated by financial concerns, the UMCA had ruled that its missionaries should be unmarried and that all its female recruits were to be over

⁴⁶⁰ Gaitskell, 'Re-thinking Gender Roles'

⁴⁶¹ As quoted in Marks, *Divided Sisterhood*, p.21; D.Gaitskell, 'Ploughs and Needles. State & Mission. Approaches to African Girls' Education in South Africa' in H.B. Hansen and M. Twaddle (eds.), *Christian Missionaries and the State in the Third World* (Oxford, 2002), pp.98-120; D.Gaitskell, 'Housewives, Maids or Mothers: Some Contradictions of Domesticity for Christian Women in Johannesburg, 1903-39', *Journal of African History*, 24, 2. 1983

thirty years of age.⁴⁶² It was unusual for women not to have married by this age. Mission authorities may have speculated that their older candidates possessed a stronger vocational calling than younger women in that they had chosen to labour for Christ over and above marriage. The mission certainly did not want single women using missionary work as a means of improving their marriage opportunities. Missionary work as a God-given vocation was therefore constantly underscored to female candidates, particularly in the course of their compulsory missionary training where it was stressed that:

Students at St. Deny's will, we trust, recognise their work as a *life* vocation. Once a missionary, always a missionary. Unless called thereto by God they would not dare to enter upon it, but once called, there can be no going back.⁴⁶³

By 1898 there were no nurses remaining within the diocese. However, the arrival of Nurse Minter in 1899 heralded a new phase in nurse recruitment for the UMCA such that by 1908 there were around six nurses in the diocese who worked five stations between them.⁴⁶⁴ This level of nursing support was still in place in 1912.

Many of the UMCA's nurses had been trained in either London or the North East of England, although Nurse Spindler, recruited in 1911, was from Wales. The majority of these women were highly qualified and had worked as nurses for many years. For example, Nurse Alice Rees had worked in a London Hospital at Stockwell Fever Hospital and at St. Albans Fever Hospital and was matron under the Metropolitan Board, before commencing missionary work.⁴⁶⁵ Similarly, Ada

⁴⁶² See 7/UMCA/3/1/1, M.N.A. General and Executive Committee minutes on the review of this policy in 1911.

⁴⁶³ *Central Africa*, Aug. 1896.

⁴⁶⁴ *Central Africa*, June 1908.

⁴⁶⁵ *Central Africa*, Aug. 1895.

Fielding, who had trained at Queen's Hospital, Birmingham, gained experience in the Sussex County Hospital and the Upton on Severn Infirmary before working in private nursing for three years prior to the confirmation of her missionary placement.⁴⁶⁶ Nurse Parsons, recruited in 1906, worked at St. George's Hospital for six years prior to leaving for Africa.⁴⁶⁷ The class status of these women is, however, uncertain, although the fact that they were unpaid suggests that they were probably from the middle classes.

The UMCA's stations at Likoma, Nkhotakota, Malindi and Mpondas, each had their own male and female African hospital wards, an out-patients' dispensary and a European hospital. It was paramount within the UMCA that nurses were competent enough to work for long periods without medical support, as the one doctor in the diocese struggled to divide his time between the various stations. Medical assistance was at times available from the Livingstonia Mission and from administration doctors as and when they were in the area.

Scattered widely throughout the diocese, UMCA nurses were therefore professionally isolated from their nursing colleagues. Nurse Minter wrote of this in an undated letter: "It seems as though there ought to be a firm bond between all us nurses, & we see so little of one another as a rule that we hardly (sic) get to know one another."⁴⁶⁸ However the majority of the UMCA nurses were members of the Guild of St. Barnabas, an organisation which assisted nurses to develop a spiritual understanding of their role. This organisation served to provide a common link between nurses who each regularly recited the Guild's own special prayer and

⁴⁶⁶ *Central Africa*, Jan. 1908.

⁴⁶⁷ *Central Africa*, July 1906.

⁴⁶⁸ Miss Minter to Travers, April 22, undated, A1XV1, UMCA, R.H.L.

celebrated the feast day of their Saint. Nurses also attended Guild meetings whilst home on furlough.⁴⁶⁹

Blantyre

Despite the Blantyre Mission's commitment to medicine, its first nurse, Miss Jessie Samuels, did not arrive until 1896, the year in which S. Luke's Hospital was opened. She had fully trained as a nurse at Glasgow's Western Infirmary.⁴⁷⁰ Both she and her successor, Nurse Farquhar, were officially employed by the mission's Foreign Mission Committee and were salaried at £120 per year, with an additional allowance made for passage and outfit.⁴⁷¹ Mission nurses were either recruited and officially employed and funded by the FMC or the Women's Committee for Foreign Missions. Each agency provided slightly differing terms of employment for its recruits. For example, the FMC provided nurses with a slightly higher salary than the WAFM but expected its candidates to pay for their own furnishings once in the field. However, many nurses, including Nurse Samuels, were privately funded by either personal friends or by the Rev. Dr. Scott's congregation at St George's in Edinburgh.

The Church of Scotland's nurses had all been in paid employment before entering the mission's service and were predominantly from the middle classes. Their ages at the point of their recruitment greatly varied. Miss Richardson, who was described by Doctor McMurtrie of the FMC as "an unaffected, healthy, nice-looking

⁴⁶⁹ Russell, *Lest We Grow Hard*.

⁴⁷⁰ Shepherd, *A South African Medical Pioneer*, p.41.

⁴⁷¹ McMurtrie to Farquhar, Sep. 3, 1898, MS7536, N.L.S. Miss Farquhar's salary was funded by Dr Scott of St. George's. Doctor Macvicar, who also commenced service at this time received £250, the single man's allowance and could expect to earn £300 on his marriage.

girl",⁴⁷² was only twenty-three years old; Miss Barthia Davidson, who commenced employment in 1914, was thirty-eight.

As the medical work at the mission developed at the central station of Blantyre and its substations at Zomba, Domasi and Mulanje, Hetherwick could state in 1910 that the mission ought to have four nurses permanently in the field, two at the Blantyre hospital and one each at the sick rooms and dispensaries of Mulanje and Domasi.⁴⁷³

A fifth nurse was required to accommodate furloughs. As was also the case for the UMCA, there were many years in which the number of nurses in the field fell below a workable minimum. During these times the medical work amongst African women was suspended whilst the doctor or minister supervised the work of male medical assistants on the male hospital wards.

In the early years of medical work, the mission was prepared to employ nurses who, although not technically qualified, demonstrated a live church interest and real sense of missionary vocation. Nurses Richardson and Lorimer were not qualified nurses. The former had previously laboured for seven years in Mr Quarrier's Homes on the consumptive women's ward, while the latter could not be deemed qualified as she had gained her nursing experience within institutions which, for technical reasons, did not meet official training requirements.⁴⁷⁴

⁴⁷² McMurtrie to Hetherwick, Jan. 25 1902, MS7539, N.L.S. See Appendix 4 for details of the professional careers of nurses prior to joining the mission.

⁴⁷³ Hetherwick to McLachlan, Feb. 3 1910, 50 BMC 2/1/105, M.N.A. The Livingstone Memorial hospital had been managed by the Administration since 1908.

⁴⁷⁴ McMurtrie to H.E.Scott, Jan. 31 1902, MS7539 and McMurtrie to Caverhill, Jan 8 1904, MS7539.

In time however, and in association with the growing professional status of the trained nurse, and the increased practice of curative medicine within the mission hospital, greater emphasis was placed on the expertise and experience of the nurse. Mission nurses were no longer expected to be just kindly, single women, they had to be accomplished professionals in their own right. Certain potential candidates were, therefore, advised to gain further practical experience at the mission's Deaconess Hospital before their departure date was confirmed.⁴⁷⁵ Other nurses were encouraged to gain midwifery and dispensing skills during their furloughs. The period also witnessed an increasing awareness amongst mission nurses of the value of nursing qualifications. For example, Miss Priest had not received a full surgical training and her nursing colleagues at the Blantyre hospital made clear their view that her skills in dressing wounds were inadequate.⁴⁷⁶

Whilst the UMCA only ever had one doctor working within its vast diocese, the Blantyre mission usually had a good supply of physicians. At various points up until 1914 it had three doctors within its employ. The Administration's medical personnel also provided assistance during times of furlough and other staffing shortages. Therefore, whilst the UMCA nurse was expected "for fully two-thirds of her time [to]... run her hospitals on her own, and to be prepared for any emergency that may arise", ⁴⁷⁷ the Blantyre nurse was recruited in the first instance as the handmaiden of western medicine. Hence, Nurse Lewis, on joining the mission, agreed "to act faithfully under the direction of Dr. Caverhill, the senior Medical Missionary attached to the Blantyre Hospital, or any other whom the Committee

⁴⁷⁵ This was the case for Nurse Priest around 1906. See McMurtrie to McGillivray, March 3 1906, MS7540, N.L.S.

⁴⁷⁶ Hetherwick to McCallum, Aug. 17 1907, 50.BMC.2/1/82, M.N.A.

⁴⁷⁷ *Central Africa*, June 1908.

may appoint in his place."⁴⁷⁸ The nurse's dependence on her medical superior was actively encouraged by the FMC. Miss Aikman, based at the Zomba Hospital, was instructed by John McMurtrie of the FMC during a medical staffing crisis: "Just keep the hospital going as far as you can till Dr. Scott gets out. Get any help you can but refuse cases for which only a doctor ought to take responsibility."⁴⁷⁹ Nurse Liddell's nervous breakdown in 1915 was attributed to the stress of having to run the hospital in the absence of medical support during the war time emergency.⁴⁸⁰

The gradual centralising of the medical work of the mission around St. Luke's Hospital reinforced the Blantyre nurses' dependence on medicine. In the first two decades of the twentieth century, as curative medicine was more systematically practised at St Luke's and as its African medical training programme became organised, the hospital adopted the ambitions and organisation of a British teaching hospital. This was an institution which confirmed the nurse's inferior position to medicine. The physical environment of the hospital was also modelled on its English counterpart. Miss Johnson of the UMCA described her experience of a religious service at the Blantyre Hospital in 1914:

The patients seemed most attentive, there were about thirty. The ward in which we had service was the men's surgical ward, with twenty beds, very much like an English ward, with plain white-washed walls, ordinary bedsteads with grass mattresses and red blankets ... The rest of the work is done by natives, who are trained to be sanitary inspectors, &c. They have four years' training and then they can obtain Government posts.⁴⁸¹

⁴⁷⁸ Agreement between FMC of Church of Scotland and Miss Janet Muir Lewis, 50.BMC.2/1/103, M.N.A.

⁴⁷⁹ McMurtrie to Miss Aikman, Dec. 9 1904, MS.7540, N.L.S.

⁴⁸⁰ Hetherwick to McLachlan, April 3 1915, 50.BMC.2/1/139, M.N.A.

⁴⁸¹ *Central Africa*, Sept. 1914.

Church of Scotland mission nurses were at times located at the outstations of Mulanje and Domasi where, in the absence of male medical supervision, on occasions they found themselves responsible for treating serious, chronic cases. However, nurses were required frequently to move between stations to accommodate the exigencies of the service. Therefore the Blantyre nurses were not forced to practise for too long independently of their medical superiors.

Livingstonia

The Livingstonia Mission recruited its first nurses, Margaret McCallum and Maria Jackson, in 1897. Margaret McCallum, aged 31, had previously nursed contagious and infectious diseases. Maria Jackson, aged 28 and “exceedingly pleasant in manner & appearance”,⁴⁸² according to her character reference, had worked as a fully qualified nurse at Glasgow’s Royal Infirmary. Prior to joining the mission, she gained experience in maternity work.⁴⁸³

In the absence of hospital facilities, both of these nurses were compelled to undertake non-nursing tasks. Miss McCallum initially assisted with the educational programme of the Livingstonia Station before continuing with this work at Bandawe. Nurse Jackson was informed prior to joining the mission that she would initially be required to provide cover during the furlough of the qualified school mistress, Miss Stewart. As a professional nurse, she considered herself an incompetent teacher. She wrote:

⁴⁸² Hill to Smith, April 12 1897, MS.7880, N.L.S.

⁴⁸³ Hill to Smith, April 12 1897, MS7880, N.L.S.

The longer I think about it, the more nervous I feel about attempting Miss Stewart's work while she is home on furlough. I know the true missionary spirit makes one willing to try anything, and if Miss Stewart had been a nurse I would have had no hesitation whatever in going out, and would gladly have helped to teach or do any other kind of work, but it seems different to deliberately take the place of a certificated teacher.⁴⁸⁴

Nurse Jackson's initial salary of £120 per annum was equal to that paid to the first nurses employed by the Blantyre Mission.

The resignation of both of Livingstonia's pioneer nurses was announced in 1899. Nurse Jackson married Malcolm Moffat and Nurse McCallum married Charles Stuart, both employees of the mission, in 1900 and 1901 respectively. Mary Fleming, the daughter of the late minister of Newtyle Free Church replaced Nurse Jackson at the Institution in 1900 on a salary of £120 per annum.⁴⁸⁵ She was joined at Livingstonia by Miss Jessie Martin, a qualified nurse, who had worked for a year at Miss de Broen's Belleville Mission in north Paris before joining the mission. As the daughter of a minister of Bathgate and granddaughter of a minister of Kirkcaldy, she was well suited to missionary work. She was officially employed as a teacher and honorary nurse at Livingstonia, the title 'honorary' denoting the voluntary capacity of her labours, or the fact that her salary had been met by sources independent of the mission. She subsequently terminated her employment in 1909 on account of ill health.⁴⁸⁶ The mission also recruited, in 1900, the honorary nurse, Winifred Knight, the daughter of a former minister of Bearsden and granddaughter of the late Dr. A. N. Somerville, a leading Free Church missionary evangelist⁴⁸⁷. The Livingstonia staff book recorded that the Somerville connection was

⁴⁸⁴ Jackson to Hill, April 15 1897, MS7880, N.L.S.

⁴⁸⁵ *Livingstonia Mission Staff Book*, p. 25, Acc.7548.D.73.

⁴⁸⁶ *Livingstonia Mission Staff Book*, p. 24, Acc.7548.D.73.

⁴⁸⁷ J. R. Fleming, *The Church in Scotland, 1875-1929* (Edinburgh, 1933).

responsible for her missionary salary, whilst the Livingstonia Committee was accountable for her initial expenses and passage to Africa.⁴⁸⁸

From 1904, the mission recruited four highly qualified nurses. Mary Ballantyne was aged thirty-one on her appointment in 1905 and had worked as a sister at Edinburgh's Royal Infirmary prior to commencing missionary service. Her starting salary was £120 per annum. She was initially appointed to Livingstonia before transferring to Mwenzo in 1909.⁴⁸⁹ Mary Henderson, who originated from Bridge of Allan, was aged twenty-six on her appointment in 1907. She was stationed at Kasungu where she worked closely with Dr. Prentice.⁴⁹⁰ Elizabeth Cole, who was considered mature at forty-three on her appointment in 1909, was originally from Ireland. She was also medically and surgically qualified and had worked in Glasgow's Western Infirmary and the Fever Hospital in Tooting, London. She commenced employment at Livingstonia in 1910.⁴⁹¹ Finally, Ruth Livingstone-Wilson, the granddaughter of David Livingstone, was appointed in 1913.

By 1907, the Livingstonia Mission had developed hospital and dispensary facilities in varying capacities at Mwenzo, Livingstonia, Ekwendeni, Loudon, Bandawe and Kasungu.⁴⁹² However, since medical missionaries were required to accommodate their medical practice with their clerical and educational duties, mission nurses were increasingly responsible for overseeing significant amounts of the medical work conducted at these stations. Nurse Ballantyne directed the hospital at Mwenzo with

⁴⁸⁸ *Livingstonia Mission Staff Book*, p. 26, Acc.7548.D.73.

⁴⁸⁹ *Livingstonia Mission Staff Book*, p. 45, Acc.7548.D.73.

⁴⁹⁰ *Livingstonia Mission Staff Book*, p.51. Acc.7548.D.73.

⁴⁹¹ *Livingstonia Mission Staff Book*, p.54. Acc.7548.D.73.

⁴⁹² See Appendix 3.

only minimal degrees of assistance from Dr Chisholm.⁴⁹³ Similarly, Nurse Henderson commanded the hospital and dispensary at Kasungu during Prentice's absences from the station.⁴⁹⁴

The Livingstonia Mission was unusual in that it was not fundamentally opposed to its nurses continuing to practise after their marriage. This was the antithesis of the situation at Blantyre where nurses Farquar, Samuels, Dewar, Lorimer and Hamilton formally ended their nursing careers on marriage, only practising in times of exceptional emergency. The situation at Livingstonia was again governed by the fact that its doctors were overburdened with non-medical tasks and responsibilities and by its lack of qualified nurses. Between 1900 and 1914, seven nurses were employed by the mission, with an average of 3 nurses working in the field at any one point across the mission's vast geographical area.⁴⁹⁵ Mrs Stuart, formerly Nurse McCallum, therefore, directed the medical work at Ekwendeni, although Elmslie remained nominally in command of this work. In 1905 she attended on approximately 4,000 patients.⁴⁹⁶

Celia Davies in her study of the profession of nursing has defined its role in bolstering the status of medicine. She writes:

There is a sense in which nursing is not a profession but an adjunct to a gendered concept of profession. Nursing is the activity, in other words, that enables medicine to present itself as masculine / rational and to gain the power and the privilege of so doing. It has clearly not had the first bite at the cherry in defining its work, and indeed perhaps we get closer to the heart of the matter in recognizing that it is trying to put a conceptual frame around

⁴⁹³ Annual Report, Livingstonia Mission, 1909, p.49.

⁴⁹⁴ Annual Report Livingstonia Mission, 1911, p.25.

⁴⁹⁵ It is important to note that this statistic does not allow for absences on account of furloughs.

⁴⁹⁶ Annual Report. Livingstonia Mission, 1905, p.12.

just those aspects of the work of health and healing that are "left over" after medicine has imposed an essentially masculinist vision.⁴⁹⁷

The performance of these feminine nurturing duties by nurses enabled the doctor to achieve that essential degree of professional aloofness and detachment from the patient which, Davies suggests, defines medicine as a 'masculine' profession. A Blantyre mission doctor wrote: "Nursing is a fine art. When to give food, what to give, how much to give, when stimulants, when quiet, when sleep, are all important life factors."⁴⁹⁸ Macvicar, writing in 1897, reinforced Davies' theories when he wrote of "perhaps the greatest practical development of the Victorian era, the development of modern nursing, without which neither surgery nor medicine could have achieved half their triumphs."⁴⁹⁹

Certain mission nurses appeared to readily accommodate the ideology of the good woman within that of the civilising mission. They took great pride in the design and cleanliness of their hospital, attending to its gardens and arranging vases of flowers throughout its wards in a truly house-proud fashion.⁵⁰⁰ Within the hospital, the African's 'natural' inferiority was superimposed onto the patient's child-like role. African patients were thus depicted in the mission journals as worthy recipients of imperial benevolence: naive or unintelligent, easily pleased with the most simple of novelties. Their delight at Santa's obligatory visit to the hospital ward was annually related to British supporters of mission. Miss Minter of the UMCA referred to her hospital patients as her 'family', an analogy which still prevails in contemporary

⁴⁹⁷ Davies, *Gender and the Professional Predicament in Nursing*, p.61.

⁴⁹⁸ *Life and Work*, April 1894.

⁴⁹⁹ *Life and Work*, Jun.-July 1897.

⁵⁰⁰ *Central Africa*, July 1903.

nursing. Nurse Thomson thrived on her motherly role, administering affection and discipline in equal measure. She wrote:

They call the Nurse *Amatee*, our mother, and for the time being they are indeed as her children. They behave almost always with wonderful decorum, and when they do not, one reading of the Riot Act is usually quite effective.⁵⁰¹

While it was also the good woman's responsibility to instil in her 'children' good morals and religious values, the daily routine of the mission hospital attempted to imbue in Africans the spirit of Christian charity. For example, recuperating patients were instructed to attend to the needs of other invalids and to help with the daily chores in the hospital.⁵⁰² Missionary doctors often perceived the fulfilment of the evangelical function of the hospital as the nurses' responsibility, portraying them as shining examples of Christian femininity. Norris of Blantyre noted:

Combined with the purely medical work is the daily preaching to the patients of the Gospel of Jesus, both directly in the hard sinners, and indirectly by the personal example of kindness and ungrudging attendances of nurses and hospital attendants...and there is no more potent means to that end than the work of European nurses in the native hospitals of this country.⁵⁰³

While the medical profession advanced at this time on the back of new scientific discoveries, that of nursing struggled to achieve a credible professional status. The perpetual association of nursing with domestic labour compromised its professional status. Moreover, within the missions, while lay members were frequently required to nurse the sick in the absence of medical staff, the fact that nurses also acted as housekeepers, sewing teachers and laundry maids was significant in further undermining their professionalism. The potential potency of this process was

⁵⁰¹ *Central Africa*, Oct. 1909.

⁵⁰² *Central Africa*, Aug. 1906.

⁵⁰³ *C.A.T.*, Jan. 3 1903.

diluted within the UMCA by the sheer lack of doctors within the mission field. Anyone who was deemed as having a medical background was appreciated by his or her UMCA colleagues. However at Blantyre, the nurse's usefulness in the absence of the doctor was openly questioned at times. Writing from Domasi, Reid complained:

A nurse anywhere without a doctor has her limitations and she has by her very training been taught to carry out orders not to act on her own initiative...No serious village cases as a rule come in because there is no doctor...But one thing I am quite clear on that nurses as nurses are unnecessary at out-stations so long as you have capable boys to draw on. It is to my mind needless expenditure in salary.⁵⁰⁴

Despite their increasing appreciation of Christian women's evangelical work, the three missions under review continued to operate as male dominated organisations with little accommodation being made to the employment of growing numbers of women. The UMCA, which was dominated by a male clergy, provided few vehicles for the airing of female opinions other than in the mission conferences. Similarly, the Livingstonia mission provided scant opportunities for the voicing of the female employee's view, whilst at Blantyre, women only secured three places on the mission council in 1908. At times the Church of Scotland mission suffered from a severe breakdown in communication between its female recruits, the mission authorities in the field and each of their parent committees in Scotland. For example, in 1903 the women's request for the urgent installation of a chimney in the steamy laundry room was made via the WAFM in Scotland rather than to Hetherwick direct.⁵⁰⁵

⁵⁰⁴ Reid to Hetherwick, Mar. 5 1913, 50.BMC.2/1/125, M.N.A.

⁵⁰⁵ Miss Rutheford to Hetherwick, Feb. 27 1903, MS7625, N.L.S.

The contemporary stereotype of the female missionary as a 'man hunter', was frequently used to denigrate the credibility of nurses. Hetherwick lamented this issue within the Blantyre mission. In 1905 he wrote of the "epidemic of matrimony" which had broken out amongst the mission nurses, a situation which resulted in three out of four of the nurses resigning from the mission.⁵⁰⁶ In 1913 he returned to the theme, suggesting that it would be beneficial if mission nurses were also members of celibate religious sisterhoods.⁵⁰⁷ However, it is interesting to note that all of the missions under review experienced the sexualization of the relationship between doctors and nurses. Howard and Nurse Minter married in the UMCA and Macfarlane and Nurse Lorimer, and Macvicar and Nurse Samuels married at Blantyre. Boxer and Nurse Knight of Livingstonia also married in 1903.

We have observed how the gendered nature of western hospitals allowed the doctor-nurse-patient relationship to mirror that of the patriarchal family. The involvement of mission doctors in public health campaigns reflected the division of labour precipitated by the industrial revolution's creation of public and private spheres. Therefore, whilst doctors were seen to 'go out to work', travelling extensively throughout the region participating in medical campaigns which may be viewed as masculine, the nurse remained behind in the hospital. There was never any doubt, however, that the doctor would resume his position at the head of the house on his return. Indeed, the good woman was expected, through her femininity and domesticity, to provide a calming and soothing haven for him away from the masculine rawness of the frontier conditions.

⁵⁰⁶ Hetherwick to McMurtrie, Aug. 25 1905, 50BMC 2/1/69, M.N.A.

⁵⁰⁷ Hetherwick to McLachlan, Oct. 16 1913, SOBMC 2/1/129, M.N.A.

In the absence of medical assistance, nurses, especially those of the UMCA, attempted to empower themselves to cope with the exigencies of the service by further developing their medical knowledge and skills. Faced with human suffering, nurses increasingly usurped what were traditionally medical procedures, including medicine's sole right to diagnose illness, with the result that the division of labour between mission medical personnel became blurred. Mrs Stuart of the Livingstonia Mission attempted ambitious medical procedures when required, in the absence of Elmslie at Ekwendeni, utilising her husband as her medical assistant. For example, in 1904, she described how she tied a severed temporal artery on a young male patient.⁵⁰⁸ However, in accommodating the sensitivities of the dominant male profession and reinforcing their special virtues of modesty and their dependence on the male doctor, few nurses would openly boast of their medical achievements, except under the guise of 'damsel in distress', fewer still would confess to actually enjoying their additional medical responsibilities. For example, a nurse who had been setting fractured bones wrote: "Now, ought not the thought of all this bungling work to stir the heart of some qualified surgeon, and bring him out here?"⁵⁰⁹ Nurse Armstrong wrote privately regarding the medical books she had been sent, stating that they were:

not much use instead of a Doctor - for instance a child was brought into the dawa with a foreign body up her nose so lightly pushed up that it was impossible to get it down with forceps; so as a last resource I referred to the "Standard Physician" but it said foreign bodies in the nose are dangerous - send for a physician at once!! However, I syringed oil up the nostril instead & the seed came out quite easily next morning.⁵¹⁰

⁵⁰⁸ Annual Report, Livingstonia Mission, 1904, p.29.

⁵⁰⁹ *Central Africa*, Dec. 1896.

⁵¹⁰ Nurse Armstrong to Travers, Dec. 15 1910, A.1.XXIV, UMCA papers, R.H.L.

Despite this, the absence of medical personnel, particularly within the UMCA, largely restricted the cases treated within the hospitals to those chronic conditions, such as ulcers, to which the nurse could easily attend unsupervised. Nurses expressed a sense of professional frustration, even boredom, with the number of ulcer cases which they described as ‘oppressing’.⁵¹¹ However, they clearly relished their independence from the day to day authority of male doctors and administrators. Nurse Thompson wrote:

The freedom of action and general absence of red tape really helps one to bear with the far heavier responsibility which the nurse (in the frequent unavoidable absences of the doctors) is called upon to sustain - as compared with her sisters at home.⁵¹²

Deirdre Wicks, in her study of the interplay of structure and agency in the creation and maintenance of the historical hierarchy within healthcare, has placed positive emphasis on nursing's achievement of professional status, separate and distinct from medicine. She excuses the nurse's participation in her own subordination highlighting the fact that nurses created their profession:

within the constrictions and freedoms of their class and the gender order at specific times and in places and institutions not necessarily of their own choosing... The occupation that resulted was both needed and feared by the medical profession. It was also an occupation that had to be constantly re-made within the institutional constraints and freedoms of the sexual division of labour.⁵¹³

The colonial environment provided a new and exotic location in which the traditional hierarchy and division of labour between doctors and nurses was reinforced. It left the dominance of medicine unchallenged and the changing role of

⁵¹¹ *Central Africa*, Oct. 1909.

⁵¹² *Central Africa*, Oct. 1909.

⁵¹³ Wicks, *Nurses and Doctors at Work*, p.72.

the nurse, particularly of the UMCA and Livingstonia Missions, largely unacknowledged by the home audience and medical hierarchy.

The expectations of their gender roles were particularly emphasised when nurses sought to contravene them. When confronted with the limitations placed on her nursing vocation by the mission's scant in-patient facilities, Nurse McCallum of Livingstonia attempted instead to control aspects of the mission's educational work such that her ambitions were perceived by contemporaries to be almost masculine in nature. For example, she wrote of her intention of visiting all of the distant out-schools:

To visit the north schools would mean camping out for a week, the south a week or ten days. Mr McAlpine may object to a mere woman! undertaking this, but I hope he will agree as only thus can I hope to gain the knowledge that will enable me to relieve him of all the school work.⁵¹⁴

In 1902 the UMCA's Foreign Mission Committee dealt with the case of a Mrs Walrath, a widowed missionary nurse who falsely claimed to be a medical doctor. The prolific communication about this woman does not adequately reveal whether the FMC objected more to her falsified qualifications or to the rumours of her intemperance and ungenteel behaviour. She supposedly "shocked the Bishop of Bombay greatly by her evil tongue" and had acted as an "unprincipled Adventurer in America".⁵¹⁵ Nurse Cullen of the Blantyre Mission was also seen to reject the enforced constraints of femininity. She was accused of behaving in a way not "becoming one in her position as a missionary", with the men of the settler community.⁵¹⁶ She also discarded the evangelising aspect of her role, a trend which

⁵¹⁴ McCallum to Smith, Aug. 9 1899, MS7882, N.L.S.

⁵¹⁵ Mrs Bengough to Father Murrell, June 6 1902, B6 UMCA papers, R.H.L.

⁵¹⁶ Anderson to Hetherwick, Dec. 24 1907, 86 Zom, 2/5/18, M.N.A.

would, in time, become more prevalent amongst missionary nurses as medical developments required the recruitment of more highly skilled practitioners. Nurse Cullen's resentment of the authority exercised by the male doctor or clerical administrator was also unconcealed. Indeed, Macfarlane described how: "Once in the middle of an operation, when a patient was under chloroform, she took a childish 'pet' and refused to do what she was told."⁵¹⁷ Clearly this nurse was questioning medical male power at its most overt point of execution, with the patient open on the table.

Nurses also found more subtle ways of diluting the inherent imbalance of power in western healthcare. For example, they occasionally refused to act as a prop for the demonstration of male medical power, ritualised in the doctor's highly symbolic ward round. Indeed, this was a principal area of contention in 1904 between Doctor Bell-Walker and Nurse Aikman of the Blantyre Mission.⁵¹⁸

The female doctors of the Livingstonia Mission confronted the male-imposed expectations of their gender simply by their professional existence. Despite this, male missionaries continued to impose confining gender specified criteria on to their missionary endeavours. Of the two women, Jane Waterston, recruited to the mission in 1878, was more prepared to overtly contest these constraints.

Born in Inverness, Scotland in 1843, she was one of six children of a bank manager and well-known figure within the Scottish commercial community. Her mother and sisters reputedly suffered from 'hysterical hypochondria' and it is possible that it

⁵¹⁷ Macfarlane to Hetherwick, Dec. 28 1907, 86 Zom, 2/5/18, M.N.A.

⁵¹⁸ Miss Aikman to Hetherwick, Aug. 4 1904, 86 Zom 2/5/16, M.N.A.

was her observations of their enforced dependence on the male provider, her father, which moulded Jane's feminist views on the necessity of female education and female emancipation in general.⁵¹⁹ Although there is speculation that Jane qualified as a nurse and midwife at Glasgow's Infirmary, she departed for Lovedale, South Africa in 1866 principally as a schoolteacher.⁵²⁰ She resigned from Lovedale in 1873 and commenced the difficult process of undertaking medical studies.⁵²¹

The 1858 Medical Act severely restricted the medical practice of women since it accepted on to the Register only those with qualifications from recognised institutions, all of which did not accept female students. Furthermore, the Register would not admit those with degrees from foreign institutions. In addition to this, the majority of Royal colleges would not examine women.⁵²² Jane Waterston was, therefore, forced to undertake medical studies at the pioneering London School of Medicine for Women, which was opened in October 1874. Her three-year course consisted of lectures in anatomy, physiology, surgery, medicine, midwifery, forensic medicine and ophthalmic surgery. She completed her medical studies in 1877 and 1878 and took her licentiate from Kings and Queen's College of Physicians of Ireland. Her father financed her medical studies. However, when his bank failed in 1878, Jane was forced to live very frugally indeed as she attempted to complete her medical training.⁵²³

⁵¹⁹ L. Bean and E. Van Heyningen (eds.), *The Letters of Jane Elizabeth Waterston 1866-1905* (Cape Town, 1983), p.12.

⁵²⁰ Bean and Van Heyningen (eds.), *The Letters of Jane Elizabeth Waterston*, p.13.

⁵²¹ S. Brock, 'A Broad Strong Life: Dr. Jane Waterston', in J. Calder (ed.), *The Enterprising Scot* (Royal Museum of Scotland, HMSO, 1986), pp.75-87.

⁵²² Bean and Van Heyningen(eds), *The Letters of Jane Elizabeth Waterston*, p.57.

⁵²³ Bean and Van Heyningen (eds), *The Letters of Jane Elizabeth Waterston*, p.111.

Jane was at Livingstonia for only six months from November 1879 to April 1880. In December 1878 the Livingstonia Sub Committee unanimously recommended that Miss Waterston be appointed female assistant at the mission and further specified that:

her duties should include the management of a Boarding School for native girls, and assistance to the medical men at the station It must in every case be understood that her position shall be subordinate to those of the regular physicians.⁵²⁴

The engagement was for 5 years at £150 for the first year, climbing to £200 for the fourth and fifth. It was agreed that the Ladies Association would fund the appointment.

Although Jane Waterston did assist somewhat in increasing the uptake of western medicine amongst Africans, she considered that there was not enough medical work at the station for both herself and Laws. Moreover, the strength of character and determination that had enabled her to achieve a medical degree despite extreme opposition from male doctors, created difficulties for her in the missionary field. Macklin of Blantyre informed Laws of his impression of Jane in 1880. He wrote:

How do you and Mrs L. get on with Miss Waterston? She is a funny one. She sent home a list of needs necessary for Blantyre, stuff that wd be in the most refined west of London practice. She mentions simple ointment: plenty of lard in the stovies – zinc ointment – as if any fool cd not make it & some other ridiculous (sic) things. She may & I believe will be useful but for the one evening I spent with her at Marura she disgusted me!⁵²⁵

Not only did Jane feel under utilised at the mission as a doctor, but since Laws had allocated to her the lowest class in the school, she also considered herself to be

⁵²⁴ Livingstonia Sub Committee Minutes, Dec. 5 1878, MS7912, N.L.S.

⁵²⁵ T. Thornton Macklin to Laws, Broughty Ferry, 9 March 1880, Laws, General Letters, Edinburgh University Library (E.U.L.).

undervalued as a teacher. She wrote to James Stewart of her resignation from the mission's service:

I cannot do the amount of teaching and looking after needed here and also practise medicine without simply killing myself...that unless the doctors were to knock about more, there is only work for one here and therefore one is enough...I was judged fit to teach Anatomy in London. I am thought fit for the Alphabet here⁵²⁶

Following her resignation and departure from Livingstonia, Moir of Lovedale wrote to Laws

You know we have Miss Waterston here. She is very ill & has been for a long while. I fear that a little more of the Lake would have killed her...Of course, one who knows her will be inclined to discount a little her confident opinions about men & things. But it is plain you were not all quite harmonious at Livingstonia any more than we are at Lovedale. And that being so, it is well that Miss W. came away.⁵²⁷

The recruitment of an unmarried, single-minded professional female to the mission's services had challenged the gendered views of the European males throughout British Central Africa. Indeed, Fred Moir reputedly wrote to his parents of a recently suffered attack of fever: "unprincipled persons put it down to wanting a visit from the doctor, who has just arrived."⁵²⁸ Furthermore, the insinuation by Laws that Jane Waterston had only come to Livingstonia in the hope of finding a husband infuriated the lady doctor.⁵²⁹

The second female doctor who entered the Livingstonia Mission's service was a more suitable choice for the mission's clerical elite. The daughter of Rev. George

⁵²⁶ Bean and Van Heyningen (eds), *The Letters of Jane Elizabeth Waterston*, p.168.

⁵²⁷ Wm. J. B. Moir to Laws, Lovedale, 20 June 1880, Laws, General Letters, E.U.L.

⁵²⁸ Bean and Van Heyningen (eds.), *The Letters of Jane Elizabeth Waterston*, p.152.

⁵²⁹ Livingstonia Sub Committee Minutes, Sept. 21, 1880, N.L.S.; Brock in Calder (ed.) *The Enterprising Scot*, p.82.

Robson of Perth and a graduate of Glasgow, Agnes Fraser married Donald Fraser, the most able of the younger generation of Livingstonia's ordained missionaries, in 1901 and was therefore not formally recognised as a doctor in her own right, but rather as a missionary wife. Moreover, the birth of her children served to enhance her image as the 'good woman'. Despite formalising the provision of medicine at Hora from 1901 and at Loudon in Ngoniland from 1903, her services as a doctor were not endorsed with an official mission salary, although she did receive a medical grant in return for her labours.⁵³⁰

Dr. Fraser was supported in her medical work by her husband who, she claimed, assisted her in most operations.⁵³¹ She was, however, first and foremost a missionary's wife, her medical work being secondary to her role of supporting her husband's missionary labours. Her protracted absences during times when she was required to travel with her husband forced her to limit the development of in-patient provision at her station.⁵³² Furthermore, in respect of her official position within the mission as an adjunct of that of her spouse, the FMC communicated principally with her husband, rarely corresponding with the doctor in her own right.

White and Black Nurses

Shula Marks has documented the development of the phenomenon known as the 'Black Peril' following the South African war. During this period, white racial fears escalated concerning the inappropriateness of white female nurses tending the bodily needs of black patients, particularly males. Marks has suggested that as such

⁵³⁰ Annual Report, Livingstonia Mission, 1902, p.37.

⁵³¹ Fraser, *Donald Fraser*, p.110.

⁵³² Annual Report, Livingstonia Mission, 1904, p.34.

racist fears grew, it became unacceptable for white women to nurse black men.⁵³³

At a distance, but not completely isolated from these views, *Life and Work*, in 1899, strove to counteract the racist opinions expressed in a South African journal and to reaffirm the object of their missionary endeavours as the worthy recipients of benevolent western medicine.

When we think of our own patients decent, inoffensive, and indeed very often helpful and gentlemanly in their behaviour, and then turn to this description of the Cape native patients the contrast becomes positively painful. What we invariably find is that the savage, 'however degraded has a perception and instinct of respect for a refined gentlewoman.'...Our experience of the primitive native as patient is a fairly wide one, and we have not found such qualities in him as the writer describes.⁵³⁴

Mission journals do not, however, record in detail the nature of the hands-on care provided by white nurses. We are aware that in times of acute emergency, or in the administering of a therapy, mission nurses readily treated black patients, but we can be less certain of their practical involvement in the basic nursing of patients within the hospital wards throughout the period under review.⁵³⁵ There are various reasons for this. Firstly, within the Livingstonia and UMCA hospitals and in the initial years of in-patient treatments at Blantyre, where chronic conditions, particularly tropical ulcers, were primarily treated, patients were not largely dependent upon nursing staff and were therefore expected to attend to their own basic needs. An account of the daily routine at the UMCA's Malindi Hospital succinctly demonstrates this point. The overseeing nurse wrote of her patients:

I seem to do very little for them. In the morning I attend to their wants, and I look in and out during the day and do what is necessary. They fetch their

⁵³³ Marks, *Divided Sisterhood*, pp.53-54.

⁵³⁴ *Life and Work*, July 1899.

⁵³⁵ By the term 'basic nursing', I refer to the activities of daily living, including assisting dependent patients to bathe, dress, eat and go to the toilet.

own fire-wood, catch their own fish, cook their own food, and sweep the house.⁵³⁶

Similarly, Dr Fraser noted that the patients within her hospital at Loudon “ do the sweeping and dusting and boiling of water required for hospital, and assist the one paid woman I have with the carrying of water and washing of their clothes and blankets.”⁵³⁷

In addition to this, convalescent patients were cajoled into attending to the needs of their fellow invalids, a factor which permitted mission hospitals to proclaim their practical lessons in Christian charity. Patients' families also provided high levels of personal care for their sick relatives. This was less prevalent at the UMCA's Likoma Hospital and tended to involve fewer of a patient's kin. This might in part be explained by the need to transfer both patients and their relatives from the mainland within the limited capacity of the *Chauncy Maples* steamer. However, in the years preceding the training of hospital dressers, familial attendance was the main stay of western medicine at both Livingstonia and at the early Blantyre hospital, as Doctor Bowie noted:

When a sick person comes here to stay he does not come alone; with him comes his mother to cook for him and drive the flies away from his couch. With the mother come the father and brother, uncles or cousins, who cut wood for the fire, smoke, sympathise and gossip with the sick man and his visitors. Most of these attendants sleep in the same room as the patient (sic) and this very soon fills up a small Hospital. It would be very difficult to prevent these people coming and staying, even if we wished to do so, which at present we do not, as we have not yet got an hospital staff to attend to the many needs of the inmates.⁵³⁸

⁵³⁶ *Central Africa*, Oct. 1904.

⁵³⁷ Annual Report, Livingstonia Mission, 1904, p.34.

⁵³⁸ *Life and Work*, Oct. 1888.

Although male medical attendants soon provided increased levels of man-power in both the mission hospital wards and dispensaries, there remained an uneasiness over their attendance on African females.⁵³⁹ There is some, albeit sparse, evidence to suggest that in the years preceding the formal training of black nurses at Blantyre and the UMCA, mission nurses were assisted on the female wards by 'heathen' women. For example in 1909, *Life and Work*, documented that since they had no African nurses they were forced to employ 'raw' or 'partially raw' girls on the women's wards.⁵⁴⁰ Similarly, in 1906, the *Likoma Diocesan Quarterly* made reference to their 'hospital girls'.⁵⁴¹ No mention is made of the duties or performance of these women. Questions therefore arise around the motivation for and the construction of the invisibility of the 'heathen' nurse.

Part of the explanation may be the mission's recognition of the important role of the African woman in the maintenance and promotion of traditional systems of belief. It was considered that the conversion of these influential women would facilitate the conversion of the indigenous community whereas, in their unconverted state, they represented a most formidable barrier to the penetration of Christianity into the region. African women were, therefore, portrayed in ambiguous terms by mission nurses. Christian female converts were frequently described as civilised, grateful and serene. Those who attended the growing number of mother and baby clinics run by nurses, which aimed to instil western child rearing ideals into the African mother, were depicted as 'good *native* women'. Their 'heathen' sisters, who

⁵³⁹ This is an irony in itself when it is considered that white male doctors readily performed intimate procedures on African women, including assisting in an ever increasing number of difficult births. It was thought that the doctor's superior training and discipline unquestionably enabled him to perform such necessary duties in the detached and professional manner which his medical inferiors, including nurses, were considered incapable of.

⁵⁴⁰ *Life and Work*, Jan.-Feb. 1909.

⁵⁴¹ *Likoma Diocesan Quarterly*, No.11, April 1906.

rejected missionary advances were, in contrast, described in savage and brutish terms. African men, however, relative to the women, were considered to have a greater degree of control and reason. Nurse Minter of the UMCA graphically depicted such a scene during a village visit to a sick woman lying in a hut filled with other women.

The patient was stretched on a bed beside a newly-lighted fire, and was to all appearances already dead...so I told them to rub her feet and hands, and a man...shouted at them to do it well, and kicked and struck at them till there were about ten rubbing her at once...at last I stopped and listened again to her heart...the women all crouching round, their faces lit up by the flaming faggots. I saw it all like a picture as I said her heart did not beat...then Bibi Siend gave one piercing shriek, which was immediately taken up by about thirty women in a most appalling yell!...I was so hemmed in by the crowd that I could not get away. However, one of the men from outside fought his way in, pushing the women helter-skelter as he came, and hawled me out, to my great relief.⁵⁴²

Mission literature frequently described the hospital and the work of its white nurses in particular, as the most symbolic practical example of Christian charity to the 'heathen'. An underlying and prevalent theme in the description by nurses of 'heathen' women was that they did not know how to nurse the sick. For example, nurses depicted the 'heathen' mother as not being able to persuade her sick child to eat, although she was otherwise attentive to her offspring and further detailed how the custom-driven interventions of 'heathen' women actually hastened death. Nurse Simpkin, who attended a catechumen women during her difficult confinement wrote:

I was able to put things right, made a fire near to her, covered her with a blanket and gave her very strong stimulating remedies, to which she showed signs of responding. I warned the heathen women relations not to disturb her, and went outside the hut to talk to her husband about moving her to hospital...I re-entered the hut to find her propped up and held, while water,

⁵⁴² *Central Africa*, Sept. 1903.

and that cold, was being poured over her, because "according to custom this should be done." She died in a few minutes.⁵⁴³

Since nursing and nurturing were supposedly 'natural' female instincts, the writings of these nurses appeared to deny the common womanhood between themselves and non-Christian women. By contrast, the Christian African woman, even in facing death, was presented as beautiful and unfearing. In this context, the physical comfort provided by nursing care was linked to the spiritual comfort of Christianity. Nurse Simpkin wrote of a dying woman made comfortable in her last hours by skilful nursing and having just received the Eucharist. The nurse "asks her, 'Do you know who has come to be with you?' She answers, with the most beautiful smile I have ever seen on anybody's face, 'Our Lord is with me now.'"⁵⁴⁴

The missionary nurse's role in ensuring a peaceful death for terminal patients is a constant theme in mission journals. It is ironic that in its cultural state of difference, nurses failed or refused to recognise the holistic healing methods of African women. The powerful missionary discourse, which constructed the provision of bedside care as a natural instinct of Christian femininity, could not celebrate or even acknowledge the nursing skills of women who were associated with ritual, primitive superstition and uncontrolled sexuality.

In assessing the general invisibility of women in history, Joan Scott, utilising literary methodology, has suggested that meaning is conveyed through the use of contrasting opposites. She observes:

⁵⁴³ A. Simpkin, *Nursing In Nyasaland* (UMCA, 1926), pp.25-26.

⁵⁴⁴ *Central Africa*, Oct. 1917.

Fixed oppositions conceal the heterogeneity of either category, the extent to which terms presented as oppositional are interdependent - that is, derive their meaning from internally established contrast rather than from some inherent pure antithesis. Furthermore, the interdependence is usually hierarchical, with one term dominant, prior, and visible, the opposite subordinate, secondary, and often absent or invisible. Yet precisely through this arrangement, the second term is present and central because required for the definition of the first⁵⁴⁵

Although Scott acknowledges inherent difficulties in applying literary techniques to the study of history, her approach allows the construction of the unnurturing 'heathen' female by white nurses to be understood in terms of the legitimising of the missionary role of the British nurse. It succeeded in enhancing the influence of nurses within a missionary environment in which they had failed to achieve professional closure or any real professional credibility. The recognition of the 'heathen' nurse would not only have undermined the nurse's professional status, but would also have shaken the premise of mission which stressed the 'heathen's' primitiveness in comparison to the uplifting civilisation which accompanies Christian conversion. Mission journals, therefore, preferred to proclaim the achievements of their male hospital assistants who as converted, educated 'boys',⁵⁴⁶ appeared to have more fully internalised the ideals of their imperial superiors.

The prevailing irony is that constructions of gender within indigenous society generally identified the basic skills, which underpin modern nursing -nurturing, cooking and providing intimate bodily care, including midwifery attendance- as female tasks.⁵⁴⁷ The medical missionaries themselves documented this division of labour amongst the families who nursed their sick relatives on the hospital wards,

⁵⁴⁵ J.W. Scott, *Gender and the Politics of History* (Columbia, 1988), p.7.

⁵⁴⁶ African students or apprentices were regularly referred to as 'boys' by European missionaries and settlers.

⁵⁴⁷ M. Vaughan, 'Which Family: Problems in the Reconstruction of the History of the Family as an Economic and Cultural Unit', *J.A.H.*, 24, 1983.

describing in various examples how one woman would hold the sick person's head whilst another would attend to his dietary requirements.⁵⁴⁸

The early official medical training courses at the UMCA, Blantyre and Livingstonia Missions were open only to men. There are various reasons for this. Firstly, an over-riding factor behind the exclusion of women was their delayed or partial conversion and education which prevented them from fulfilling the prerequisites of training. The female child's gardening and child care responsibilities contributed to her absences from school, particularly during the busy hoeing season.⁵⁴⁹

Secondly, Kings Phiri has documented factors in the nineteenth and twentieth centuries which threatened the traditional matrilineal *mbumba* within Nyasaland. These included the influence of the slave trade; the penetration of patrilineal groups, such as the Ngoni and Muslim Swahili traders; the patrilineal teachings of missionaries and the impact of the capitalist settler economy.⁵⁵⁰ The effects of these influences cannot be generalised, each affecting individual groups in different ways. Given these pressures on the matrilineal system, there may have been reluctance amongst male leaders to allow females and the ritual labour and child-bearing capacity which they represented, to be lost to the community.

By contrast, young African men appreciated the benefits which the growing settler economy offered. The formal apprenticing of young boys as hospital dressers soon conferred status upon trainees. The payment of a regular monetary wage was fundamental to this. By 1913, hospital attendants at Blantyre were earning between

⁵⁴⁸ *Life and Work*, April 1898.

⁵⁴⁹ *Life and Work*, Feb. 1889.

⁵⁵⁰ Phiri, 'Some Changes in the Matrilineal Family System Among the Chewa', *J.A.H.*, 24, 1983.

10/. to 15/. per month depending on their qualifications. This would rise to one pound per month after a stated period of service. Those with the higher qualification of medical assistant earned from 25/. to 30/. per month and ultimately could earn between £2 or £3 per month.⁵⁵¹ In addition to this, a uniform, the handling of western medicines and the use of medical equipment, which appeared strange and fascinating, also strengthened the appeal of medical training for African men. Howard observed how the trainee:

can next be trusted to visit patients in the villages who send up to say they are ill. This necessitates being equipped with a thermometer, and, still more imposing, a watch, and the assistant really begins to feel that he is somebody.⁵⁵²

Disregarding the structural limitations on the African female's uptake of education and other resources, mission personnel remained suspicious of the converted woman's dedication to Christianity. Whether or not 'to be danced',⁵⁵³ remained a charged issue for female and male catechumens, while it was frequently documented that the women who brought their babies to the dispensary continued to dress them in charms. African women were, therefore, perceived as unreliable and less than fully committed to the benefits of the new civilisation.

However, by 1915, Nurse Burridge of the UMCA's Nkhotakota mission had trained an African woman to help her in the woman's hospital with the daily dressing of wounds and assisting at operations.⁵⁵⁴ At Blantyre, the organised teaching of female nurses was initiated in 1910 with Nurse Hamilton giving the women lectures

⁵⁵¹ Course of Instruction and Scheme of Examinations for Native Hospital Assistants and Medical Assistants, Dec. 1913, 50BMC 2/1/130, M.N.A.

⁵⁵² *Central Africa*, Nov. 1908.

⁵⁵³ "To be danced" was the initiation ritual that signified the adolescent's sexual coming of age.

⁵⁵⁴ *Central Africa*, April 1915.

in bandaging, general nursing and dispensing. Two years later, Hetherwick wrote in his report:

and next spring the first of our women nurses will have finished her three year's course of training in our Hospital and receive her certificate as a fully trained native nurse. Two others have enrolled themselves this session for the course, and without doubt others will follow in their footsteps.⁵⁵⁵

Three more girls were apprenticed in 1914. However, despite these advances, when a student nurse named Hannah, who had been in training for two years, suddenly ran off with the trainee teacher, Duncan Somanje, with whom she had been in 'clandestine correspondence', the old stereotypes of the African woman's lack of discipline and uncontrolled sexuality were reinforced.⁵⁵⁶ Nevertheless, the image of the caring African Christian woman continued to attract attention. As a correspondent in *Life and Work* proclaimed:

Less than four years ago, we merely dreamt of trained, reliable Christian girls in charge of the female wards, and now it is a reality and one of the greatest steps in advance among the African women of the present day.⁵⁵⁷

The Livingstonia Mission appeared to more readily appreciate the potential influence which African women might have upon the uptake of western medicine. As early as 1902, Nurse Knight initiated the process of equipping the older female students with knowledge of wound care and bandaging procedures.⁵⁵⁸ Two years later, several girls from the Institution received instruction from Miss Fiddes on invalid cookery, although these skills were primarily intended for use within the Christian home rather than the hospital.⁵⁵⁹

⁵⁵⁵ Annual Report, 1912, 50 BMC.2/1/123, M.N.A.

⁵⁵⁶ Hetherwick to White, June 26 1912, 50 BMC.2/1/120, M.N.A.

⁵⁵⁷ *Life and Work*, Jan.-Feb. 1914.

⁵⁵⁸ Annual Report, Livingstonia Mission, 1902, p.25.

⁵⁵⁹ Annual Report, Livingstonia Mission, 1904, p.26.

More significantly, the Livingstonia mission willingly acknowledged the skills of the uneducated Christian nurse. A 'native nurse', who was a widow was employed at the Institution in 1904,⁵⁶⁰ whilst in 1907, Nurse Ballantyne suggested that her African female nurse worked more efficiently than her two educated male counterparts. However, the African nurse's domestic competence appeared to be valued more highly than her caring skills. Nurse Ballantyne noted:

If she only had been privileged in her education as these boys, she would be double their worth. You walk into the dispensary any morning, when much work is waiting to be done, to find one of these medicals dusting a large table with a feather. The more practical Maria may be following at your heels with a sensible duster in hand, and, with a look of pity for him, dust the table as it should be with her sari.⁵⁶¹

A Christian woman was also being trained to assist in the new hospital at Bandawe in 1908. One year later, she was described by Berkely Robertson as being responsible for helping the women patients and performing simple dressings.⁵⁶²

The training of female African nurses within the Livingstonia Mission was ad hoc and practically based, whilst their hospital duties were principally domestic in nature. The Christian status of these women, however, was considered of greater importance than their academic competence. This situation remained unchanged in 1913 despite the fact that, from 1910, limited theoretical and practical training was provided for African nurses at Blantyre. At Livingstonia, by contrast, no immediate plans for the initiation of similar instruction existed. As a correspondent noted:

⁵⁶⁰ Annual Report, Livingstonia Mission, 1904, p.26.

⁵⁶¹ Annual Report, Livingstonia Mission, 1907, p.9.

⁵⁶² Annual Report, Livingstonia Mission, 1909, p.40.

Our two female nurses are rather old to learn anything but elementary things, and one of them cannot even read, but they are reliable Christian women, and that is a lot in their favour. Perhaps in the future we may get younger and better educated women to train, at least we are hoping so.⁵⁶³

Deirdre Wicks has described a discourse of healing, which pre-dates the scientific discourse of medicine that has dominated western therapeutics from the eighteenth century onwards. The previously described 'duality of focus' in the nurse's role, as assistant of scientific medicine and holistic practitioner in her own right, forces the nurse to exist in co-operation and tension with her medical superiors.⁵⁶⁴ Wick's substantive point is that it is nursing's preservation of this traditional discourse of bedside healing within its practice and knowledge base which ensures and maintains its professional status, distinct and separate from that of medicine.

However, up until 1914, this caring discourse, which highlights the nurse's nurturing role and civilising example, actually served to constrain and limit the nurse within the missionary environment. The nurse's medical achievements in the field were overshadowed by a discourse that emphasised the femininity of the nurse, irrespective of her race. This militated against the implementation of an officially recognised re-definition of the division of labour between doctors and mission nurses, despite the fact that, particularly within the UMCA, nurses were becoming increasingly confident in performing the medical procedures that their colleagues in British teaching hospitals would never experience. For example, Nurse Simpkin of the UMCA wrote regarding amputations: "the patient is now invariably taken to the

⁵⁶³ Annual Report, Livingstonia Mission, 1913, p.16.

⁵⁶⁴ Wicks, *Nurses and Doctors at Work*.

nearest mission hospital, and in the doctor's absence the nurse, or nurses, assisted by the trained boys, remove the mangled limb." ⁵⁶⁵

Although it may be argued that missions 'liberated' African Christian women from certain potentially oppressive aspects of indigenous culture, such as polygamy and the rituals surrounding child birth, western patriarchal and patrilineal ideologies undermined the traditional influence held by women within matrilineal society. Within the hospital environment, African nurses were not only constrained by the imposition of western constructions of femininity, but in a situation in which the white nurse reigned supreme, the black nurse was forced into the low class position of the probationer of the British nursing profession. Therefore the heavy domestic labour, so commonly associated with nursing, was, in the women's wards of the hospitals, normally undertaken by black hands.

Medical Assistants

The African male medical assistant is represented in mission literature as a strange hybrid between the doctor and the nurse. By studying the motivations underpinning the origins of their role and the details of their training, it is possible to achieve a closer understanding of the assistants' position in the gendered mission medical hierarchy.

The medical training of African males, initiated under Doctor Macvicar in 1896, was intended to produce attendants who would facilitate the penetration of masculine medicine well beyond the confines of the hospital. While nineteenth-

⁵⁶⁵ Simpkin, *Nursing In Nyasaland*, p.40.

century doctors in Britain initially feared that the organisation of nursing would lead to the de-skilling of their profession, it appears that in Nyasaland in the period under review, these concerns did not arise with reference to the training of medical assistants.⁵⁶⁶ There was simply too few western doctors in the region for the generation of competition between them and their African medical inferiors. Moreover, there was also an urgent need for trained personnel who could assist mission staff to administer western medicine to African patients. Indeed, it was often considered that African patients were more willing to receive allopathic treatments from medical assistants rather than European practitioners, as a Blantyre missionary acknowledged in 1908:

It is really through these boys that we reach raw patients to advantage. We notice over and over again how much more readily they will submit to take chloroform, for instance, if administered by one of the boys, and they too can coax patients when all our efforts are of no avail.⁵⁶⁷

However, missionary doctors probably never seriously visualised their medical assistants as doctors; competing in equal terms with them for European and African patients alike. From the envisioning of their training, the medical assistants' role was carefully defined as one of 'assistant', while the limits placed on their medical knowledge by white doctors and nurses effectively limited their professional potential. In 1906, the Livingstonia Mission's Annual Report stated with regard to its medical assistants: "there is no pretence made of these students being the

⁵⁶⁶ M. Lyons, 'The Power to Heal: African auxiliaries in Colonial Belgian Congo and Uganda', in D. Engles and S. Marks (eds.), *Contesting Colonial Hegemony. State and Society in Africa and India* (London, 1994), pp.202-223, in contrast, describes how this was a major concern for doctors in the Congo and Uganda.

⁵⁶⁷ *Life and Work*, Nov.-Dec. 1908.

equivalent of medical students at home".⁵⁶⁸ The doctor, therefore, always ruled supreme at the head of the hierarchy of health workers.

Macvicar described his plans for African dressers in 1896:

we must then scatter over the surrounding country small dispensaries, each conducted by a properly trained and certificated native Christian dresser and dispenser, whose business it will be to attend to all small ailments himself, and to send all serious cases to the central hospital...In a civilised country it would be a grave error to encourage men to practice Medicine and Surgery in a fractional kind of way. In an uncivilised country where doctors are hundreds of miles apart and there is a thick population, these Doctors are justified in doing so if they can get boys well enough educated to train.⁵⁶⁹

By 1900, Macvicar's first graduates, David Mothela and Harry Kambwiri were operating dispensaries at Domasi and Pantumbi in Angoniland whilst John Gray Kufa was based at Mlumba.⁵⁷⁰

The settler economy and Protectorate Government, realising the economic, health and labour-controlling benefits which could be derived from the practice of western medicine, generated demand for trained medical assistants. This in turn motivated the Blantyre Mission to further develop its training programmes. In addition to this, the mission hospital, which was not only expanding but increasingly practising curative medicine, required greater numbers of trained assistants. By 1901, S. Luke's employed thirteen hospital attendants in various stages of training. John Gray Kufa was the chief dispenser and chloroformist whilst Bernard Dziko was the head surgery 'boy'.⁵⁷¹

⁵⁶⁸ Annual Report, Livingstonia Mission, 1906, p.17.

⁵⁶⁹ *Life and Work*, Oct. 1896.

⁵⁷⁰ *Life and Work*, Jan. 1900.

⁵⁷¹ *Life and Work*, Apr.-Jun. 1901.

The hospital attendants from Blantyre began to inspect the encampments of the various carrying companies from 1901, treating minor ailments on the spot and bringing more serious cases to the hospital.⁵⁷² As the migrant labour system developed, medical assistants would attend to the casualties who collapsed en-route between the labour camps and their distant villages. In 1905 the Oceana Company, which employed five thousand Africans on its cotton plantation, opened its own hospital which was dually operated by a former hospital attendant from Blantyre working under the supervision of the government medical officer.⁵⁷³ Qualified personnel also provided medical treatments for the employees of the railway construction company, while by 1914, a medical assistant known as Zakariah was acting as the 'native' sanitary inspector of the Blantyre Township.⁵⁷⁴ Vaccination campaigns against the frequent sporadic outbreaks of smallpox also dominated medical assistants' time.

Although demand for the trained African's medical services continued to grow, scepticism remained amongst settlers over his ability to practise 'civilised', scientific medicine. These racist prejudices were reinforced in 1900 when the medical assistant known as Columba proved unreliable. Mr. Cox of Cox Brothers.

Coffee Planters reported:

the boy then informed me he would return upon the following Friday and I told him I would call in the people from a distance to be vaccinated on the Saturday morning, the people arrived but the gentleman did not turn up on the Friday or the Saturday so the people again returned to their homes 'a distance of 8 miles, women, children & men' The lymph has all dried up on the arms of those vaccinated, so if he goes on with the work he will have to

⁵⁷² *Life and Work*, Apr.-Jun. 1901.

⁵⁷³ *Life and Work*, Sept. 1905.

⁵⁷⁴ *Life and Work*, Jan.-Feb. 1914.

start afresh only I trust you will not send him to me again. I did what I could for him, but he has proved the colour of his blood or skin.⁵⁷⁵

By 1908, Hetherwick anticipated a more intensive demand for trained medical assistants following the passing of the Vaccination Ordinance, which prohibited the practice of variolation amongst Africans and made vaccination compulsory. In attempting to actively mould the mission's training courses to meet any skills demanded of government vaccinators and, in part, motivated by his desire for official recognition of the mission's medical qualification, Hetherwick stated: "We would be prepared to modify the courses in view of any suggestions that the Government might offer such as would make the Courses of study more generally useful."⁵⁷⁶

As the Blantyre mission continued to respond to wider demands for trained medical assistants, not only did the number of students in training continue to rise, but their tuition was also further organised and developed. In 1905, the mission council minutes recorded plans for the centralisation of advanced educational courses, including technical instruction and medical training at Blantyre's Henry Henderson Institute as a means of standardising and developing teaching techniques whilst making more effective use of equipment and other resources.⁵⁷⁷ In 1906, *Life and Work* announced that their new advanced medical course would be for three year's duration and would consist of theoretical and practical tuition. Candidates would

⁵⁷⁵ Cox, to the Blantyre Mission, March 22 1900, 50.BMC.2/1/32, M.N.A. Sceptism was even expressed over the work of John Gray Kufa whose skills were generally acknowledged as of the highest standard. In 1899 *The Central African Times* reported that his name translated as John Gray Death. The newspaper documented that this title was "Rather a gruesome name for one of his calling and not likely to inspire much confidence." C.A.T, April 8 1899.

⁵⁷⁶ Hetherwick to Norris, Dec.3 1908, 50 BMC. 2/1/96.

⁵⁷⁷ *Council Minutes of the Blantyre Mission*, 25 Jan. 1905, Acc.9069, N.L.S.

qualify as Medical Assistants.⁵⁷⁸ Their junior medical course would also last for three years and would produce Hospital Assistants and Dressers.⁵⁷⁹ In time, demand for training places outran supply, such that by 1906, the Blantyre Mission ceased to formally apprentice students.⁵⁸⁰

The training of African medical assistants developed more slowly within the UMCA for various reasons. The mission's overall philosophy, as has been previously documented, only gradually acknowledged the value of scientific medicine in the preservation of the health of its British personnel and only latterly appreciated its use as an evangelical strategy. Therefore the need for medical middlemen to facilitate the uptake of western treatments was not immediately identified. Moreover, centred on Likoma Island, the mission was a great distance, both geographically and ideologically from the settler community of the Shire Highlands and therefore was not affected by its growing demand for trained African medical assistants. More specifically, since the mission had only one practising doctor and, given his many other duties, such as building hospitals and travelling extensively throughout the diocese, it was extremely difficult for him to initiate the training of African assistants.

The doctors of both missions questioned the ability of Africans to uphold the medical profession's ethical standards and therefore selected candidates for training very carefully.⁵⁸¹ Indeed, four years after the initiation of medical training at

⁵⁷⁸ *Life and Work*, July 1906.

⁵⁷⁹ *Council Minutes of the Blantyre Mission*, Jan. 25 1905, Acc.9069, N.L.S.

⁵⁸⁰ *Life and Work*, Jan.-Feb. 1906.

⁵⁸¹ Lyons in Engles and Marks (eds.), *Contesting Colonial Hegemony*, has documented the prevalence of these concerns in the Belgian Congo and Uganda and relates them to the insecurities of a newly formed profession, pp.210-211.

Blantyre, Howard of the UMCA expressed his ambition to follow suit but found that "up to now, I have not come across a suitable person."⁵⁸² In time, the UMCA devised a lengthy apprenticeship in bottle washing at the hospital as a means of assessing the commitment of candidates. Lyons suggests that 'suitable' recruits were those who appeared to have internalised the values of Christian capitalism; education, hard work and morality.⁵⁸³ The UMCA further stipulated that their medical students must be honest. They were expected not steal little boxes and bottles in the dispensary or to give out medicines free.⁵⁸⁴ Their training was designed to further instil these values:

After a year or two as bottle-washer the apprentice generally becomes a half-timer at school, helping with the dressings for the first part of the morning, but reading in the afternoon with the monitors, or boys preparing for the college. When he leaves school he usually becomes the doctor's personal boy, accompanying him on his rounds to visit the other stations in the diocese ... his afternoons are occupied by special lessons in elementary anatomy and physiology, or ambulance lectures, and so forth. A knowledge of English is essential.⁵⁸⁵

On the commencement of their new three year medical syllabus in 1914, the UMCA had eight students in training at Likoma and two at St Michael's College.⁵⁸⁶ By 1926, twenty-five dawa attendants were trained or were undertaking training at Likoma.⁵⁸⁷ However, medical training at the UMCA was less organised and developed than at Blantyre. In 1905, Howard admitted to Hetherwick: "I have borrowed from Dr. Norris his copy of the lectures to Hospital Assistants written by

⁵⁸² *Central Africa*, Sept. 1900.

⁵⁸³ Lyons in Engles and Marks (eds), *Contesting Colonial Hegemony*, pp.210-213.

⁵⁸⁴ *Central Africa*, Nov. 1908.

⁵⁸⁵ *Central Africa*, Nov. 1908.

⁵⁸⁶ *Central Africa*, April 1914.

⁵⁸⁷ Simpkin, *Nursing In Nyasaland*, p.55.

Dr. Macvicar...I think that it will be very useful as a basis for lectures, but I am afraid that it is rather too far advanced for any of my boys to read by themselves."⁵⁸⁸

By 1902, African male medical assistants at Livingstonia remained few in number. Their medical training had taken the form of an apprenticeship conducted under the auspices of individual medical missionaries. Reuben, a dispenser, assisted Dr. Fraser in Ngoniland,⁵⁸⁹ whilst the medical assistant under Innes at Karonga was described as having received an "interrupted and elementary course".⁵⁹⁰ Boxer's assistant at Bandawe had received the necessary training in pharmacology which enabled him to make up the doctor's prescriptions. He also dressed ulcers and administered chloroform during operations.⁵⁹¹ It was increasingly appreciated by Livingstonia Mission doctors that the effective uptake of western medicine necessitated African assistants being placed at distant dispensaries from where they would refer more serious cases to a central hospital for attendance by the European mission doctor. However, in 1902, it was acknowledged that the mission did not have the necessary means to develop permanent hospitals across its mission stations or instigate the organised training of medical assistants.⁵⁹²

Similar to conditions experienced by the UMCA, the Livingstonia Mission did not witness any real externally imposed demand for the training of medical assistants, as did their counterpart in the Shire Highlands. Although Mwenzo and Karonga had shown signs of commercial development and potential at the start of the century from as early as 1902, the traffic on the Stevenson Road had lessened. This

⁵⁸⁸ Howard to Hetherwick, Jan. 1 1905, 86/zom/2/5/17, M.N.A.

⁵⁸⁹ Annual Report, Livingstonia Mission, 1904, p.34.

⁵⁹⁰ Annual Report, Livingstonia Mission, 1902, p.53.

⁵⁹¹ Annual Report, Livingstonia Mission, 1902, p.48.

⁵⁹² Annual Report, Livingstonia Mission, 1902, p.54.

resulted in fewer carriers being referred to the mission's medical facilities at Mwenzo by trading companies.⁵⁹³ Similarly, by 1904, it was acknowledged that Karonga had not fulfilled its earlier promise of commercial importance. Innes noted:

Out of seven trading concerns in 1899 and 1900 we have only one left, and that one, The African Lakes Corporation, Limited, does not to-day employ tens where, a few years ago, hundreds were in demand.⁵⁹⁴

The mission initiated a medical course at the Institution in 1903, which was intended to equip medical assistants with the skills necessary for them "to act as assistants to European medical men."⁵⁹⁵ The prerequisite of study was that students were to have passed the final examination of the Institution's 'Normal Course' at not lower than second class and have demonstrated "evidence of spiritual gifts".⁵⁹⁶ The medical course was for three years' duration and included the study of anatomy, physiology, chemistry, materia medica, surgery and medicine. By 1904, two students had commenced medical studies although difficulties in teaching the course had become apparent, including the mission's lack of translated medical texts.⁵⁹⁷ On qualifying as a medical assistant in 1907, Yoram Mnyanje Nkata remained at the Institution from where he attended a new dispensary at Mlowe, a lakeshore village 15 miles from Livingstonia, once a fortnight. Operating under the nominal supervision of the European doctor, he was instructed to refer more serious cases to the mission hospital. The other student who completed his course at the

⁵⁹³ Annual Report, Livingstonia Mission, 1902, p.57.

⁵⁹⁴ Annual Report, Livingstonia Mission, 1904, p.46.

⁵⁹⁵ Annual Report, Livingstonia Mission, 1903, p.3.

⁵⁹⁶ Annual Report, Livingstonia Mission, 1903, p.3. The predominantly arts based Normal Course consisted of instruction on scripture knowledge, English, vernacular, writing, arithmetic, teaching, school management, geography, history, theory of music, singing, drill and drawing.

⁵⁹⁷ Annual Report, Livingstonia Mission, 1904, pp.14 and 26.

same time as Yoram was considered unsuitable for more advanced medical studies but reliable enough to assist Elmslie in his work.⁵⁹⁸

Although the Livingstonia Mission placed considerable emphasis on the medical student's academic ability, in the absence of external demand for the skills of medical assistants, his commitment to Christianity and evangelism was more highly valued by the mission's authorities. Potential students had to satisfy missionaries of their moral and spiritual suitability for medical studies. By 1909, there was only one student undertaking such studies, while a year later the medical course was temporarily suspended as "though there have been several applicants, none...have proved suitable."⁵⁹⁹ The Nyasaland Missionary Conference and the Government officially endorsed two medical courses in 1910 for medical assistants and hospital orderlies. By 1911, the mission had two students undertaking studies in each of these courses under the instruction of Dr. Innes.⁶⁰⁰

Although the content and organisation of medical training was directed by doctors, as a result of restrictions on their time, a greater part of a student's practical teaching, particularly within the UMCA, was conducted by nurses. Indeed, Doctor Wigan admitted this in 1914, when he wrote:

Perhaps the most important work is that of teaching the boys, and so far I have done almost nothing in that direction, leaving it to the nurses, but when I return from Kota Kota where I go on Tuesday for a few days, I must try and take my share of the teaching.⁶⁰¹

⁵⁹⁸ Annual Report, Livingstonia Mission, 1907, p.8.

⁵⁹⁹ *The Livingstonia News*, April 1910, p.25.

⁶⁰⁰ Annual Report, Livingstonia Mission, 1911, p.13.

⁶⁰¹ *Central Africa*, Nov. 1914.

It may not have been inappropriate for nurses to largely train students, given the high proportion of basic nursing evident within the junior medical courses. By 1913, the junior medical course at Blantyre included lectures on wound care, general ward work and cleaning, sponging the patient and invalid feeding.⁶⁰² However, it is important to note that male medical attendants and dressers were never envisaged as male nurses. Catherine Burns has, highlighted, with reference to South Africa, the enforced invisibility of male nurses by western healthcare officials who could not throw off the traditional binaries of the white doctor supported by the black or white female nurse. To this was superimposed indigenous beliefs of appropriate gendered behaviour which viewed the provision of intimate care as a female responsibility. African medics in South Africa were therefore confined to the perceived 'masculine' areas of health work, including working on the mines and participating in public health campaigns.⁶⁰³

Following a similar pattern in Nyasaland, and having emerged out of indigenous and European conceptions of gender, the medical assistant was modelled in the image of the male doctor and was intended to move quickly outwith the control of the nurse and the hospital into independent practice at dispersed out-stations. By 1913, the Advanced Medical Assistant's course at Blantyre contained lectures in chemistry, physics, clinical surgery, clinical medicine and even fifty lectures on midwifery; a real sign of growing confidence in black medical professionalism.⁶⁰⁴

⁶⁰² Blantyre Missionary Institution and Hospital First Medical Course for Hospital Attendants, Dec. 1913, 50BNC. 2/1/130, M.N.A.

⁶⁰³ C. Burns, "A Man is a Clumsy Thing Who Does Not Know How to Handle a Sick Person": Aspects of the History of Masculinity and Race in the Shaping of Male Nursing in South Africa. 1900 – 1950', *Journal of South African Studies (J.S.A.S.)*, 24, 4, 1998.

⁶⁰⁴ Blantyre Missionary Institution Advanced Medical Training for Medical Assistants, 50BMC 2/1/130, M.N.A.

By 1914 Doctor Wigan of the UMCA was also attempting to organise the medical tuition provided by his mission along similar lines.⁶⁰⁵

Despite this, the medical assistant's position remained ambiguous and largely undefined. Burns has described black medical attendants as 'male nurses' whereas Lyons refers to those trained after 1945 as 'near doctors.'⁶⁰⁶ In being taught in varying amounts by both doctors and nurses, medical assistants experienced attempts by each of these groups to enforce on to them the different values of the medical and nursing professions. For example, Nurse Spindler of the UMCA, clearly aiming for the students to internalise and demonstrate the supposed qualities of the British nurse, wrote:

It is hard to make them realise the importance of details, and the sacred and high ideal with which we ourselves regard our profession, and they, like us, need the spirit of patience, perseverance, and humility to make their work a success.⁶⁰⁷

In addition to this, reflecting the mission's ultimate evangelical ambitions, medical assistants were expected to conduct ward services and to participate in other religious activities. For example, at Livingstonia, medical students were required to conduct morning and evening worship on the wards.⁶⁰⁸ Furthermore, Edward of the UMCA even conducted circumcision campaigns at certain villages under the supervision of the station's head priest.⁶⁰⁹

⁶⁰⁵ *Likoma Quarterly Diocese*, No.42, Jan. 1914.

⁶⁰⁶ Lyons in Engles and Marks (eds.), *Contesting Colonial Hegemony*, p.214; K.A. Shapiro, 'Doctors or Medical Aids - The Debate Over the Training of Black Medical Personnel for the Rural Black Population in South Africa in the 1920s and 30s', *J.S.A.S.*, 13, 2, 1987.

⁶⁰⁷ *Central Africa*, April 1913.

⁶⁰⁸ Annual Report, Livingstonia Mission, 1904, p.26.

⁶⁰⁹ Mponda Station diary, Sept. 15, 1912. 145.Dom/2/1/7.

Ultimately the African assistant was required to balance the varying professional and religious influences which underpinned his mission medical training in a manner which did not compromise his culturally specific, gendered identity. On the ward and in the dispensary, many medical assistants gravitated towards the 'masculine' aspects of care, such as performing minor surgery, pulling teeth and stitching.⁶¹⁰ Basic nursing care was either performed by the relatives of dependent patients or by the most junior of students who assisted male patients to wash before their formal studies began each day, an unsavoury chore which was necessary for the achievement of their ultimate medical ambitions. It was therefore documented that the dwa boys of the Nyasaland Diocese "are keenly interested in the theoretical part of the work, but rather object to do (sic) the disagreeable part of the nursing. It is sometimes rather difficult to make them understand that it is all part of the work."⁶¹¹

Others who had received medical training ultimately placed this secondary to a stronger religious calling. Harry Kambwiri Matecheta, one of the first ordained ministers at Blantyre epitomized this group. Matecheta, whose Yao-speaking father assisted the pioneering Church of Scotland at Blantyre, had grown up through the ranks of the mission's education department where he also received instruction on printing and medicine. As a loyal adherent of the mission and its teachings, he was ordained deacon by D.C.Scott in November 1894. Thereafter, he pioneered the mission's work at Panthumbi amongst Ngoni speaking people in the early 1890's. He was ordained minister on 9 March 1911.⁶¹²

⁶¹⁰ *Central Africa*, Oct. 1910.

⁶¹¹ 'Hospitals in Nyasaland Diocese' undated paper - probably around 1920. A.3. UMCA, R.H.L.

⁶¹² H. Kambwiri Matecheta, *Blantyre Mission. Stories of its Beginning* (Blantyre, 1951).

At the Livingstonia Mission, where medicine itself received less development than the mission's educational and evangelist programmes, medical assistants were encouraged to attach a spiritual component to their medical endeavours. The mission proudly published, "Extracts from a native evangelists' diary", in 1905 which incorporated the following:

we went to a village called Mphamba. On the way we met a wicked man who was a polygamist...One of us said to him, "How are you getting on with your terrible sickness?" The man said, "I have never felt any pain in my body all these days," "No, you are very sick indeed... We were once in the same position as you are, but as soon as we heard that there is a great Physician, who is willing to save those who are terribly ill, we ran to Him and asked Him to heal us. To-day we are getting better, and are not so bad as you are."⁶¹³

Two of the better known medical assistants of the Livingstonia Mission were Charles Domingo and Stefano Kaunda. Domingo was the son of a cook. He had been brought to Malawi as a young boy in 1881, becoming a dispensary assistant to Laws before undertaking studies at the Institution. He completed his theological training in 1900 and also taught within the Institution. However, by 1908 when he finally left the mission he had still not been ordained.⁶¹⁴ He subsequently returned to the northern province of Malawi as a Watch Tower evangelist and as a strikingly effective critic of colonial society. Stefano Mnjuzi Kaunda was born in Ngoniland and had been held with his mother as a slave before arriving at the mission. He initially trained as a teacher before becoming a dispensary assistant in 1899. He died in 1911 whilst still acting as a medical assistant and as a member of the group of educated African Christians.⁶¹⁵

⁶¹³ *H.F.M.R.*, April 1905, p.172.

⁶¹⁴ McCracken, *Politics and Christianity*, pp.241-242.

⁶¹⁵ *The Livingstonia News*, Oct. 1911, p.73.

John Gray Kufa of Blantyre represented those who embraced the practice of secular, scientific medicine and the western capitalism, which accompanied it. Shepperson and Price suggest that John Gray Kufa "was clearly marked out as the nearest thing to an African doctor in the Protectorate."⁶¹⁶ Originally from the Kongoni mouth of the Zambezi, he had been baptized at Blantyre in 1890 after attending the mission for five years. His influence and apparent commitment to the mission was recognised and by 1893 he had been ordained a deacon. In 1898, Gray Kufa was the first African to achieve ninety percent in a surgical examination and in time became the chief medical assistant at the Blantyre mission. By 1913 he was employed by the Bruce estates at Magomero as estate hospital dispenser. Furthermore, he had become relatively wealthy. He wore well-cut western clothes, purchased land at Nsoni on which he supported both crops and cattle and owned his own brick house, which had a veranda.⁶¹⁷

John Gray Kufa's involvement in the unsuccessful Chilembwe rising has been thoroughly documented. Hetherwick may have viewed him as a member of the new group of educated African Christians who, in the years prior to 1915, were increasingly frustrated by their exclusion from social, political and commercial advancement.⁶¹⁸ He wrote of Kufa following his execution:

He died a penitent soul...so he has paid the last penalty for his crime. Why he entered on such a course is beyond me...he himself told me it was ambition to be a big man...but he was surely too wise to see the hopelessness of the whole scheme.⁶¹⁹

⁶¹⁶ G. Shepperson and T. Price, *Independent African* (Edinburgh, 1958), p.243.

⁶¹⁷ Shepperson and Price, *Independent African*, p.245.

⁶¹⁸ White, *Magomero*, p.123.

⁶¹⁹ Hetherwick to Alexander, Feb. 15 1915, 50.BMC.2/1/138, M.N.A.

It is, however, possible that John Gray Kufa was politically radicalised through his experiences in caring for the sick labour tenants on the Magomero Estate. Under the management of W.J.Livingstone, a distant relative of David Livingstone, the *thangata* land rental system was extensively practised. Under these arrangements, Lomwe immigrants from Portuguese East Africa were provided with eight acres of land on plantations, the rent on which was two month's labour per year. The *thangata* system was open to abuse. For example, planters could easily command up to five months of labour from African tenants by refusing to sign their tax certificates. They could also command labour in the rainy season, when it was essential for tenants to work on their own land. Tenants were powerless to address these abuses, since failure to meet the planters' demands could result in them losing their entitlement to their eight acres.⁶²⁰

In his work in the dispensary on the Magomero Estate, Gray Kufa must have witnessed the physical, social and economic distress which *thangata* placed upon African tenants.

McCracken has suggested that Eliot Kamwana, a graduate of the Livingstonia Mission Overtoun Institution, may have developed a commitment to reform the abuses of colonialism through his experience as hospital assistant in the Main Reef Mine near Johannesburg.⁶²¹ However, similar to John Gray Kufa and other educated African elites at the time, Kamwana was frustrated by the restrictions,

⁶²⁰ White, *Magomero*, pp.87-91.

⁶²¹ McCracken, *Politics and Christianity*, pp. 231, 250

which the colonial system placed on the social and political advancement of Africans.⁶²²

African Medical Assistants and Nurses

Although male medical assistants commenced their training effectively performing basic nursing care for dependent individuals, their junior medical qualification was intended as a prerequisite for the advanced medical course which came close to qualifying them as doctors. White and black female nurses, by contrast, limited by their gender and constrained by the ideals of femininity, which continue to haunt modern nursing, were confined to hospital and village work under the doctor's supervision. Although staffing limitations on occasions forced white missionary nurses to accept medical responsibilities, these were not formally recognised by the British medical or nursing professions.

It is interesting to note that whilst mission doctors referred to black female nurses as 'native' nurses, they refused to allow medical assistants to be known as 'native' doctors. It would appear that mission doctors simply could not contemplate their black equivalent. The *Nyasaland Diocesan Quarterly*, reported on this issue in 1909:

Dr. Howard said he was speaking of boys who had reached the position of 'hospital attendant'. He deprecated by the way the application of the term 'doctor' to these boys. The native name 'sing'anga' was much better. After three years they might according to Zomba regulations become 'medical assistants' or 'dressers'.⁶²³

⁶²² White, *Magomero*, pp.73-145; McCracken, *Politics and Christianity*, pp.227-264.

⁶²³ *Nyasaland Diocesan Quarterly Paper*, No. 25, Oct. 1909.

It is ironic that the term sing'anga in the vernacular actually denoted a traditional herbalist.⁶²⁴

The roles and professional identities of mission medical personnel within Nyasaland, including white and black nurses and medical assistants, were defined with reference to the male-dominated medical profession. For structural reasons, Church teaching and medical training were more accessible to male Africans. However, the gender-specific identities of the nursing and medical professions, when combined with racial prejudices and indigenous gender codes, resulted in male medical assistants being drawn towards 'masculine' medical tasks, whilst being denied full professional status as doctors.

⁶²⁴ King, *The Story of Medicine*, p.23.

CHAPTER 5

MISSION HOSPITALS: 1890-1914

By the end of the nineteenth century it was generally considered in the West that the modern teaching hospital was the most effective institution in which to practise curative, scientific medicine.⁶²⁵ The model of the modern, well-managed hospital, clean, well lit and ventilated was transported out to Africa in the ideals of the medical personnel of the UMCA, Blantyre and Livingstonia Missions who had been professionally socialised within the British teaching hospital.

The mission hospital symbolised in mission medical discourse the most practical example of Christian charity. In "a land of darkness polluted by fear and superstition", the hospital epitomised a sanitised vacuum in which disease resulted from the forces of nature as opposed to the malevolence of an aggrieved spirit or the witchcraft of a jealous neighbour.⁶²⁶ Therein, separated from their contaminating 'heathen' community, African patients could not only be converted to Christ, but also to 'God-given' rational medicine.

Referring Agents and the Uptake of Missionary Medicine

Janzen identifies the concept of a 'therapy manager' within African society who was usually the senior male member of the matrilineage. These senior relatives determined which medical doctor or therapist should be invited to treat the ailments of the junior members of the lineage.⁶²⁷ The African patients of the UMCA,

⁶²⁵ B. Abel-Smith, *The Hospitals 1800-1948. A Study in Social Administration in England and Wales* (London, 1964); Granshaw and Porter (eds.), *The Hospital in History*,

⁶²⁶ Butchart, *The Anatomy of Power*, pp.74-91.

⁶²⁷ Janzen, *The Quest for Therapy*.

Blantyre and Livingstonia Mission hospitals were encouraged to present for treatment by ‘referring agents’.⁶²⁸ However, unlike Janzen’s therapy managers, referring agents were usually missionaries, their African employees or European settlers and Government agents. School pupils identified as in need of treatment by their European or African teachers, were sent to the dispensary for treatment. Patients from the villages or labour camps were referred to the hospital by other European missionaries, African medical workers, government agents or European employers of labour. In some instances, invalids, particularly those who were mission converts, and therefore familiar with the mission’s medical service, would self-refer or encourage their kin to attend the hospital or dispensary.

This chapter will demonstrate that referring agents, who directed African patients to the missions’ medical facilities, particularly the hospitals, were a necessary requirement for the uptake of in-patient treatment by the African sick.

Analysis of Hospital In-Patient Treatment

The UMCA

Between 1894 and 1916, in-patient treatment became available within the UMCA at the central station of Likoma, Nkhotakota, Malindi and Mponda’s. As the uptake of western medicine gradually increased at each of these locations, temporary wards were rebuilt in brick and the separate male and female ward provision was augmented. In 1900, the temporary hospital for Africans at Likoma was described

⁶²⁸ I have developed the term ‘referring agent’ from the contemporary British healthcare system, whereby the general practitioner, in his or her role as gatekeeper to the hospital’s services, ‘refers’ the patient to the relevant hospital consultant.

as consisting of “a large, well-built reed house. It has a window at one side with wooden shutters... There is a verandah, and a low partition separates this from the Hospital, so that there is plenty of ventilation.”⁶²⁹ The following year, Howard described the alterations made to this hospital as consisting of the addition of three windows and a small ante-room and the laying of a new floor of brick tiles.⁶³⁰ By 1906, the temporary hospital provision at Likoma was made permanent as the original church on the island was converted into an infirmary. The building process was described:

The two transepts and the west end were preserved, as they had been rebuilt in 1900, and were in good repair. The nave and chancel were pulled down, but much of the material of which they were composed found its way into the new walls... The present structures bear but little trace of their ecclesiastical origin. There are two quite separate buildings. One consists of the dispensary, with, operating room and store, the main men’s ward and two small wards opening out of it. The other is the women’s hospital, two large wards opening into a walled courtyard, in which are the kitchen and store room.⁶³¹

By 1903, Nkhotakota had temporary hospital facilities for twenty-five African patients.⁶³² Permanent wards for males and females were planned and constructed by Howard in 1904. This hospital design was also utilised for the permanent hospital at Malindi in 1908. According to a correspondent in *Central Africa*, the men’s hospital consisted of:

One large ward and two smaller ones, and there is a nice wide veranda in front. This has a kind of brick bench where the patients spend most of the day. The large room will accommodate about twenty patients. It has two windows and is well ventilated from above. It has also a wide open fireplace with seats on either side... The women's hospital is much the same,

⁶²⁹ *Central Africa*, Sept. 1900.

⁶³⁰ *Central Africa*, April 1901.

⁶³¹ *Central Africa*, June 1906. The symbolic significance of the hospital being constructed from the church is striking.

⁶³² *Central Africa*, June 1906.

only it has two large wards instead of one large and two small ones. The new dispensary has a small operating-room opening out of it.⁶³³

All of the missions under review separated their European and African patients. Furthermore, reflecting the mission doctor's responsibility for the health of his missionary colleagues, European hospital facilities were generally constructed prior to those erected for Africans. Such European hospitals usually provided accommodation for up to three patients and were specifically designed to promote the recuperation of the patient. For example, in 1903, the European hospital at Nkhotakota consisted of two rooms, the larger of which was described as having:

a large bow window facing the north with a glorious view of the lake, and two more large windows facing east and west, and provided with gauze shutters to keep out mosquitoes, so that they need not be closed at night. The floor is tiled – we hope later to have it cemented – and the ceiling is made out of native grass mats.⁶³⁴

The room had one bed in a corner and another at the bow window which enabled the invalid to take in the view during the day. The wards were also equipped with book shelves, and fireplaces which had been fitted with scientific bends which prevented the fire from smoking into the room.

It is important to note that for most of the period under review, the African patients treated within Likoma hospital essentially came from the eastern mainland via the steamer, rather than from Likoma itself. For example, between March 1900 and March 1901, the 75 patients treated were principally from the eastern mainland, as were the 221 in-patients treated in 1912.⁶³⁵ It was also observed in 1900 that the dearth of patients at the hospital was the result of poor steamer communications

⁶³³ *Central Africa*, Jan. 1909.

⁶³⁴ *Central Africa*, July 1903.

⁶³⁵ See UMCA Annual Report for 1900 and *Central Africa*, Oct. 1912.

between Likoma and the eastern mainland “as so many persons who might be brought here do not come.”⁶³⁶

There were various reasons for this pattern of use of the mission’s hospital facilities. Firstly, whilst Likoma’s African population grew rapidly in the twentieth century, the indigenous population was small in the 1890’s and early 1900’s. Secondly, it is possible that as a result of the success of the mission on Likoma, chronic conditions were treated early enough to avoid the need for in-patient treatments. In 1912, when over 100 patients per day were attended on at the dispensary, around one quarter of these were schoolboys who had been referred by their school teachers direct.⁶³⁷ In addition, as a result of limited in-patient beds and a possible reluctance of those on Likoma with kin support to subject to hospital treatment, acutely sick patients were also at times attended on by medical assistants and European nurses within their own homes. Between March 1900 and March 1901, forty patients received domiciliary medical visits on Likoma, the majority of whom were already associated with the mission.⁶³⁸ By contrast, those from the mainland who were in need of intensive treatment had no choice but to submit to in-patient attendance at the various mission stations. Once on the steamer, their option to terminate treatment and return to their village was seriously curtailed.

The number of in-patients treated at Likoma gradually increased between 1901, when 35 were admitted, and 1905, when 167 patients were treated, rising to a peak in 1909, when 376 patients were admitted within the year.

⁶³⁶ *Central Africa*, Sept. 1900.

⁶³⁷ *Central Africa*, Oct. 1912.

⁶³⁸ See UMCA Annual Report for 1900.

The first permanent hospital was opened at Nkhotakota in 1904. The numbers treated were obviously much lower than at Likoma, given Nkhotakota's isolation from the more receptive eastern mainland. However, the attendance at its dispensaries was similar to Likoma and represented school children referred by their teachers and a growing number of women and children from the surrounding mission villages. The mission continued to view its medical work at Nkhotakota as the principal means of breaking down the entrenched opposition to Christianity and, in 1912, considered that the example of missionary nurses able to speak the language would provide the most effective means through which Nkhotakota's strong Muslim component might be reached.⁶³⁹

The stations of Mponda's and Malindi, situated to the south of the lake in the Yao heartland also faced opposition from local people. Islam, which did not threaten the pillars of Yao culture - polygamy and initiation rites - was strong in these regions. The two stations were opened in 1896 and 1898 respectively. Mponda's was originally intended as a base site for supplies sent for Likoma and Nkhotakota. Malindi was an engineering station, which in its pioneering years, had been utilised as a construction site for the mission's steamer and was the location at which all necessary maintenance work on the vessel had been undertaken. Malindi was described as "a Yao station, also surrounded by Mohammedan opposition, so the work is often uphill."⁶⁴⁰

Malindi hospital, made permanent in 1908, was at times required to accommodate around forty patients simultaneously. This hospital could, therefore, treat

⁶³⁹ *Central Africa*, Oct. 1912.

⁶⁴⁰ Hospitals in Nyasaland Diocese, undated, A3. UMCA Papers, R.H.L.

approximately the same number of patients as that of Nkhotakota. By contrast, the Likoma Hospitals could accommodate “over eighty patients at once in the two native hospitals...and this does not include the many babies and small children, who come because they cannot be left behind.”⁶⁴¹ Many of the patients treated at Malindi were from distant villages or had been referred for treatment via the *Chauncy Maples*.⁶⁴² The hospital also occasionally catered for the accident victims of the railway construction work being undertaken at that time.

Communication difficulties proved a considerable barrier to the advance of mission work at both Malindi and Mponda's. The mission had used Swahili and Chinyanja at Likoma, Nkhotakota and on the eastern littoral and was relatively unfamiliar with the Yao language. It followed that the medical work at these stations was seriously hampered by the language barriers and the poor response to evangelical preaching. Similar to other regions, it was principally young men and boys who again formed the first Christian community at these stations.⁶⁴³ In 1912, the Reverend Russell wrote of local resistance to the mission work at Malindi:

It is distressing to one who knows the people, and is allowed to go in and out amongst them, to see the number of horrible cases of sickness which might be cured if properly attended to. And in most cases nothing can be done to help, the people absolutely refusing to have their sick carried into the Mission Hospital and receive our help, owing to the fear instilled into their minds by the false teachers amongst them. The utter helplessness of some of these poor souls is too pitiable for words... The teaching and preaching in the village meets with very little response. Fear, superstition, lust and vice claim these people body and soul.⁶⁴⁴

The first permanent mission hospital was not built at Mponda's until 1915.

⁶⁴¹ Yarnton Mills, *What We Do in Nyasaland*, p.128.

⁶⁴² Malindi Station Diary, Nov. 23 1909, 145/Dom/1/6/1, M.N.A.

⁶⁴³ *Central Africa*, Aug. 1914.

⁶⁴⁴ *Central Africa*, June. 1912.

Although at a distance from the settler economy which centred on the Shire Highlands, the UMCA was not completely isolated from the medical needs of the new Protectorate. By 1911, the nurse at Nkhotakota regularly attended to the Boma's sick prisoners, police and African employees for a quarterly payment of 10/. This transaction remained altruistic in nature, as was noted in the district annual report: "Though they have been frequently urged to accept a higher figure, owing to the amount of extra work thereby entailed, the Mission has constantly refused to do so, stating that they merely require a nominal remuneration for the value of the drugs &c thus expended."⁶⁴⁵

However, the patients treated within the UMCA's hospitals and dispensaries were largely restricted to those touched by the mission via its schools, religious classes, employment of labourers and dispensing trips on the eastern mainland. The UMCA in-patients were, therefore, referred to the hospital by European missionaries, African teachers and healthcare personnel, with most of these invalids being forced to travel considerable distances from their homes via the mission steamer. Given the finite numbers of staff, both African and European, employed by the UMCA, the numbers referred to the hospital for treatment were necessarily limited.

Livingstonia

Kerr Cross's small hospital at Karonga, constructed in 1895, was one of the first purpose built in-patient facilities of the Livingstonia Mission and was described as

⁶⁴⁵ Kota Kota Annual Reports, 1910-1911, p.15. NCK.5/1/1, M.N.A.

being of “native fashion”.⁶⁴⁶ However, as has been previously described, the Free Church of Scotland Mission did not erect permanent brick hospitals until well into the new century. The hospital at Dr. Chisholm’s Mwenzo station, constructed in 1903, consisted of a main building, which was flanked on either side by a ward. The hospital also had a kitchen and a store.⁶⁴⁷ In 1907, the hospital at Ekwendeni was constructed in the form of two individual cottages each of which contained two smaller wards. This architectural plan was at variance with the more common hospital design which consisted of two larger wards. However, Elmslie considered that patients and their relatives felt more comfortable in the smaller, more private rooms. His hospital could accommodate from four to eight beds. Furthermore, the cottages, which had been constructed out of bricks, had red tiled roofs and verandahs on which patients could partake of the open air.⁶⁴⁸

The permanent hospitals constructed after 1908 by the Livingstonia Mission tended to centre around a main block, which housed the dispensary and operating theatre. This was flanked on either side by male and female wards. However, the architectural plan of the Kasungu Hospital, built under the direction of Prentice in 1910, was more in keeping with that of S. Luke’s of Blantyre in that it was constructed around the four sides of a central courtyard. This architectural design facilitated the segregation of male and female patients whilst maximising the light and ventilation available to each ward. Three years later Prentice further separated male and female access to the enclosed outside space by building a walled division across its central axis.

⁶⁴⁶ Kerr Cross to Smith, Oct. 4 1895, MS7878, N.L.S.

⁶⁴⁷ Annual Report, Livingstonia Mission, 1903, p.43.

⁶⁴⁸ Annual Report, Livingstonia Mission, 1907, p.29. I am uncertain as to whether the hospital in its entirety could accommodate four to eight beds.

The David Gordon Memorial Hospital, which was formally opened by Sir William and Lady Manning on August 16 1911, was equipped with the most advanced hospital facilities within the Protectorate. The Infirmary was designed by a British architect, Burnet, in collaboration with Dr. Mackintosh of Glasgow's Western Infirmary.⁶⁴⁹ The hospital contained an out-patients' department, consulting rooms, a laboratory and operating theatre, complete with sterilizing and recovery room, as part of its central block, with two ward pavilions on either side.⁶⁵⁰

The new hospital had been funded by the Misses Gordons, in memory of their brother, as early as 1901. However, the building of this infirmary was given lower priority by Laws than the Institution's industrialising programme. Therefore, despite the fact that the donors were distressed by the lack of advancement on their legacy, the hospital was not realised until around ten years later.⁶⁵¹ However, this delay in the construction process enabled the hospital to incorporate within its scheme the technical advancements which Laws had introduced within the Institution, including efficient electric lighting, heating and running water.⁶⁵²

The Livingstonia Mission also required patients to self-refer to the hospital and dispensary or be sent to the nurse or doctor by 'referring agents', including medical assistants, other missionaries, European agents and school teachers. However by 1910, essential referrers to the hospital's facilities were simply not in place since, by that point, the Livingstonia Mission had trained only a handful of medical

⁶⁴⁹ Fairly Daly to Miss Ballantyne, Oct. 4 1907, MS7866, N.L.S.

⁶⁵⁰ Annual Report, Livingstonia Mission, 1910, p.14.

⁶⁵¹ Fairly Daly to Laws, Feb. 16. 1906, MS7865, N.L.S.

⁶⁵² Annual Report, Livingstonia Mission, 1912, p.10.

assistants.⁶⁵³ Furthermore, since the mission was at a considerable distance from the labour encampments and settler estates of the Shire Highlands, they attended on only a few sick Africans who had been referred by European agents. The mission's in-patients, therefore, tended to have been referred by the missionaries themselves. For example, in 1891, Dr Steele's first in-patients at Njuyu had been sent to the mission by Mr. McCallum.⁶⁵⁴

It was also widely acknowledged across the Livingstonia Mission that, similar to the experiences of the UMCA, the African sick avoided accepting in-patient treatment at the mission's hospitals. Dr. Fraser documented of her hospital at Loudon: "how I tout for patients and advertise myself may be dangerous if it comes to the ears of the British Medical Association!"⁶⁵⁵ Four year's later, she further noted:

there is no doubt the people here have a strong objection to coming to a place where people have died, mainly for fear of getting their beds, blankets, or mats, so that one feels that the admission of practically hopeless cases militates against the greatest good of the greatest number, in increasing the reluctance of patients, who would undoubtedly profit by careful treatment, to avail themselves of it.⁶⁵⁶

Given western medicine's incorporation within an African plurality of medical treatments, it was further observed that patients often did not present at the hospital before other indigenous treatments had proved unsuccessful, by which time the invalid's condition was frequently in an advanced state of deterioration, as was documented in the annual report from the Institution:

⁶⁵³ See Chapter 4.

⁶⁵⁴ Steele to Laws, Jan 21 1891, MS7895, N.L.S.

⁶⁵⁵ Annual Report, Livingstonia Mission, 1904, p.33.

⁶⁵⁶ Annual Report, Livingstonia Mission, 1908, p.29.

Unfortunately we have still to complain of patients not reaching us till they are in a moribund condition or till their disease has reached a stage when operative treatment is precluded from offering much hope of success. It is with reluctance that the desire of some of these has had to be acceded to, and they have returned to their homes only to die.⁶⁵⁷

Dr. Fraser noted how she at times had to convince “some reluctant parent or husband that I can’t and won’t undertake to treat a certain case outside hospital.”⁶⁵⁸

Whilst other stations within the Livingstonia Mission struggled to convince potential patients of the benefits of in-patient treatment, that of the Institution initially attended on relatively high numbers of patients. However, it was recognised that the majority of these invalids were students of the Institution or construction workers employed within the Livingstonia Station. Many of these labourers, who were at a distance from family support, had been referred to the hospital by missionaries and African mission workers.⁶⁵⁹ By 1904, Laws was forced to acknowledge that the reduction in patients attending the Livingstonia dispensary, the principal source of patient referrals to the hospital, directly correlated with the reduction in the number of migrant construction workers employed by the Institution.⁶⁶⁰ As these trends intensified, even the new David Gordon Memorial Hospital struggled to fill its beds. Nurse Cole noted in 1913: “Although all have a free invitation, I am sorry to say we can seldom get our two wards full. The women’s ward has not had more than three or four in it, and at present there is only one woman whose ulcer is slowly answering to a twice-daily

⁶⁵⁷ Annual Report, Livingstonia Mission, 1911, p.11; Annual Report, Livingstonia Mission, 1913, p.15.

⁶⁵⁸ Annual Report, Livingstonia Mission, 1904, p.34.

⁶⁵⁹ Annual Report, Livingstonia Mission, 1902, p.12.

⁶⁶⁰ Annual Report, Livingstonia Mission, 1904, p.24.

dressing.”⁶⁶¹ The following year Fairly Daly encouraged Dr Innes to increase the use of the hospital facilities, instructing:

It seems to some of us that if it is possible for Miss Cole and you to do a little itinerating work in the villages at odd times, you might help to make better known the advantages of the hospital and attract patients to it, but this is a matter you on the spot can best judge of.”⁶⁶²

Blantyre

From 1900 onwards, S. Luke's Hospital at Blantyre was involved increasingly in the growing settler economy of the Shire Highlands where, by 1901, it was common place for commercial agents to refer certain of their sick labourers to the mission for treatment.⁶⁶³ As early as 1899, the Annual Medical Report demonstrated the significant role of European commercial agents as referrers to the Blantyre hospital. In that year, 62 people self-referred from the surrounding villages, whilst 153 had been sent to the hospital by their European employers.⁶⁶⁴

Given its location at the heart of the Shire Highlands, it is probable that from the outset Macvicar envisaged his hospital as a teaching institution and centre of curative medicine. The design of Blantyre hospital was certainly advanced by African standards. It consisted of two principal male and female wards that faced each other across a central courtyard. The opposite side of the square was occupied by the Isobel Bowie Scott Ward, which provided two beds for the European sick and a residence for the nurse.⁶⁶⁵ The dispensary and surgery, which contained a consulting or dressings room and a laboratory, completed the hospital plan. The

⁶⁶¹ Annual Report, Livingstonia Mission, 1913, p.16.

⁶⁶² Fairly Daly to Innes, Mar. 31, 1914, MS7868, N.L.S.

⁶⁶³ *Life and Work*, July-Sept. 1901.

⁶⁶⁴ *Life and Work*, Jan. 1900.

⁶⁶⁵ *Life and Work*, April-June 1901.

male ward for Africans, ward 1, contained 24 beds and a bathroom. The ward also provided two small rooms for African attendants and housed the operating theatre. The female ward, ward 2, accommodated 12 beds and also provided two smaller rooms for hospital attendants. In addition to this, a smaller ward for six male patients was accessed from the female ward. Since most missionary hospitals separated their male and female patients as a means of ensuring that no sexual impropriety occurred between the sexes, ward 2's unusual plan demonstrates that the mission staff must have been satisfied with the general supervision of patients available throughout its wards.⁶⁶⁶

The wards were constructed of burnt brick and had iron roofs. Ward 1, was described as being a "lofty, spacious building", whilst the operating theatre was lighted from three sides and had a tiled floor.⁶⁶⁷

The amount of light flowing through the wards of S. Luke's was far greater than that incorporated into the design of the UMCA and Livingstonia hospitals, which purposely limited the number of windows throughout their infirmaries in an attempt to accommodate their patients' fears that the spiritual sources of their illness could enter the hospital through its windows. The difference in hospital design between the three missions is reflective of Blantyre's increasing focus on the treatment of acutely ill labour migrants, who, sick and far from familial support, were forced to accept the treatments and care offered by the hospital, even if they found its architecture alienating.

⁶⁶⁶ *Life and Work*, April-June 1901.

⁶⁶⁷ *Life and Work*, April-June 1901.

By contrast, dissatisfied invalids who normally lived on Likoma Island and those who resided close to the stations of the Livingstonia Mission were more likely to abscond from hospital treatments and facilities that did not accommodate their indigenous beliefs on disease causation.

The stores and kitchen, which supplied both the European and African patients, were located between the European ward and ward 2 of the Blantyre hospital. In addition to this, three small buildings, which were separate from the square hospital complex, acted as isolation wards for infectious conditions. The hospital also utilised an efficient heating system within its design which may have deterred patients from lighting their own fires within the centre of the ward as commonly prevailed within the UMCA and Livingstonia Missions. This central heating system incorporated a:

deep underground fire-chamber...about six feet deep by seven long, arched over and from this a flue is to lead under the hospital floor for the regulation of the temperature of the wards. It could be made as hot as a brick-kiln if necessary, and yet by a gentle iron-plate arrangement will give just sufficient fire to cook a single cup of tea.⁶⁶⁸

S. Luke's Hospital, therefore, resembled the British teaching hospital in its design and gained as a result of this the admiration of mission doctors and health personnel from other missions. For example, Dr Fraser of Livingstonia documented her medical assistant's envy of the professional and organised hospital facilities at Blantyre. She wrote:

⁶⁶⁸ *H.F.M.R.*, Feb. 1897.

We took Reuben, the dispenser, with us to Blantyre, and the result of seeing the well-equipped hospital of that Mission has made him dissatisfied with any ideal short of cement floors and iron beds.⁶⁶⁹

From 1900 onward, the Blantyre Mission witnessed a sharp rise in the demand for its hospital facilities. While 236 in-patients were treated in the Blantyre hospital in 1899, this number had risen to 722 in 1901.⁶⁷⁰ The increased use of the hospital by labour migrants was accelerated by the construction of the railway from 1903. Furthermore, whilst tropical ulcers continued to require in-patient treatment, an increasing number of hospital patients were suffering from acute conditions such as pneumonia, dysentery and industrial accidents which reflected the morbidity factors associated with tenga tenga work and the labour encampments that were located in the Shire Highlands. An enteric ward was opened as early as 1903.

The Blantyre Mission demonstrated the changed emphasis of the treatments provided at its central hospital by regularly listing in its journal comprehensive statistics of its curative rates. For example, in January 1905, it listed the numbers of patients who, recovered, were discharged improved, were still healing or who were unrelieved.⁶⁷¹ In 1905, the average length of stay for inpatients was just 28.6 days, compared to the average of seven or eight weeks at the UMCA in 1912.⁶⁷² The mission also published the annual rate of in-patient mortalities. Reflecting the treatment of acutely ill migrants who were far from kin support, on occasions these statistics could be particularly high. For example, in 1904, twenty-nine patients

⁶⁶⁹ Annual Report, Livingstonia Mission, 1904, p.34.

⁶⁷⁰ See Appendix 5.

⁶⁷¹ *Life and Work*, Jan. 1905.

⁶⁷² *Life and Work*, Jan. 1905; *Central Africa*, Oct.1912.

died in hospital.⁶⁷³ In 1903, the mission pressed the need for a mortuary to the FMC. Hetherwick wrote:

The mortuary in connection with the Hospital here is a most urgent need. At present any bodies have to be put into the Ward Bathroom till they can be buried, and as the Bathroom is attached to the Male Ward it will be seen that the arrangement is not a good one.⁶⁷⁴

Another factor stemming from the mission's focus on the acute medical needs of settler commerce was that the ratio of male to female patients treated in its hospital wards significantly favoured men. In 1899, 201 males were treated in comparison to 35 females and children, whilst in 1906, the year of a dysentery epidemic, 628 males and only 98 females were attended on at Blantyre.⁶⁷⁵ The reduced numbers of female patients treated reflected the lack of involvement of women in the new economy. Given the more rapid turnover of patients and the reduced numbers of female to male patients, the hospital was forced to place its cooking arrangements on a firmer footing. Whereas in the UMCA and Livingstonia hospitals, female patients were encouraged to cook for themselves and for male invalids, just as they would do in their villages, the Blantyre hospital employed women as cooks and washerwomen. They also contracted two boys who were responsible for cleaning the wards, serving the food at mealtimes and other unskilled labour.⁶⁷⁶

Following a temporary increase during the 1906 dysentery epidemic, the numbers of in-patients treated within the Blantyre hospital fell off from 1907. The medical report for January 1908 accounted for the difference from preceding years as

⁶⁷³ *Life and Work*, Jan. 1905.

⁶⁷⁴ Hetherwick to McMurtrie, Oct. 30 1903, 50.BMC 2/1/50, M.N.A. There are no details as to how in-patients interpreted the hospital's treatment of the recently dead when they were accustomed to the traditional funeral rite commencing immediately after the death.

⁶⁷⁵ *Life and Work*, Jan. 1900 and *Life and Work*, Jan.-Feb. 1907. See Appendix 6.

⁶⁷⁶ *Life and Work*, April -June 1901.

resulting almost entirely from a reduction in the numbers of ulcer cases and cases of dysentery treated.⁶⁷⁷ It was considered that the improved working conditions of the employees on the railway line had a significant bearing upon these diminishing statistics, while the reduction in ulcer cases was attributed to the increasing willingness of the surrounding villagers to have their sores treated immediately at the dispensary before they became chronic. Hetherwick, however, detected a reduction in subscriptions to the hospital from commercial agents at this time and related this to more general economic changes in the region. He wrote of the Blantyre Hospital:

We have still a large number of our beds here unsupported by private subscription. In fact some of our supporters are falling off. The Flotilla Company used to support two beds and it is now defunct and the Lakes Company are reducing the number of their beds owing to a reduction of the numbers of their employees. The railway is affecting the traffic and the "tengatenga" are much fewer in number than (sic) they were five years ago. Also things are pressing hard with the Companies now on account of the general slackness of trade in the country and the stopping of the through route to the Congo Free State by the Sleeping Sickness on the borders of the Protectorate and the Congo State. The Railway Company will likely take up one or two beds when they are once fairly settled to work .. but their future seems to me to be doubtful... The Byrne's Estates are in liquidation... The Oceana Company at Chiromo is closing down their estates there... The only bright spot in the outlook just now is the establishment of the Imperial Tobacco Company which has erected a Factory and plant at the Railway Headquarters at Limbe... When they are settled I shall apply to them for their support in the Hospital.⁶⁷⁸

Despite these diminishing trends, the overall secular, service-providing philosophy which underpinned Blantyre's central hospital remained unchanged. This approach to medicine continued to differentiate S. Luke's, not only from the hospitals of the UMCA and Livingstonia Missions, but also from the health facilities available at its own satellite stations at Domasi, Mulanje and Zomba, following the relinquishing of

⁶⁷⁷ *Life and Work*, Jan-Feb. 1908.

⁶⁷⁸ Hetherwick to McCallum, Sept. 16 1908, 50.BMC2/1/93, M.N.A.

Livingstone Memorial Hospital to the Administration. At these outstations, where chronic conditions were principally treated, less emphasis was placed on the secular/medical notion of the success rate and more on the missionary, evangelistic definition of that term.

Between 1908 and 1914, the central Blantyre hospital continued to treat an average of around four hundred patients annually. This was in direct contrast to the meagre numbers of in-patients attended on within the UMCA and Livingstonia Missions and was possibly indicative of the Blantyre Mission's continued use of 'referring agents' over and above its own missionaries and commercial agents. For example, its medical assistants regularly directed the sick to the hospital. In addition to this, the mission formally promoted the crucial referring role of African school teachers. It therefore provided lectures on the subject of hygiene and disease for its teachers in training at the Institution from 1910. By 1912, James Reid, acting head of the mission in Hetherwick's absence, could report to the Government that between thirty and forty teachers had received weekly instruction on elementary anatomy, physiology, common diseases of the country, hygiene, public health and first aid.⁶⁷⁹

Whilst the Blantyre Hospital focused on the sick labourers of European commerce on the Shire Highlands, the Livingstone Memorial Hospital, located in Zomba, the Administration's centre of influence, frequently attended on Government employees. The Zomba hospital had been funded by the daughter of David Livingstone, Mrs Agnes L. Bruce, and was opened in September 1903. It was a brick building with an iron roof which incorporated within its design a male ward of

⁶⁷⁹ Reid to Government Secretary, Jan. 12 1912, 50BMC 2/1/18, M.N.A.

fourteen beds and a female ward for six patients. Its furnishings had been donated by Captain Livingstone Bruce and included modern iron-framed beds which facilitated cleaning.⁶⁸⁰ The hospital beds were endowed by business firms, individuals and the Administration at an annual rate of £10. For example, the annual medical report for January to February 1908 documented the Government's contribution of £50 in support of five hospital beds in the previous year.⁶⁸¹

The hospital's annual report for 1907 acknowledged that a large proportion of the 250-300 patients attended on in the preceding year had suffered from chronic ulcers. However, acutely ill migrant labourers, principally Ngoni workers of the Public Works and Transport Departments of the Administration, were also commonly treated.⁶⁸²

The Zomba hospital struggled to cope with staffing shortages from 1907 in the wake of Henry Scott's transferral to the Kikuyu Mission. Norris of the Administration initially provided temporary medical assistance. However, in view of the Government's nascent medical service in the Zomba region, Norris ultimately recommended to Hetherwick that the mission should formally lease the Livingstone Memorial Hospital to the administration doctors.⁶⁸³ This arrangement, which thus enabled the Blantyre Mission to then focus its medical efforts on its Domasi station, was formalised in 1908.

⁶⁸⁰ *Life and Work*, Feb. 1903.

⁶⁸¹ *Life and Work*, Jan.-Feb. 1908.

⁶⁸² *Life and Work*, Jan.-Feb. 1907.

⁶⁸³ Norris to Hetherwick, Nov. 26 1907, 86/Zom/2/5/21, M.N.A.

Early In-Patient Treatments

The patient frequently first encountered western medicine in the missionary doctor's dispensary or clinic, which was usually held in a purpose-built building, but had been conducted from the doctor's veranda or bedroom in the earliest days of mission. In-patient treatments provided an alternative arrangement to the invalid walking many miles each day from his home to the clinic for the redressing of his ulcerous wounds. Early surgical treatments, usually initiated following traumatic injury, also required in-patient post-operative care, which was provided at Blantyre and the UMCA in temporary reed hospitals of increasing size. The first in-patients of the Livingstonia Mission were also accommodated within other forms of temporary accommodation, before the construction of permanent brick hospitals.

In-patient treatment was celebrated in mission discourse as a practical example to the 'heathen' of Christian charity. However, it was appreciated that traditional beliefs of disease causation would only in time be broken down. Early mission hospitals, therefore, attempted to accommodate the traditional beliefs of the African patient within their design. In direct contrast to the ordered Nightingale wards of the turn of the century British teaching hospital, the mission wards were described as dark and stuffy. Patients initially objected to the hospital's windows, in part because they found their ventilation chilling, but also because, in some cases, they feared that these would allow access to the evil forces responsible for their illness. Howard discussed this issue in relation to his temporary hospital at Likoma:

The open window was a great grievance, and it required several mats to stuff it up to their [the patient's] satisfaction... Still, a wood fire burning in the middle of the mud floor, a string or two of dried fish hanging against the walls, and an ancient shoe which is the especial treasure of one of the

patients, serve to convince one that it is truly native, and would promptly be condemned by any self-respecting sanitary inspector.⁶⁸⁴

The new hospital at Bandawe was described in similar fashion in 1908:

If you go into the ward of an evening you will see the central chimney with its fire on either side. Round this are lying, like so many spokes of a wheel, so many patients or their friends ... if the patients are not yet asleep there may be so much talking going on that you cannot make your voice heard, for the Tonga is a great gossip ... Along the ward sides can be seen the beds. On these are some patients more recently operated on. After one of the more serious operations we can get the people to lie on a bed for a day or two, but they clearly love to get down on the floor with their feet at the fender ... Many of the patients do not realise what a chimney is for, and build their fires to the extreme outside of the fire-place, so that the smoke goes up the nice white-washed walls, and they are no longer white.⁶⁸⁵

Traditional fears also had to be accommodated in the choice of the hospital's site as well as its design or members of the targeted African community would simply refuse to reside there. In 1902, the men's reed hospital at Likoma was found to have been built on ground which was believed to be haunted by witches or *afiti* (spirits). Rejected by the sick of Likoma, the building was instead utilised by the invalids who had been transported from the mainland via the Chauncy Maples for treatment, who were not aware of its problematic background.⁶⁸⁶

In the early phase of mission, the death of a patient within the hospital raised inevitably many concerns and fears for fellow invalids. Mission journals commonly described how so great were these fears that invalids would simply run away after such an event. When Dr. Bowie's first in-patient died on the ward, his hospital was boycotted by fearful patients who were thereafter accommodated by the doctor

⁶⁸⁴ *Central Africa*, Sept. 1900.

⁶⁸⁵ Annual Report, Livingstonia Mission, 1908, pp.41-42.

⁶⁸⁶ *Central Africa*, Aug. 1903.

within his own home.⁶⁸⁷ Furthermore, the Kasungu hospital of the Livingstonia Mission found itself with temporarily vacated wards in 1909, its patients having fled in the wake of the deaths of two invalids within one week.⁶⁸⁸

The In-Patient Experience

This section will principally focus on the UMCA mission hospitals, as primary sources on patients' experiences are more readily available for this mission than for Livingstonia and Blantyre. It will be demonstrated that, despite attempts by European medical staff to enforce western expectations of the role of the patient onto the African invalid, the encounter between mission health professionals and their African in-patients was more accommodative of indigenous systems of healing than the readers of mission journals might have imagined.

For those invalids who had been referred from the east coast of the lake, their hospitalisation must have been a traumatic experience. The process which converted the African community member to individual patient and passive recipient of western medicine began with a journey on the principal symbol of western power on the lake, the mission's steamer. For many women and children this would have been the first time that they had ever been so far from home. The steamer would usually travel to whichever hospital was closest to the patient's pick up point; Nkhotakota, Malindi or Likoma, often arriving at the mission station at the most inopportune times which, in further disorientating the patients, must have

⁶⁸⁷ King, *The Story of Medicine*, p.85.

⁶⁸⁸ Annual Report, Livingstonia Mission, 1909, pp.32-33.

inadvertently ensured their passivity. Canon Winspear of the UMCA described this process:

It was always difficult for the steamer work to keep rigidly to a timetable and it frequently happened that she arrived in the very late evening with many patients for the hospital who had to make their way from the beach to the hospital ward. There the Mission nurses were waiting to provide any attention needed immediately and to issue bedding for each patient. They often wondered when the procession of sick folk would cease and make it possible to close the wards for the night.⁶⁸⁹

For the more seriously ill, further trips in the steamer were required in order for them to receive the necessary medical attention. For example, in 1903, Nicholas of Pachia, who had been wounded by a leopard, and Basil Sutenga, who had sustained a fractured radius and ulna, were subsequently transferred from Likoma all the way to Malindi in order for them to be under the doctor's direct supervision.⁶⁹⁰

The African patient was obviously not aware of the passive child-like role he was expected to enact in accordance with the conventional British model of the patient. However, the mission's various hospital rituals and routines, whether consciously or otherwise, attempted to ensure the patient's compliance with prescribed treatment regimes and his or her voluntary subjection to the doctor and nurse's authority. The steamer serves as a most conspicuous example of this process. The significant number of patients who had been transferred from their villages across the lake to the hospital had effectively lost whatever autonomy they might have had in terminating their in-patient treatment, as their normalisation process, from patient to established community member, was dependent upon their return journey via the mission's steamer. Furthermore, their official discharge from the hospital was

⁶⁸⁹ Winspear, 'Some Reminiscences', *Nyasaland Journal*, 13, 2, 1960, p.56.

⁶⁹⁰ Malindi hospital cases for 1903, 145.Dom/10/4/6, M.N.A.

entirely dependent upon the steamer's timetable. For many patients, therefore, their departure from the hospital was delayed significantly beyond the cessation of their medical treatment. For example, the Likoma hospital reports for 1903, described how case number 72, Chikoko of Mtumba, who had been admitted on August the 26th with chronic ulcers and was deemed 'cured' by December 1, was not discharged until the steamer's arrival at the island on the 19th of the same month.⁶⁹¹

Mission medical staff principally held the balance of power in their routine interaction with African patients since they acted as gatekeepers for admission to and discharge from the hospital. This was particularly enforced on occasions when those who had been admitted on the same day from an individual village were discharged separately. For example, cases 73, 74 and 75 of the Likoma hospital report of 1903, were two sisters and their mother, who had been referred from Mtumba with chronic ulcers. Whilst the mother and one of her daughters were both discharged after a three month stay, the other child remained as an in-patient for a further three months.⁶⁹²

The mission hospital's admission procedure was of particular importance in emphasising the individual's transformed status from that of autonomous being to submissive patient. Ervine Goffman's famous study of the interactionist nature of the asylum identifies the symbolic importance underpinning the institution's admission procedure. He notes:

The recruit comes into the establishment with a concept of himself made possible by certain stable social arrangements in his home world. Upon

⁶⁹¹ *Likoma Hospital Report*, 1903, Dom. 10/4/6, M.N.A.

⁶⁹² *Likoma Hospital Report*, 1903, 145 Dom/10/4/6 M.N.A.

entrance, he is immediately stripped of the support provided by these arrangements.⁶⁹³

He further observes:

Admission procedures might better be called 'trimming' or 'programming' because in thus being squared away the new arrival allows himself to be shaped and coded into an object that can be fed into the administrative machinery of the establishment, to be worked on smoothly by routine operations.⁶⁹⁴

The majority of mission hospitals under review symbolically underscored the in-patient's changed status by means of a ritualised admission process in which the individual was usually stripped of his outside clothing, which was replaced with some form of hospital uniform. He was then issued with some prized items, such as a blanket or some crockery, which had to be returned on his discharge from the hospital. In 1901, *Life and Work*, described the admission procedure for new patients at the Blantyre hospital: "On admission each patient is bathed, his head is shaved, a clean nsaru or short shirt is given to him, and he is put to bed."⁶⁹⁵ Similarly, within the Loudon station of the Livingstonia Mission, Dr Fraser noted that as a result of a donation from the Wellington Church her patients were "respectably attired in a sort of uniform of which they are immensely proud."⁶⁹⁶

Vaughan has however suggested a difficulty in knowing how ideas were "'read' by those at whom they were directed."⁶⁹⁷ In many respects, it may have been possible for the African patient to have interpreted aspects of westernised health care in

⁶⁹³ E. Goffman, *Asylums: Essays on the Social Situation of Mental Patients and other Inmates* (Harmondsworth, 1961), p.24.

⁶⁹⁴ Goffman, *Asylums: Essays on the Social Situation of Mental Patients*, p.26.

⁶⁹⁵ *Life and Work*, April-June 1901.

⁶⁹⁶ Annual Report, Livingstonia Mission, 1904, p.34.

⁶⁹⁷ M. Vaughan, 'Health and Hegemony: Representation of Disease and the Creation of the Colonial Subject' in Engels and Marks (eds.), *Contesting Colonial Hegemony*, p.173.

terms of continuity with traditional systems rather than the revolutionary ideals of Christian rationale and benevolence they supposedly represented. Paul Landau's study of surgical evangelism proposes the cultural translation of surgical procedures in terms of a rite of passage, which was given added emphasis by the fact that traditional healing systems did not cut the body. Utilising the example of a common tooth extraction, Landau has noted how the "experience of surgery, even dentistry, left its mark. When the ordeal ended, the patient, much like the initiate, was physically different and in some pain."⁶⁹⁸ Landau further summarises:

surgical missionaries focused on the southern African body as a discrete site, with a view to producing 'an individual' and a Christian. At the same time, the new moral community, that of believers, lay waiting to absorb converts as novitiates.⁶⁹⁹

Landau's study is speculative in that he appears to interpret the patient's subjection to a surgical procedure at the hands of a European missionary as representative of a new and more general rejection, on the patient's part, of indigenous therapies. However, as has been previously demonstrated, it is erroneous to discuss western medicine in terms of it replacing its indigenous type as the former was instead incorporated within a plurality of treatments.⁷⁰⁰

It is possible to suggest that the hospitals for the treatment of the chronic sick, in part, provided an alternative lineage for their inmates. The early patients of the mission hospitals were, similar to the first converts of Christianity, those who had been in some way excluded from their traditional lineage or who had the least to

⁶⁹⁸ P. Landau, 'Explaining Surgical Evangelism in Colonial Southern Africa: Teeth, Pain and Faith', *Journal of African History*, 37, 2, 1996, p.277.

⁶⁹⁹ Landau, 'Explaining Surgical', *Journal of African History*, 37, 2, 1996, p.281.

⁷⁰⁰ See Chapter 2.

gain from it; former slaves and young men in particular.⁷⁰¹ The hospital provided necessary food, shelter, community and in some instances, Christian conversion, during the patient's lengthy illness and continued to harbour many of these invalids after their recovery. Certain former patients became the first African medical assistants on the wards, whilst others became involved in the provision of ancillary tasks within the hospital. For example, Annetta Chipyela, a long-stay amputee within the Likoma hospital was eventually employed as its cook⁷⁰²

Transformed by their hospital experience, these former patients performed the highly important and almost evangelistic function of encouraging others to undergo medical treatment. For example, the woman known as Duchess who had been treated by Doctor Robinson of the UMCA was said to have been “most truly grateful, and did more than any one person to gradually gain the confidence of the natives of Likoma in the good intentions of the medical work of the mission.”⁷⁰³ Indeed, it is significant that the opening of the permanent hospital at Nkhotakota was marked with the celebration of a feast of rice and beef for a large company of past and present patients.⁷⁰⁴

In-patient treatment within the mission hospitals aimed to ‘civilise’ all aspects of the African patient's life through practical instruction on hygiene (and, as was noted in the journals, cleanliness was next to Godliness), self-discipline and Christian charity. Many patients in the hospitals were not bed bound. Moreover, the majority of invalids could self-care. The hospital routine was therefore utilised as a means of

⁷⁰¹ Vaughan, *Curing Their Ills*, pp.61-62.

⁷⁰² Likoma Diocesan Quarterly Paper (NDQ), no.11, April 1906.

⁷⁰³ *Central Africa*, Aug. 1906.

⁷⁰⁴ Likoma Diocesan Quarterly Paper (NDQ), no.5, Oct. 1904.

structuring and introducing 'civilising' purpose into the 'heathen's' life. The patient's day was divided into a regimented list of tasks and events interspersed with religious teaching. *Life and Work*, thus documented: "Indirectly also each patient is taught cleanliness, and obedience to those rules of health which are the foundations of a healthy life, things he had never thought of before."⁷⁰⁵ In-mates were instructed on how often they should bathe and wash their bandages and their hospital uniforms. They were also kept busy with general chores such as sweeping the floor and dusting. Nurse Ballantyne described her activities amongst the patients at Livingstonia:

My work with the patients has chiefly been trying to lead them into more cleanly habits – teaching them to use the basin provided for washing in instead of a tea cup as they usually do, teaching them not to expectorate all over the place, and also trying to teach the convalescents to help their fellow sufferers...The female convalescents help the native nurse to clean the wards, &c.⁷⁰⁶

The UMCA's journal described how male patients would "re-string the bedsteads that need repairing, both of hospitals and schools, and all help to roll bandages when the old sheets, etc.; which are so kindly sent from England, are cut up."⁷⁰⁷ In addition to participating in sewing classes, female patients were also expected to cook for the men as well as for themselves, although reports do at times record the employment of a hospital cook. Moreover, children, who were usually accommodated within the female wards, were required, where possible, to attend daily school lessons, while those patients with chronic conditions, which required lengthy in-patient treatments, received lessons in morality, self-discipline and Christianity.

⁷⁰⁵ *Life and Work*, Nov. 1902.

⁷⁰⁶ Annual Report, Livingstonia Mission, 1907.p.9

⁷⁰⁷ *Central Africa*, Feb. 1914.

In the UMCA journals, long-stay patients, were frequently portrayed as children, with the nurse fulfilling the role of nurturing mother. Inmates were described as having childlike qualities; innocence and naiveté, who displayed unhidden delight at the small gifts presented to them by the mission. A nurse wrote: "They are so easily pleased; a smile, a joke, a little tobacco, a few bananas, any one of these things makes them all happy for the day."⁷⁰⁸ Supporters of the UMCA in Britain were also regularly informed of how the nurse had delighted her patients with an informative magic lantern show before leading them through their bedtime prayers.⁷⁰⁹

It is important to note, however, that those patients who had already converted to Christianity formed a smaller elite group within the larger group of hospital patients, as was outlined in the many descriptions of Christians dying in the hospital. For example, a member of the mission staff wrote in 1910:

One, a woman with a heart case, who rapidly grew worse but was conscious until very near the end, herself asking for and receiving the Blessed Sacrament. There were several Christians in Hospital at the time and they came to the service and behaved most devoutly. It was very impressive, the dying woman raised on her pillows, the kneeling natives, the priest in his vestments, and only one hurricane lamp for illumination.⁷¹⁰

These patients, whom the hospital had rescued from the fear and terror of irrational superstition, on occasions verbalised their gratitude in the missions' public reports. One invalid, who was described as a vision of restful thankfulness sincerely told how "If it had not been [for] the Hospital I should have been dead by this time."⁷¹¹

⁷⁰⁸ *Central Africa*, March 1904.

⁷⁰⁹ *Central Africa*, March 1904.

⁷¹⁰ *Central Africa*, Sept. 1910.

⁷¹¹ Hetherwick's Report for 1908, 50.BMC.2/1/96, M.N.A.

Discourse of the 'Uncaring African'

I have discussed previously mission medical discourse's utilisation of contrasting opposites as a method of conveying meaning.⁷¹² The prevalence of disease amongst the African community was represented within this discourse in terms of degeneration, darkness and heathenism. This contrasted sharply with the combined effects of Christianity, rational scientific medicine and the resultant mental and physical regeneration of the African subject under the mission's auspices. More specifically, missionary medical discourse was composed of a number of singular themes, each of which effectively demonised certain members of indigenous society, in particular, those who held traditional authority, who were viewed as amongst the most resistant to Christian conversion. Therefore, whilst chiefs, headmen and influential women were described as the epitome of the inherent evils of traditional culture, the individual African subject and potential convert was portrayed within this discourse as the innocent victim of primitiveness and superstition.

The case of a student at the UMCA's St Michael's College, a boy with heart disease, provides an example. On the commencement of his illness, his relatives, believing him to be bewitched, removed him from the mission. On his return, the hospital staff stripped him of the many charms found hanging round his waist before initiating his treatment, which was described in the mission journal:

The various pains were treated as they occurred, and gradually he got better...He did not, however, get quite well. The palpitation of the heart remained and he never has very good health. The reason is simple - he has

⁷¹² See Chapter 4

heart disease. This was the basis on which all the rest had been superimposed. His bewitchment was cured, but his real disease remains where it was before.⁷¹³

The article went on to relate how the boy in question subsequently qualified as a teacher who paid his medical fees to the mission in advance.

In addition to this, the discourse of the unnurturing 'heathen' women who did not instinctively know how to nurse the sick was contrasted with the female Christian converts who commenced their nurse training from 1910 onwards.

Missionary medical discourse aimed to construct the African colonial subject, with each individual component of this discourse serving to further legitimise individual aspects of the work of medical missionaries to the supporters of mission in Britain. Within the mission journals, it is possible to decipher yet another aspect of the missionary medical discourse in the frequent examples provided of the reluctance of the 'heathen' to assist non-kin in times of need or sickness.

On occasions such descriptions were particularly graphic. For example, an early UMCA publication described one of the first patients treated at Nkhotakota. She was a slave wife who had suffered extensive burns and had been left lying on a veranda by her husband. Despite being in full view of her neighbours, she had lain there unassisted until mission staff found her and took her to the mission for treatment.⁷¹⁴ A discourse thus developed which emphasised the hospital's role in encouraging convalescent patients to attend to the needs of other invalids. The

⁷¹³ *Central Africa*, Oct. 1906.

⁷¹⁴ Yarnton Mills, *What We Do in Nyasaland*, p.108.

hospital was therefore promoted as the most effective means of practically demonstrating the Christian message of "Love one another as I have loved you". A correspondent in *Central Africa* thus documented:

We forget that no religion except Christianity has ever taught the care of the sick and the suffering as a religious duty...Remember that every mission hospital at every station is a standing witness of the fact that Christianity is a religion of love.⁷¹⁵

It is not, however, suggested that the discourse of the 'uncaring African' was constructed simply as a missionary fund-raising device. Rather, it was a common theme within mission literature.⁷¹⁶ Stuart has offered an explanation of the treatment of the sick by Africans in his analysis of the obligations of care and other social responsibilities shared by those within the matrilineage, which were not extended to those outwith this kin structure. However, he tempers this argument by emphasising the power of human compassion and the fear that the direct injury of another individual could result in an expensive *mlandu* for the perpetrator's matrilineage.⁷¹⁷ It would therefore appear that the discourse of the 'uncaring African' developed out of ignorance of traditional culture and was continued as part of the further legitimising of the work of medical missionaries within the hospital setting. However, by exoticising a perception of difference in this way, missionaries failed to identify African indifference to aspects of human suffering with the minimal social support provided for certain groups within western society at that time.

⁷¹⁵ *Central Africa*, July 1910.

⁷¹⁶ See also MacDonald, *Africana*, Vol.1, pp.87-88, who highlighted the African practice of encouraging certain sick people to, in certain circumstances, go out to a hut in the bush in which they would either die or spontaneously recover. This convention may be interpreted as a form of public health.

⁷¹⁷ Stuart, 'Christianity and the Chewa', pp.45-48.

Despite being a model of Christian charity, the mission hospital was certainly not a provider of unlimited bounty. At all three missions, patients were expected to contribute financially towards their own treatment. There were various motivations for this, financial being just one. It was also considered that, in accordance with basic rules of economy, a charge in money or in kind promoted western medicine as a hard-earned luxury rather than a facility that was 'cheapened' from ease of access. Moreover, it was judged that patients who paid for treatments were more likely to follow them through to completion rather than absconding in the middle of them. More importantly, mission philosophy refused to pauperise the sick. Howard therefore documented of the UMCA's convalescent patients who were paid for their labour:

But one does not want to pauperize them, but instil some principle of self-help...out of their wages of 8d. or 1s. a week they pay 4d. a week, for maintenance... Sometimes after three or four months they go away cured, with two or three dress suits in the form of yards of cloth.⁷¹⁸

The UMCA did however categorise as 'worthy poor', certain patients who were described as the cases "one always finds in an English parish, who, either from old age or chronic illness are quite unable to support themselves."⁷¹⁹ Appeals were made for the funding of these unfortunates in the mission journal. It is interesting to note that the 'worthy poor' were invariably perfect examples of Christian conversion. Edith Mrombe, who was "a regular and devout communicant and always cheerful in spite of her helpless condition", was typical of this group.⁷²⁰

⁷¹⁸ *Central Africa*, Aug. 1906.

⁷¹⁹ *Central Africa*, March. 1898.

⁷²⁰ *Central Africa*, March 1898.

Mission In-Patient Treatment

It remains consistently difficult to gauge the patient's true impression and experience of hospital treatments amid the prolific mission medical discourse. Analysis therefore is dependent upon a patching together of disparate small details from numerous individual private letters as well as published and unpublished reports. What emerges is a picture of a medical system, which, for many patients, not only mystified and amazed, but also violated, and threatened.

Patients' astonishment at the effects of chloroform has been well documented together with their fear of amputation's mutilation. However, despite the increased uptake of surgery, many patients continued to refuse operations, preferring to live with their pain rather than subject themselves to the doctor's knife. Similarly, the physician's use of tubes which penetrated the body, such as naso gastric and urinary catheters, were also commonly rejected by invalids and their families.⁷²¹

Mission personnel usually held traditional beliefs responsible for this rejection of treatment. They did not appear to accept that their therapies, on occasions, subjected patients, to unnecessary suffering. For example, the Likoma hospital reports for 1900 described case number 11, Anao of Mbweka, a village chief who had developed a suppurative arthritis of the elbow. It was documented that "Healing proceeded steadily. Patient refused another anaesthetic so that 2 pockets just under the skin were slit up without an anaesthetic (sic)". The entry for the 15th of May subsequently described how the patient ran away during the night: "Apparently

⁷²¹ *Likoma Report*, 1900. Out-patients visited in their own homes. Case P. 145.DOM.10/4/7, M.N.A.

he must have been a little off his head & got up & walked away.”⁷²² The pain from his non-anaesthetised treatment evidently was not considered a factor in his absconding.

Communication difficulties, which were rarely referred to in the mission journals, continually threatened the doctor/ nurse/ patient relationship. This was a more significant problem within the UMCA than in the Church of Scotland mission. Where the Blantyre mission required its recruits to prove competent in the language within two years of initiating field work, arrangements were more lax within its Anglican counterpart. Despite the fact that nurses, would make regular close and intimate contact with patients, nursing recruits were informed by the UMCA’s Committee that linguistic skills were not required for the post of mission nurse. Nurse Minter wrote privately in exasperation of this policy: “how are you to judge of what a person is when he can't make you understand what he wants? I'm tired deadly tired of hearing that nurses don't need to know the language.”⁷²³ Doctor Howard expanded further on the communication problem:

for 5/6 of her time a nurse is in the position of doctor. She has got to make her own diagnosis...A nurse who doesn't know the language is no more use relatively than a priest or a teacher who doesn't. She can't find out what is the matter and still more she can't do any mission work...Now I have got 4 nurses here & 3 of them are hopeless at the language...Nurse Armstrong is an excellent little person, but even now I go into the dawa & find her uncertain as to whether the patient has constipation or diarrhoea!!!⁷²⁴

The Blantyre Mission did however experience some language difficulties in the doctor-patient relationship, particularly within its central hospital, where the medical needs of migrant labourers were increasingly serviced. One source wrote:

⁷²² *Likoma Hospital Report*, 1900, Case No.11, 145/Dom/10/4/7, M.N.A.

⁷²³ Miss Minter to Travers, March 15, undated year, A1XV1, UMCA, R.H.L.

⁷²⁴ Howard to Travers, April 9 1903, A1.XV1, UMCA, R.H.L.

“With some of the patients it is found impossible to hold any communication as their language is unknown to any one here and, they are ignorant of Yao or Manganja or any dialect spoken hereabouts.”⁷²⁵ On occasions the African patient was held accountable for the unavoidable language difficulties and resultant confusion that hindered the practice of western medicine. For example, the station journal at Bandawe documented in 1884:

To-day Dr Scott attempted to reduce a dislocation of the elbow said to be of five weeks standing. Finding reduction impossible he after further questioning discovered that the accident occurred fully a year ago. Deceit is so universal amongst the natives that their statements can never be relied upon.⁷²⁶

Whilst certain mission medical personnel focused upon the problems which language barriers posed for the hospital's evangelical function, the consequence of poor communication between the patient and the doctor could be both tragic and fatal. The case of a little child whose naevus on her chest was excised under general anaesthetic provides an example. Despite her mother being warned to starve her before the procedure, the child aspirated in the middle of the operation. The surgical report stated:

It appeared that patient had vomited & her mouth was full of sticky nchima!- Tracheotomy did not appear indicated & would not have been allowed by the mother... Then the mother took up the child & went away towards Ngani where it died.⁷²⁷

Cultural differences between European healthcare personnel and their African patients also, inhibited communication and threatened the effectiveness of western medicine, although mission staff did appear to work very hard to bridge the cultural

⁷²⁵ *Life and Work*, June-July 1900.

⁷²⁶ *Bandawe Mission Station Journal*, Oct. 28 1884, MS7911, N.L.S.

⁷²⁷ *Likoma Hospital Reports*, 1900, Case 54, 145.Dom/10/4/7, M.N.A.

gap. One nurse described the problems of diagnosing illness: "Then you ask, "when did the child beg (sic) to be ill?" And the mother says, "When the rice was so high". If you have not learnt amongst other things, exactly how the rice grows, you have not much idea how long the child has been ill!"⁷²⁸ Similarly, Dr Fraser described her diagnostic difficulties: "Often one can learn nothing more than that it began "Long ago", and that "it ached all over very much". Leading questions often result in either a wholesale admission or denial of everything."⁷²⁹

Similar problems were also experienced in prescribing dosages of medication.

Fraser noted:

as spoons are unknown, the most explicit directions one can give are: "Drink a very little in the morning, at noon, and in the evening; finish it in so many days". And in case one's injunctions are disregarded one must not give enough to do any serious damage if it is disposed of immediately, or shared with anyone else in the village who is also suffering from "nyamakazi".⁷³⁰

At times the problems posed by cultural differences may have been almost insurmountable. We can only imagine what the "Boy from Kuyu", a patient of the UMCA whose chronic leg ulcer was grafted with the excised skin from circumcisions, thought of his surgery. Indeed the fact that he promptly removed all the bandages from his leg, thus destroying the grafting, perhaps indicated his confusion or unhappiness with the procedure.⁷³¹

Agnes Fraser also documented, with regard to her medical work in Nyasaland, how there was limited comprehension of the role of the invalid diet in the recuperation

⁷²⁸ *Central Africa*, Oct. 1917.

⁷²⁹ Annual Report, Livingstonia Mission, 1902, p.38.

⁷³⁰ Annual Report, Livingstonia Mission, 1902, p.38.

⁷³¹ Short Reports of Special Cases 1899, UMCA, 145.Dom/10/4/7, M.N.A.

process. Cultural etiquettes and prohibitions frequently frustrated her attempts at introducing milk and fowl into the Ngoni's daily diet, as men were only permitted to drink milk in its curdled form, whilst women and chiefs habitually would not consume either of these ingredients. Fraser, therefore, resorted to duplicity for the sake of a perceived greater good.

If they are on the station, I can manage by doing the cooking myself; and if they inquire about anything I bring them, I just tell them "It is the food of our country" and a little flavouring helps to prevent them from recognising milk.⁷³²

Western medicine's all powerful 'gaze' contrasted sharply with the treatments employed by traditional diviners who looked beyond the invalid to the wider society for precipitating causes of illness. Western physicians, by contrast, sought to discover the source of disease by focusing upon the patient's body, including his or her most intimate parts, which they did not scruple to touch or manipulate. Patients and their kin must have struggled to accommodate the physical intrusiveness of the new medicine, particularly in midwifery cases where the male doctor violated the traditional gendered role of female kin. The case of Keziah Bisawao, who was attended on by both Bishop Hine and Doctor Howard, provides an example. Following the removal of her dead foetus, the report stated: "The placenta did not follow so this was extracted with the hand in utero. The vagina was washed out & a slight rupture of the perineum was sewn up."⁷³³ It must have been even more traumatic for older people to be subjected to the white doctor's intimate medical examinations. Case number 43 of the Likoma Hospital Report of 1913 was a

⁷³² Annual Report, Livingstonia Mission, 1902, p.39.

⁷³³ Case no. 3, Likoma Hospital Reports, 1900, 145.Dom.10/4/7, M.N.A.

“neglected looking old man”. The report of his physical examination by the doctor stated:

In the hypogastrium, middle line occupying the position of the bladder is a hard rounded tumour size of a cricket ball. It feels quite fixed. ... And on the under surface of the glans penis another small sore can be felt; the prepuce cannot be pulled back.⁷³⁴

Interaction Between In-Patients and Healthcare Staff

Sociological interactionist studies of the struggle for control between hospital staff and their patients have highlighted the asymmetrical power relations in favour of doctors and nurses. Within mission hospitals, the accumulating effect of language difficulties and cultural barriers, together with the patient's unfamiliarity with western medicine, stacked the power balance in favour of healthcare personnel. Despite this, African patients and their families still managed to influence their situation.⁷³⁵ Contrary to their image as passive recipients of care portrayed in mission journals, patients achieved a negotiated order within the mission hospital. Their refusal to always submissively adopt the role of grateful recipient of western imperialism resulted in the mission healthcare personnel having to regularly tolerate ‘problem patients’ within their hospital wards. The ‘problem patient’ was the converse of the ‘model’, defined in sociological studies of nursing:

Ideally, from the nurse's perspective, all patients should be sick when they enter the hospital, should follow eagerly and exactly the therapeutic programme set up by staff, should be pleasant, uncomplaining, fit into the hospital routine, and should leave the hospital “cured”.⁷³⁶

⁷³⁴ *Likoma Native Hospital Report*. Case no. 43, Jan.-Sept. 1913, 145.Dom/10/4/4, M.N.A.

⁷³⁵ For examples of studies of the nature of the interaction between medical personnel and their patients see; Goffman, *Asylums: Essays on the Social Situation of Mental Patients*; Friedson (ed.), *Profession of Medicine*; C. Rosenthal, V. Marshall, A. Macpherson and S. French, *Nurses, Patients and Families* (London, 1980).

⁷³⁶ Rosenthal, Marshall, Macpherson and French. *Nurses, Patients and Families*, p.27.

Non-compliance with treatment was a principal complaint of mission staff who, from the earliest days of dispensary work, described how patients attended infrequently for the dressing of their chronic ulcers. However, within the hospital, when a patient's non-compliance with treatment was coupled with their disruption of the ward routine, the power balance was redressed. For example, when a head captao suffering from dysentery entered the Blantyre Hospital, the medical staff's expectations of the poor thankful African patient were threatened by the amount of luxury items in his possession and his numerous attendants:

He has brought a wooden trunk with his clothes also an umbrella, a leathern girdle with a big native knife stuck in it, and two or three very impressive pairs of old boots and slippers.⁷³⁷

However, when this man countered the doctor's orders by eating prohibited food and refusing to take his medicine, he was instructed to leave the hospital.

As patients became more familiar with western medicine, they increasingly dictated their preferred treatment. Ranger has observed this trend in his study of yaws at the UMCA's Masasi mission in Tanzania, where the long established topical treatments were rejected in favour of new modern injected types.⁷³⁸ From the earliest days of mission in Malawi it was observed, at both Blantyre and the UMCA, that the patient's evaluation of a medicine's effectiveness depended upon the amount he or she had been given and how foul tasting the remedy was. Small amounts of palatable medicine were unacceptable.⁷³⁹

⁷³⁷ *Life and Work*, Feb. 1898.

⁷³⁸ Ranger, 'Godly Medicine', in Feierman and Janzen (eds.) *The Social Basis of Health and Healing*, pp.266-268.

⁷³⁹ *Life and Work*, March 1890.

Moreover, there is evidence within the UMCA hospital records to suggest that medical circumcision became increasingly popular amongst Christian school boys who were suffering from 'likojo' or cystitis with haematuria. For example, Edward from Msumba, case number 1 of the Likoma Hospital Report for 1899 was convinced that circumcision would cure his urinary pain, despite the fact that he had no phimosis. He had been warned that the surgery would not cure his cystitis, none the less, he undertook the procedure without anaesthetic.⁷⁴⁰

Reflecting processes identified within interactionist studies of the institution, pecking orders soon developed amongst patients. Long-stay patients who were more familiar with the staff and the hospital's routine were more likely to be permitted to demonstrate moderate levels of assertiveness. Zamani, who had been a patient at Nkhotakota Hospital for nearly a year, provides an example:

I can't tell you what a nice patient he is, always polite and grateful. I think he gives the tone to the rest. He always acts as spokesman when there is any matter of importance to be communicated to me; such as the unpalatable freshness of the fish, or the scarcity of firewood, or the sleeplessness or want of appetite of one of his companions.⁷⁴¹

By contrast, the least successful in influencing their care, specifically, the duration of their in-patient treatment, were those who annoyed the European staff with excessive complaints or those who were presumed hypochondriac. For example, it was written of a woman suffering from constipation: "She had not much the matter with her, & exaggerated the pain because she wanted to stay in hospital."⁷⁴² She was discharged after only ten days. Patients who demonstrated 'hysterical behaviour', also evidently exasperated medical staff. The school girl, Monika, who

⁷⁴⁰ *Likoma Hospital Report*, 1899. Case no.1, 145.Dom/10/4/7, M.N.A.

⁷⁴¹ *Central Africa*, March 1904.

⁷⁴² *Likoma Hospital Reports*, 1899, Case no.20, 145.Dom/10/4/7, M.N.A.

attended the dispensary with suspected colic and dysmenorrhoea, was described as “hysterical & makes no effort to control herself.” It was concluded that “The pain was exaggerated (sic) by the patient's hysterical tendency.”⁷⁴³

UMCA hospital records also demonstrated that certain mentally incapacitated patients, who were amongst those most in need of long term care from the hospital, were discharged when their behaviour disrupted the smooth running of the wards. Chitunje of Utonga whose chronic ulcer required treatment was such a case. He was described as an “ill-nourished boy - abdomen distended. Eats enormously”. His report described him as:

Mentally deficient, wanders off alone and is away for hours without food, often comes back late at night in an exhausted condition. Patients complain that he is very dirty, and so deaf that he cannot be made to understand.⁷⁴⁴

He was discharged after just fourteen days. However, the UMCA's medical staff were possibly more tolerant of disruptive patients who were capable of making the mental and social step towards conversion. Chivala of Matoka's, a slave child with chronic ulcers was also a regular absconder from the ward. The report stated:

Patient became very irregular about coming to be dressed, & was altogether very unmanageable...In November he never came oftener than once a week to be dressed & was living a regular wild life only returning to sleep in the hospital. He did not come for food but begged it in the village.⁷⁴⁵

This patient was only officially discharged from the hospital five months after his admission when he was caught stealing cassava. However, he was subsequently readmitted some months later and, despite continuing to abscond from the ward,

⁷⁴³ *Likoma Dispensary*, 1903, short reports of special cases, Case no. 12, 145.Dom/10/4/6, M.N.A.

⁷⁴⁴ *Likoma Native Hospital Report*, Jan.-Sept. 1913, Case no.1, 145.Dom/10/4/4, M.N.A.

⁷⁴⁵ *Likoma Hospital Reports*, 1899, Case no.5, 145.Dom/10/4/7, M.N.A.

completed his treatment at the Mponda station. The mission journal proudly announced his new Christian name of Stefano following his baptism.

In 1909, the role of the UMCA hospital in effecting conversion was questioned by Nurse Thompson, who also referred to a more general mission policy, which tested the commitment of those who had commenced ‘hearing’ the Christian message as in-patients. According to this nurse, such patients could not become catechumens until they had returned to their own villages. She wrote:

It is very occasionally we hear of any one *directly* brought to Christ through the medical department. One reason of this is that the hearers in hospital are not allowed to become catechumens then and there unless they belong to that special station, but must wait until they return to their homes.⁷⁴⁶

The conversion rate of the central Blantyre mission hospital may also be questioned since the treatment of acutely sick migrant labourers, whose in-patient stay averaged just 29 days in 1905, left very little time for the healing of the soul in addition to the body.⁷⁴⁷ Despite the limited baptisms that directly resulted from the hospitals’ influence, many Africans experienced the Christian message as in-patients, through the prayer sessions and other services that formed an integral part of the daily routine on the wards. However, as has previously been demonstrated, the African sick often accepted missionary medical treatments whilst rejecting the religious doctrines that accompanied them.

African Medical Pluralism and Therapy Managers

The British teaching hospital, in which mission medical personnel had been professionally socialised, dictated that the relatives of in-patients adopt the role of

⁷⁴⁶ *Central Africa*, Oct. 1909.

⁷⁴⁷ See chpt. 3

passive visitors. Relatives were expected to hand over the care of their loved one completely to the qualified practitioners whose authority they accepted unquestioned. Sociological research has demonstrated that conflict between hospital personnel and a patient's relatives is more likely if the latter step beyond the role of passive, deferential visitors.⁷⁴⁸ I have discussed previously how, as a result of staffing shortages, familial attendance on the most incapacitated patients on the wards of the mission hospital was a necessity in the pioneering years of missionary medicine. However, European healthcare workers were shocked by the authority held by the patient's matrilineal kin in determining what medical treatment should be sought for the patient's illness and when, in the event of poor results, another therapy should be pursued. This was the exact opposite of the legal situation in Britain where all mentally competent adults were deemed capable of consenting to their own and their children's treatment. In Malawi, therapy managers, who were usually the senior male members of the matrilineage, made such decisions for all adults and children under their authority.⁷⁴⁹ The point to be emphasised, therefore, is that western medicine was unable to completely convert its patients from traditional therapies in cases where the therapy manager was opposed to scientific remedies.⁷⁵⁰

Despite this, missionaries continued to promote the hospital as a clinically sanitised domain, amid a sea of superstition, in which disease was caused by nature. By the same token, doctors continued to write in combatant terms of stripping the sick

⁷⁴⁸ Rosenthal, Marshall, Macpherson and French, *Nurses, Patients and Families*, chapter 4.

⁷⁴⁹ Janzen, *The Quest for Therapy*. Janzen utilised the phrase, 'therapy manager' within his study.

⁷⁵⁰ This reflects theories of why alternative medicines have not achieved mainstream usage within the western world. Health systems can only dominate when they are supported by a ruling elite. However, within the Blantyre hospital which frequently treated migrant labourers who were far from kin support, the referring agent may have superseded the influence of the traditional therapy manager.

African of his charms and washing off his traditional medicines before treating the patient. Indeed Mr Piercy of the UMCA described how he found in his Christmas stocking a small box, which contained the charms which Howard had cut from the necks of patients at Likoma hospital. He wrote:

It was amusing to hear of his "short way" with such, simply cutting them off before treating heathen patients at all; doubtless on the grounds of "medical etiquette" that you must be off with one physician before you are on with the next.⁷⁵¹

Medical missionaries continued to portray their patients as the involuntary victims of the superstitious beliefs of their therapy managers. They found it particularly distressing when a patient's kin rejected their recommended treatments and removed their relative from the hospital against the doctor's professional advice. In the case of Ajini of Petuuji, a teenage boy whose leg ulcer required scraping under anaesthetic, the doctor delayed his discharge from the hospital for a full six weeks in the vain hope that consent for surgery might finally be given.⁷⁵²

The staff of the mission hospital were also continually being made aware of their position within the plurality of medicine and were reluctantly forced to adapt to this. They, therefore, frequently encountered patients who had tried many other indigenous treatments for their illness before arriving at the dispensary. Records also demonstrate instances of patients leaving the hospital after many weeks of unsuccessful treatment in order to try other traditional therapies. Moreover, mission doctors recognised the effectiveness of some of these traditional remedies. The

⁷⁵¹ *Central Africa*, May 1904.

⁷⁵² In-patient reports at Malindi Hospital, Oct. 1914 to Oct.1915. Case no. 13, 145.Dom/10/4/3, M.N.A.

UMCA dispensary records describe the case of a boy who suffered from scabies and acute eczema of the scrotum:

Two days ago he developed an acute septic superficial dermatitis of the inside of his thighs & scrotum. Sulphur ointment was ordered, but patient begged to go home to try a native cure, it consists of a decoction used as a lotion...It seemed successful for in a few days he returned quite well as far as the scrotum was concerned.⁷⁵³

As noted previously, UMCA missionaries appeared to appreciate that the patients' fears of disease causation were not left at the hospital door on admission. Reflecting the gradualist approach of earlier medical missionaries, mission doctors were more accommodating of these beliefs and the actions which sprang from them than was routinely portrayed in mission journals. Writing of a patient at Malindi, who was suffering from a painful, collapsed lung, bronchitis and pleurisy, and had treated himself on the ward, a doctor noted:

The lung symptoms were much the same, there was no pneumonia, but he began to lose heart, & said 'nilepela', & thought that he was going to die! These symptoms were mainly mental but they made him very ill...About 8am he bled himself (kema likole) to the extent of about 8 ounces. This really seemed to give some relief altho (sic) there was no obvious cyanosis & it certainly comforted his mind.⁷⁵⁴

There was even an occasion when a traditional therapist was consulted with the mission's blessing. It was when a boy who had been treated for a snake bite continued to complain of pain and maintained the unshakeable belief that a number of the snake's teeth had been left in the wound. Scepticism remained although the success of the traditional treatment was acknowledged, as a correspondent noted:

A native doctor was called who proceeded to extract the teeth in the following manner - First, he put into his mouth a small piece of four

⁷⁵³ Case no. 13, short reports of special cases, Likoma Dispensary 1900, 145.Dom.10/4/7, M.N.A.

⁷⁵⁴ Case no.33, Malindi Hospital, cases for 1903, 145.Dom.10/4/6, M.N.A.

different kinds of roots - medicine - along with a piece of charcoal and a little salt. Having chewed these, he next applied his mouth to the suspected spot where the teeth were. He now commenced a process of suction and biting the tissues around, spitting out the saliva into a leaf which was carefully preserved. After a time a search was made among the saliva and two teeth were found. The teeth were most carefully tied up and taken away by the doctor, to be mixed with medicine to act as a preventative against snake bites. Needless to say the lameness and pain speedily disappeared.⁷⁵⁵

It is important to note that while the steadfastness of the plural system was recognised, the missionaries were aware that even the most committed Christian converts had not managed to completely abandon their traditional understanding of the causes of disease. Canon Winspear noted in his memoirs:

Of course there are the few who have attained a high standard of education, and so ought to be able to understand the difference between medicines produced as the result of scientific experiment and study of cause and effect, and the charm designated as a medicine, which depends for efficacy on the power of the unseen spirits...But one does find from time to time that well educated men will rely on such charms when the European medicines fail. I fear too that many Christians are prone to place faith in charm, and to wear them secretly under their clothing.⁷⁵⁶

It is ironic that, whilst many of their patients may have retained their beliefs in traditional, ritualistic treatments, the long term influence of mission hospitals was a gradual secularising of the medical work of the mission. The increasing practice of more ambitious surgery coupled with the growing expectations of the mission staff, referring agents and Africans themselves, forced medical missionaries to focus more on their direct medical as opposed to their evangelical role. As has been previously described, this secularising process occurred more rapidly at the Blantyre central hospital as the medical needs of settler commerce ultimately compromised the hospital's underpinning missionary intention.⁷⁵⁷

⁷⁵⁵ *Nyasa News*, no.6, Nov. 1894.

⁷⁵⁶ Winspear, 'Some Reminiscences', *Nyasaland Journal*, 13, 2, 1960, p.71.

⁷⁵⁷ See Chapter 3.

Despite these trends, the discourse of missionary medicine, which informed the supporters of mission in Britain, continued to celebrate the hospital's benevolent function as an example of Christian charity, that was powerful enough to transcend linguistic and cultural barriers. The transformation of the 'uncaring African' into the Catechumen and medical trainee, who willingly cleaned the ulcerative sores of the sick, emphasised the essential role of the hospital within the missionary field. On a more practical level, the mission hospital provided a claustrophobic environment in which the encounter between mission medical personnel and their African patients could take place.

Ultimately, science-based medicine was unable to dominate in Africa, as it had done in the West. This was partly because it could not accommodate the need felt by Africans for spiritual as well as physical healing. Western medicine was, instead, incorporated within the African plurality of treatments. Moreover, despite the mission's' celebration of the ever-increasing demand for medicine, up to 1914, the number of in-patients treated, was relatively insignificant and was almost entirely dependent upon the influential role of referring agents.

It would appear that missionary medicine reached the majority of its subjects by means of its public health activities. However, under this guise, the uninformed villager would have been unable to distinguish the practice of mission medicine from the military campaigns evident on the establishment of colonial rule.

CHAPTER 6

MISSIONARY MEDICINE IN THEORY AND PRACTICE

This thesis has studied the operation of missionary medicine as a distinct component of mission activities. In analysing the origins and development of missionary medicine within the Livingstonia, Blantyre and UMCA Missions, this study has looked inwards towards each mission as a key organisation. In contrast, this chapter will look outwards at the changing attitudes to disease during the early twentieth century, the impact of missionary medicine and the increasing emphasis on public health campaigns. In the case of sleeping sickness, it will be demonstrated that the role of mission doctors, in the campaign to control this disease, was largely confined to lobbying the Government on public health policy rather than extensive practical participation. Furthermore, although medical missionaries actively participated in smallpox campaigns, the effectiveness of this aspect of mission medicine was limited and as the new century progressed, was increasingly government-led. The period from the 1890's to 1914, may be viewed, therefore, as a crucial period in defining the parameters of future missionary medical services relative to that provided by the Protectorate Government.

Disease: Theory and Practice

Between 1875 and 1914, although influenced by developments in secular medicine, missionary medicine maintained the religious ideologies that underpinned its missionary medical discourse. Megan Vaughan suggests that while the practice of mission medical work altered gradually between 1900 and the 1940's, the

representation of this work in mission journals remained consistent.⁷⁵⁸ The discourse of missionary medicine, which highlighted the relationship between suffering and sin, remained a powerful device through which the British public were informed of the activities of medical missionaries. Vaughan further suggests that “Suffering and Sin were inseparable in the medical missionary discourse” and describes how:

This association, though also present in the ‘secular’ medical discourse on Africa, did not survive unchallenged in the thinking of colonial medical departments. For mission doctors and nurses, however, it remained a central tenet of their work.⁷⁵⁹

However, as missionary medicine continued to professionalise and secularise in the early twentieth century, certain missionary doctors, in keeping with the advancement of scientific knowledge, developed views on the aetiology and transmission of disease that were at variance with the themes of suffering and sin maintained within the discourse of missionary medicine.⁷⁶⁰ Motivated by secular rather than spiritual concerns, these medical missionaries targeted their skills and resources, at specific times, on individual diseases and conditions prevalent within the mission field. The treatment of ulcers provides example of this process.

Ulcers

Considerable numbers of Africans, including those who were not in close contact with the missions’ other services, experienced missionary medicine within the dispensary or as part of a village visit by missionary healthcare staff. The treatment

⁷⁵⁸ Vaughan, *Curing Their Ills*, pp.65-66

⁷⁵⁹ Vaughan, *Curing Their Ills*, p.66.

⁷⁶⁰ See chapter 3, which discusses the secular and spiritual factors that influenced the practise of medicine by individual missionaries.

of chronic ulcers dominated these out-patient clinics from the initiation of missionary medical endeavour in Africa.

It is thought that these sores were directly related to malnutrition.⁷⁶¹ The tropical ulcer's ability to destroy healthy tissue initially astounded medical missionaries. In 1904, a correspondent in *Life and Work* described ulcer patients in the Zomba district:

it is amazing to see how much destruction of tissue may follow any one of these simple wounds when neglected. Some times half a foot sloughs away, or the bone becomes diseased and a long lasting suppuration ensues. Most of the hospital work at present consists of treating such cases as these.⁷⁶²

Missionaries preferred to treat ulcers in the pioneering years of mission as their treatment regimes were relatively inexpensive, in that they did not require specialist buildings or equipment, and, in comparison to surgery, were free from the risk of life threatening secondary complications. It was of even greater importance for the reputation of missionary medicine in the pioneering years that evident improvement of the ulcer could be expected within weeks or months of the commencement of regular therapy.⁷⁶³ Dr. MacFarlane could therefore document of his pioneering medical work in Portuguese East Africa:

Writing at the end of 1914 one can safely say that this preliminary stage is past. For ailments which they have seen successfully treated the people come to us with confidence: they have discovered that we have 'the medicine' for ulcers, for malaria, and for many other things. Their fear of us is gone, and they are sure now that our intentions at least are good, whatever our medicines may turn out to be.⁷⁶⁴

⁷⁶¹ Vaughan, *Curing Their Ills*, p.61.

⁷⁶² *Life and Work*, March 1904.

⁷⁶³ *Life and Work*, Feb. 1898.

⁷⁶⁴ Medical Report for Lomweland, 1914, 86/Zom/2/8/1, M.N.A..

The treatment of ulcers also provided the emotive imagery within the discourse of missionary medicine of the doctor laying his hands upon the African's bodily sores, as Christ laid his hands upon the sick. The treatment of ulcers, therefore, provided British supporters of mission with valuable evidence of the Christian missionary's civilising influence amongst the 'heathen'. Mission journals contain numerous examples of the African's makeshift dressings for these ulcers being replaced with clean, white bandages, in symbolic representation of the benevolent, healing influence of Christian charity. Howard of the UMCA described the physical and mental 'transformation', which occurred in the sufferers of chronic ulcers in the course of their protracted in-patient treatment within the UMCA mission hospitals. He wrote:

The hopeless condition of these sufferers when left in the village is truly terrible...they pass nearly all their life inside a dark hut. About once a week they crawl down to the lake to wash and soak off the dry leaves which form the only dressing for their sores; then they apply a fresh lot of leaves, with the object of keeping away the flies which torment them.⁷⁶⁵

However, on receiving either curative or palliative treatment from the mission, Howard noted that these patients "get quite a new outlook on life and they generally show it by their gratitude and cheerfulness. One feels sure that if the transformation wrought in one of these patients could be seen, no subscriber to an endowed mat could feel that their money had been misspent."⁷⁶⁶

Medical missionaries generally advocated the application of aseptic dressings to ulcerous sores. Neil Macvicar described the procedure, which was usually administered by trained, African medical attendants.

⁷⁶⁵ *Central Africa*, July 1904.

⁷⁶⁶ *Central Africa*, July 1904.

First he washes his hands, then he removes the old bandage, then he again washes them. He next removes the inner dressing and cleans the sore, scrubbing the skin around with soap and water for a distance of several inches. He gets the ulcer itself as clean as he can, washing it with clean water or else with weak carbolic lotion and using small pieces of lint. He gets it and the skin around dry. Then he powders on it boric acid powder mixed with a little iodoform and covers it with a piece of clean absorbent wool or lint, or what is much better a gauze bag filled like a little pillow with saw-dust. Then the bandage is applied.⁷⁶⁷

Reflecting their varying professional experience gained prior to joining the mission and their awareness of developments within the field of medicine, missionary doctors and nurses occasionally advocated the application of different topical remedies and dressings to the sores. For example, Willie Scott of Blantyre recommended the use of dry boracic and lint dressings in the treatment of large ulcers.⁷⁶⁸ Neil Macvicar prescribed a number of remedies for these including application of sulphur or carbolic acid as well as Boracic acid, depending on the severity of the ulcer.⁷⁶⁹ However, boracic acid was discredited as an antiseptic treatment in 1894. Willie Scott noted: “Now bacteriologists find that boracic acid has little or no bactericidal action, micro-organisms can even be cultivated in a strong solution of it.”⁷⁷⁰

Africans appeared to appreciate missionary medicine’s effectiveness in the treatment of these sores. From the earliest days of mission, dispensaries were deluged with ulcer cases. By March 1889, the Blantyre Mission doctor was attending on approximately 35 ulcer cases per day at the dispensary.⁷⁷¹ Norris of

⁷⁶⁷ *Life and Work*, Feb. 1898.

⁷⁶⁸ *Life and Work*, Jan. 1893.

⁷⁶⁹ Macvicar, *Lectures to Hospital Assistants*, pp.12 –13.

⁷⁷⁰ *Life and Work*, Jan. 1894.

⁷⁷¹ *Life and Work*, March 1889.

Blantyre described the mission’s dispensary work in 1901. “From half past six each morning until mid-day six boys are engaged dressing ulcers.”⁷⁷² Severe ulcers required in-patient treatment. Between 1896 and 1899, the numbers of patients with ulcers treated as in-patients within the Blantyre Hospital were as follows:

Table 3: In-Patients with Ulcers Treated at Blantyre Hospital 1896-99⁷⁷³

Year	1896	1897	1898	1899
Ulcers treated	58	117	89	38
Total patients treated	134	321	195	236

The Livingstonia Mission and the UMCA recorded a similar prevalence of ulcer cases.⁷⁷⁴ In 1909, the Blantyre Mission documented significant success in reducing the numbers of ulcers on which they were required to attend:

An analysis of the illnesses represented in this number is encouraging, for it shows that the ulcer cases, which have been steadily diminishing in number for several years, are a still smaller proportion of the total in the year that has just finished, leaving a larger number, relatively and absolutely, of other varieties of cases. The faith of the natives in our ability to heal ulcers is universal; they are not so trustful of our skill in other departments of medicine and surgery...The reduction of the ulcer cases is simply due to the fact that the majority of the serious ulcers in the district round Blantyre served by the hospital are now healed.⁷⁷⁵

However, whilst the discourse of missionary medicine celebrated the missionary doctor and nurse’s treatment of ulcers, it is important to note that beyond the pioneering phase of mission, ulcers were attended on by medical assistants who thus enabled the mission doctor to focus on the treatment of more challenging medical conditions. Macvicar could therefore record in 1898: “The treatment of ulcers is

⁷⁷² *Life and Work*, April-June 1901.
⁷⁷³ *Life and Work*, Jan. 1897, Feb. 1898, Jan. 1899, Jan. 1900.
⁷⁷⁴ *Central Africa*, Sept. 1894, Feb. 1910; Jack, *Daybreak in Livingstonia*, p.324.
⁷⁷⁵ *Life and Work*, Jan.-Feb. 1909.

almost entirely in the hands of native assistants, and it is, except when our drugs run short, perhaps the most successful part of the work.”⁷⁷⁶ Boxer of the Bandawe station of the Livingstonia Mission also noted that his medical assistant attended on all the ulcer cases at the dispensary.⁷⁷⁷ Agnes Fraser, also of Livingstonia, described the conditions treated within her dispensary at Loudon.

The vast majority of the cases that come belong to one of a few classes of very common ailments, which my dispenser can be left to attend to, so that often very little of my time is taken up.⁷⁷⁸

Furthermore, by the turn of the century, the trained medical assistants of the UMCA routinely travelled on the *Chauncy Maples* and treated the out-patients on the eastern mainland. Ulcers predominated amongst the conditions that they treated.

Physical and Moral Hygiene and Public Health

I have demonstrated in chapter three that missionary doctors were motivated by a variety of professional and spiritual influences that affected how they practised medicine. The promotion of public health and physical and moral hygiene by mission healthcare staff was also underpinned by spiritual and secular theories of disease causation. Whilst the discourse of missionary medicine associated hygiene with physical health, Christianity and inner purity, secular theories of disease promoted cleanliness as an effective means of curtailing the transmission of germs and other microorganisms.

⁷⁷⁶ *Life and Work*, Feb. 1898.

⁷⁷⁷ Annual Report, Livingstonia Mission, 1902, p.48.

⁷⁷⁸ Annual Report, Livingstonia Mission, 1904, p.34.

Missionary doctors accommodated these spiritual and secular theories of disease causation on an individual basis. However, since these diverging ideologies often shared a practical end point, the medical missionaries' support for secular rather than spiritual theories of disease was often concealed.

Medical missionaries had been professionally socialised in post-Chadwickian Britain. The nineteenth century public health movement had sought to deal with the problem of dirt and waste, particularly in urban areas, through social intervention.⁷⁷⁹ Drains, cesspools and burial grounds were cited by this movement as sources of contamination, which could generate widespread contagion if their maintenance remained unregulated. However, this movement did not address the diseases that were precipitated by social problems, such as overcrowding and malnutrition, as it was considered that these conditions were related to the inappropriate lifestyles of the poor.

By the early 1900's, the public health movement had become influenced by contemporary hereditary theories, eugenics and the mental sciences.⁷⁸⁰ Therefore, whilst improvements in public health were gradually achieved, the individual's personal responsibility for disease was increasingly emphasised. Furthermore, in keeping with social Darwinian principles, certain people, including alcoholics and vagrants, were considered to be biologically susceptible to their conditions.

⁷⁷⁹ G. Jones, *Social Hygiene in Twentieth Century Britain* (London, 1986), pp.5-24

⁷⁸⁰ Jones, *Social Hygiene*, pp. 5-24. Jones also observes that there was wide support for the principles of social hygiene amongst churches and particularly stresses the Church of England's backing of the eugenics movement in 1910 and 1912. See Jones, *Social Hygiene*, p.47.

Environmental theories of disease causation continued to prevail in Africa in the early 1900's.⁷⁸¹ However, germ theory and theories of social hygiene gradually pervaded colonial medical discourse at this time such that environmental explanations of disease causation were progressively given less emphasis.

Swanson suggests that by the turn of the century, the combined impact of European fears of epidemic disease and racism had encouraged the segregation movement of the Cape Colony.⁷⁸² As the fear of African contagion gradually pervaded mission medical discourse, significant efforts were made by each of the missions under review to demonstrate that the Africans who had been in receipt of their 'civilising' influence, principally their school pupils, had internalised approved standards of hygiene. A correspondent in *Life and Work*, noted: "We are endeavouring in the foundation of this new society to insist upon cleanliness, and not as a hobby but as a religious duty. One of the first Mission principles is 'wash and be clean'".⁷⁸³

Medical missionaries who internalised the religious ideologies that underpinned the discourse of missionary medicine supported the association of cleanliness with Christianity and dirt and disease with 'heathenism' and sin. Mission journals contain many such examples. A correspondent in *Life and Work* reported that:

An eye for dirt and disorder is an excellent adjunct to a Missionary's qualifications in this country. "Cleanliness is next to godliness" – We never realised the truth of this saying till we came here. Here, cleanliness assumes almost a sacramental aspect – the outward man rarely failing to reveal the inward grace.⁷⁸⁴

⁷⁸¹ Vaughan, *Curing Their Ills*, pp.29-54.

⁷⁸² Swanson, 'The Sanitation Syndrome', pp.387-410.

⁷⁸³ *Life and Work*, April 1894.

⁷⁸⁴ *Life and Work*, June 1895.

However, certain missionary doctors were motivated in their war on germs and disease by more secular concerns.

The period from the 1890's to the first decade of the new century witnessed outbreaks of infectious disease, including smallpox, dysentery and plague, many of which were exacerbated by the social changes generated by the new settler economy.⁷⁸⁵ In the period prior to the advent of antibiotics, western medicine struggled to demonstrate its effectiveness over and above its African counterpart.⁷⁸⁶ Furthermore, since many of the diseases suffered by African communities resulted from malnutrition and since the missionaries did not effectively address the issue of food redistribution within the Protectorate, the disease process often continued unaltered in spite of the availability of missionary medicine.

Faced with repeated outbreaks of infectious disease, rather than promoting the inner purity of the patient, medical missionaries were forced to focus their efforts on the bedrocks of practical health promotion -hygiene and diet- as a means of directly tackling such conditions,. Norris of Blantyre, a medical missionary who prioritised the professional aspect of his role, described this rationale in 1901. He wrote:

The feeding and the clothing in the Hospital are essential, for cleanliness and dieting are the only effective treatment in so many diseases we have to deal with here...The diseases we have to treat are very varied, the two most common and most fatal being dysentery and pneumonia.⁷⁸⁷

Norris was amongst those missionary doctors who associated the increasing epidemics of dysentery with the operation of the settler economy. In 1901, he noted

⁷⁸⁵ See Chapter 1.

⁷⁸⁶ Landau, 'Explaining Surgical Evangelism', *J.A.H.*, 37, 1996, pp. 261-281.

⁷⁸⁷ *Life and Work*, April-June 1901.

that dysentery was more common between the months of September and March, when the pre-harvest food shortages were exacerbated by the numbers of tenga tenga labourers who gathered on the Shire Highlands.⁷⁸⁸ Furthermore, although pneumonia was associated with the cold season, Norris observed, from as early as 1901, the connection between this disease and tenga tenga work.

Other medical missionaries, who had not completely internalised the theories of sin and suffering that underpinned the discourse of missionary medicine, continued to promote environmental theories of disease causation. In 1895, David Kerr Cross of Livingstonia, who later joined the Government Medical Service, associated elephantiasis with a unique combination of environmental conditions and personal responsibility. He observed:

Those who live in moist, warm, humid, districts, who have much to do with the turning over of the soil, who when warm and moist, lie on the damp ground, who drink stagnant, or impure water, and who do not keep the lower limbs, and other dependant parts of the body, clothed, expose themselves to this other form of Malarial or Elephantoid fever.⁷⁸⁹

Regardless of the underlying motivational factors, in promoting public health and personal cleanliness, medical missionaries, and missionaries in general, effected a powerful social engineering device through which they attempted to manipulate and control the lives of their African adherents. Christians were expected to present themselves as clean and smart, whilst Christian wives and mothers were instructed to maintain organised and sanitary households. For example, *Life and Work* documented in 1896: “The wives are all expected to help in the laundry, clean the

⁷⁸⁸ *Life and Work*, July-Sept. 1901.

⁷⁸⁹ Kerr Cross, ‘Notes on a Central African Disease’, *The Nyasa News*, 8. 1895.

church on Saturday mornings, do their husband's and children's sewing, and keep their households going and their houses clean."⁷⁹⁰

Although not a qualified doctor, Donald Fraser of the Livingstonia Mission introduced instruction on sanitation measures into his sermons. His wife described such an event:

Yet, realising that the pulpit had to fulfil a manifold function in the life of the community, as the most reliable way of disseminating instruction and warning, he felt he was no less bringing to the people the will of God when he occasionally spoke about some hygienic precaution, such as the boiling of drinking water or the sanitation of a village when some epidemic threatened. In the absence of a specialised theological vocabulary, a sermon on salvation might turn out to refer to the destruction of vermin. It helped to bring home to his listeners the sense that God's interest in them extended to everything connected with their life, and that their new religion, like their old beliefs, must affect every detail of their daily existence.⁷⁹¹

Students of the Blantyre and Livingstonia missions received formal instruction on hygiene. Hetherwick informed the Deputy Governor in 1910 that the Blantyre Mission provided lectures on hygiene and public health to students in standards IV, V and VI of the Institute. The course comprised of instruction on:

Food. Air. Water. Housing. Personal Hygiene. Occupations in relation to disease. Mode of spread and prevention of malaria, small-pox, dysentery, Ankylostomiasis, Venereal diseases, Sleeping Sickness etc.⁷⁹²

⁷⁹⁰ *Life and Work*, Sept. 1896; Gaitskell, 'Housewives, Maids or Mothers', *Journal of African History*, 24, 2, 1983.

⁷⁹¹ Fraser, *Donald Fraser of Livingstonia*, p. 171. Personal hygiene was at one point a condition of membership of Dr. Prentice's wife's singing class at Kasungu. Prentice noted in his annual report: "As bodily cleanliness had been a condition of membership while the class was held in the house, and soap is the luxury of the few, that condition was not enforced in school, and the membership grew to over fifty". See, Annual Report. Livingstonia Mission, 1901, pp. 25-26.

⁷⁹² Hetherwick to the Deputy Governor, Jan. 18 1910, 50BMC 2/1/104, M.N.A.

Teachers in training received lectures on the recognition and treatment of common diseases in addition to those on hygiene and public health. A course was also given to female students within the Institute in 1908, comprising of lectures on:

The Body and its organs; Food and Drink; Clothing and Cleanliness; Simple Diseases and Treatment; Hospital Work and women's part in it in this and other countries; influence of Women in the Family, the Church and in Native Life...especially their influence in putting down Native customs that are contrary to the Christian life and Faith.⁷⁹³

Lectures on hygiene were also given to teachers at the Livingstonia Mission from 1908.⁷⁹⁴

The arrival of the jigger within the Protectorate created an even greater need for the promotion of hygiene and self-discipline. The jigger or *matekenya*, as it was known in Nyasaland, was a sand flea, which had been transported to West Africa in 1872 from Brazil. It arrived at Karonga in 1892. The female insect commonly burrowed into the hardened skin of the human foot and remained incubated there until her larva was matured and expelled back into the dust from where it would continue an ongoing cycle of infection. If not immediately extracted, a jigger infection could result in the development of painful ulcers on the feet and even the hands. These ulcers were utilised by Europeans in Nyasaland as an example of the African's lack of self-discipline and unsanitary behaviour. Doctor Kerr-Cross wrote in 1895:

As the insect is engaged penetrating the spot it has selected, there is a slight tickling of a not altogether unpleasant nature experienced. In America, it would seem, the insect seldom or never, is allowed to mature in the tissues of man. It is different however, in Central Africa, where the natives are ignorant of the insect, or through carelessness, and want of cleanliness, allow the results to attain to formidable proportions.⁷⁹⁵

⁷⁹³ Hetherwick to the Deputy Governor, Jan. 18 1910, 50.BMC.2/1/104, M.N.A.

⁷⁹⁴ Annual Report, Livingstonia Mission, 1908. p. 42.

⁷⁹⁵ *Nyasa News*, No.9, Aug. 1895.

The jigger was portrayed by the Blantyre Mission as a heaven-sent lesson in hygiene:

The jiggers are simply dancing about the Dormitories. They are *seen* holding their jinks. We wage war with salt and hot water and washing. Most of these plagues are sent, not to drive us to inoculate for jigger, small-pox, influenza or any other prevailing infirmity, but to teach us to be clean.⁷⁹⁶

Howard of the UMCA went further in making war upon the jigger by designing his own 'jigger hospital' at Mtonya in the Yao hills on the eastern side of the lake, in which the principles of hygiene could be more systematically applied. The hospital was "so constructed that every part of it can be easily and effectually flushed out daily with water, and water is the one thing that jiggers cannot live in."⁷⁹⁷ The working rationale on which the hospital had been based was that if the worst affected school children were isolated within a hospital whose floors were regularly washed, the infectious larvae expelled from the sores on their feet would be washed away before it could infect another individual. However, the jigger defied this logic. Canon Eyre wrote with an air of defeat:

We are waiting to congratulate ourselves on the result, but *Matekenya* (jiggers) are incomprehensible insects, and come and go without any apparent rule or regulation. They come when they like and go when they like, and that's about all we really know about them.⁷⁹⁸

If jiggers were viewed as a practical menace, there were also perceived moral threats to the well-being of Africans. As theories of the degeneration and regeneration of the African continued to dominate medical missionary discourse,

⁷⁹⁶ *Life and Work*, Jan. 1895.

⁷⁹⁷ *Central Africa*, March 1908.

⁷⁹⁸ *Central Africa*, May 1908. The Jigger Hospital was subsequently closed.

Christian teachings were that Africans should live in nuclear families rather than within the indigenous lineage system, which was governed by traditional systems of control. Christian converts were also required to renounce traditional rituals, which were considered by missionaries to be detrimental to a Christian lifestyle. For example, attendance at age-related initiation ceremonies was prohibited as these were considered to be occasions for excessive drunkenness, sexual promiscuity and sin.⁷⁹⁹ Science-based theories of disease causation supported the recommendations of the discourse of missionary medicine regarding the lifestyle of Africans, since monogamous relationships were thought to reduce the incidence of sexually transmitted disease, whilst temperance precluded degenerative liver disease and its associated conditions.

Medical missionaries also advocated western systems of maternity and childcare. It was considered that the use of the missions' obstetric services by African women would limit the perceived social and moral control of African midwives whose traditional influence over indigenous society was condemned by missionaries. Nurse Franthan, who was employed by the UMCA at Msalabani, wrote of traditional midwives:

These women are an immense power working against us...our chief hope is in those just entering on their married life, and the young girls – the rising generation – the future grandmothers, as until we have Christian grandmothers we cannot hope to breakdown the heathen customs which attend births, marriages and deaths.⁸⁰⁰

⁷⁹⁹ *Life and Work*, Aug 1889; Sept. 1890

⁸⁰⁰ *Central Africa*, May 1903

On a more practical basis, it was also considered that mission-based deliveries were safer for African women, particularly for complicated births, than those overseen by ‘primitive’ women.⁸⁰¹

By the new century all three missions were celebrating the increased use of their midwifery services. As early as 1900, Dr. Boxer of Bandawe noted that his new dispensary might also be utilised as a maternity hospital as required.⁸⁰² The Blantyre Mission also recorded an increasing number of deliveries conducted by its healthcare personnel. For example, in 1897 the mission’s medical staff attended on ten confinements, whilst by 1912 this number had risen to eighteen.⁸⁰³ The mission also observed increased use of its obstetric services between 1911 and 1917.⁸⁰⁴

Despite the growing popularity of the hospital confinement, medical missionaries were generally only involved in complicated deliveries. It was acknowledged that it would take time before African women were routinely delivered in mission hospitals. Nurse Burridge of the UMCA noted in 1915:

I have had several maternity cases, but only where some difficulty has occurred, as in normal cases the old village women are very “canny”, but their trust in one is pathetic, and they are very grateful for help rendered at such times.⁸⁰⁵

The effective social and physical rearing of the African child was also considered essential for the creation of a self-disciplined African Christian. Missionaries criticised the African mother’s disorganised feeding programmes believing these

⁸⁰¹ Vaughan, *Curing Their Ills*, pp.66-67

⁸⁰² Annual Report, Livingstonia Mission, (1900), p.18.

⁸⁰³ *Life and Work*, Feb. 1898 and Jan.-Feb. 1912.

⁸⁰⁴ *Life and Work*, Jan.-March 1911 and Jan.-March 1917.

⁸⁰⁵ *Central Africa*, April 1915.

resulted in self-indulgent adults.⁸⁰⁶ More generally, the African child's diet was criticised as detrimental to his physical health. In keeping with western systems of weaning, medical missionaries advocated delaying the introduction of solid food and instead promoted cow's milk as the principal component of the infant's diet. African mothers were also encouraged to bring their children to the dispensary for medical treatment and for instruction on western systems of childcare.⁸⁰⁷ Nurse Burridge of the UMCA described her work in the dispensary at Likoma:

First come the village people of which the larger proportion are mothers and babies, some poor little darlings with malaria, others with coughs, others with bad eyes, some with merely very small stomachaches; but all alike welcome; for if the mothers will come to us for little things, we feel instinctively that they will seek us when there is something serious the matter with their children.⁸⁰⁸

Mrs Stuart, formerly Nurse McCallum, described the health education imparted to the women of Ekwendeni in 1911.

As usual our hospital and dispensary while under the charge of a woman are mainly of use to our women and children. Many little sufferers have been helped back to the life put in danger by the ignorance of their mothers, and, as the result of our *Crusade in favour of cow's milk* in preference to the popular gruel for infant feeding, milk has become so extensively used that we can only with difficulty buy milk for our own use.⁸⁰⁹

Missionaries also promoted the artificial feeding of orphans. Agnes Fraser of Livingstonia noted:

Infant life, too, is being saved by demonstrating how to bring up orphans on cows' milk. Formerly their one substitute for a child's natural nourishment was a water gruel – so useless that one could scarcely wonder that, feeling the futility of the attempt, they often buried the living child with the dead

⁸⁰⁶ Vaughan, *Curing Their Ills*, p.67.

⁸⁰⁷ *Central Africa*, Oct. 1910.

⁸⁰⁸ *Central Africa*, Oct. 1910

⁸⁰⁹ Annual Report, Livingstonia Mission, 1911, p.20.

mother. We might infinitely multiply examples, showing the scope there is for medical work along educational lines.⁸¹⁰

Dr Fraser, in 1914, further described the beneficial effect of health education on child health. She wrote:

Belief in the importance of proper feeding is gaining ground. Nowadays I have half a dozen people waiting in our backyard each morning till we separate our cream, that they may get the boiled milk to cook with for their ailing children. If a woman dies in the neighbourhood in childbirth or during lactation, the friends generally come in to begin a feeding-bottle and arrange for daily supplies of prepared milk. We are no longer troubled by grandmothers strenuously opposed to this unnatural style of feeding, though they have no alternative to suggest – wet nursing being deemed by them absolutely poisonous. I have had a four-day-old orphan brought in for me to adopt by an old man who had carried it over fifty miles, feeding it only water by the way, ‘knowing you didn’t approve of solid food for infants.’⁸¹¹

Despite the increasing acceptance of European methods of childcare, the African woman and mother continued to be portrayed within medical missionary discourse as lacking the ‘natural’ nurturing instinct of her western Christian counterpart. The African woman was, therefore, presumed to be in need of considerable guidance from missionaries, particularly European Christian women. As late as 1910, Dr. Turner of Livingstonia observed: “Our poor infant babies are still suffering from their worst enemies, their mothers, and we still struggle with the prejudices of the past generations.”⁸¹² Parents who did not follow Dr. Prentice’s instructions to encourage their sick infant to drink milk were reported to have explained: “We, we are black people; what do we know?”⁸¹³

⁸¹⁰ Fraser, ‘A Missionary’s Wife’, *International Review of Missions*, 3, 1914, p.465.

⁸¹¹ Fraser, ‘A Missionary’s Wife’, *International Review of Missions*, 3, 1914, p.468.

⁸¹² *The Livingstonia News*, April. 1910, p.25.

⁸¹³ *Aurora*, Feb. 1900, p.7.

The missions' success in socially moulding their growing Christian communities is, however, debatable. Missionaries continued to record, both privately and in their published journals, the participation of certain of their converts in traditional ceremonies.⁸¹⁴ Furthermore, although medical missionaries discouraged the African sick from utilising the services of indigenous medical men, they continued to find charms and other devices held by a number of their patients.⁸¹⁵ Certain mission converts were intellectually, socially and physically moulded by Christian missionaries, but the numbers involved were small. Instead, most of the new Christians shared beliefs that were the product of a synthesis, neither traditional African, nor modern Western, but a combination of the two.

Malaria, Contagion and Segregation

From the late 1890's, influenced by the new discipline of tropical medicine, certain medical missionaries began to promote science-based theories of the inherent contagion of Africans. These theories had particular significance when applied to those on the aetiology of malaria, the principal threat to European health in the tropical environment.

At the end of the nineteenth century, spearheaded by the London and Liverpool Schools of Tropical Medicine, extensive research was undertaken on the aetiology of malaria. Curtin has detailed the resultant new approach which promoted segregation between Africans and Europeans in the control and treatment of malaria. This theory was advanced by two doctors, Christophers and Stephens,

⁸¹⁴ *Life and Work*, Aug. 1889.

⁸¹⁵ *Central Africa*, Oct. 1906.

whose research on malaria was supported by the British Royal Society. According to Curtin, it was considered that:

because of the Africans' apparent immunity, blood samples from adults rarely revealed actual plasmodia in the bloodstream, but children with clinical symptoms had parasites in their blood. Children were therefore thought to be the prime source of infection, and Christophers and Stephens believed it was imperative to protect Europeans from the vicinity of African children between birth and the age of five.⁸¹⁶

An essential aspect of missionary doctors' endorsement of the new discipline of tropical medicine and its findings on malaria, was their acceptance of the research which had identified the African child as a reservoir for the laveran which infected the mosquito vector. Therefore, rather than viewing the African child as an empty vessel, an innocent amid the evils of 'heathenism', as depicted within missionary evangelical discourse, the medical missionary instead began to regard the child as a major threat to European survival in Africa. Certain mission doctors, therefore, supported segregation as a means of limiting the spread of malaria to Europeans. For example, Norris of the Blantyre mission discussed the findings of the research:

For the propagation of malaria two main conditions are necessary – breeding places of the Anopheles mosquito and centres of infection in close proximity i.e. within ¼ mile...it has been proved from many observations that native children are permanent centres of infection, even when not suffering from attacks of "fever" themselves. We cannot at Blantyre adopt the only perfect method for the prevention of European infection which is suitable to the condition of the country here, i.e. the isolation of all Europeans by the removal of all natives at night time to at least ½ mile from the European residences, owing to the permanent arrangements of the mission buildings⁸¹⁷

Caverhill of Blantyre also supported segregation, in theory, as a means of limiting the transmission of malaria to Europeans. He wrote:

⁸¹⁶ Curtin in Feierman and Janzen (eds.), *The Social Basis of Health and Healing in Africa*, p.240.

⁸¹⁷ *Life and Work*, April-June 1902.

As regards prevention the importance of segregation is brought out: this means the placing of your station from a third to half a mile from native huts, this being beyond the flight of mosquitoes which nearly always become infected from the children in a native hut. It is recognised of course that this can never be carried out in its entirety, as there must always be some married teachers' houses on the station, but these should be as few as possible and as far away as possible from a European house. The schoolboys and girls being mostly over ten years of age are not such a source of danger.⁸¹⁸

A correspondent in *Aurora*, the journal of the Livingstonia Mission, also deliberated on the practical application of the new research on malaria and noted:

With regard to the usual arrangements of mission stations in having native quarters in proximity to the houses of Europeans, the new view of malarial fever ought to lead to change of plan... The obvious plan to follow is to have no native quarters close to houses of the staff...⁸¹⁹

Even Howard noted in a Report to the Medical Board of the UMCA:

It should be recognised that the neighbourhood of the lake shore is the great breeding ground of anopheles at most stations of our mission; and also that anopheles, and very possibly infected ones are present in almost every native. In other words, "*It must be realized that malaria is an infectious disease, and that it is present in practically every native hut.*"⁸²⁰

Theories concerning the aetiology of malaria increasingly united missionary doctors and those of the Administration in their approach to medicine. The language used by Dr. Hearsey, the Principal Medical Officer, in 1903 resonated with that of certain mission doctors. The PMO observed: "Native dwellings have been removed at a distance from townships, and in view of the fact that malarial plasmodia are nearly

⁸¹⁸ *Life and Work*, April 1905.

⁸¹⁹ *Aurora*, June 1901, p.16.

⁸²⁰ Howard Medical Report, 1904, p.10.

always present in native children, much importance has been attached to this measure.”⁸²¹

It was presumed that over time, in response to their constant exposure to the malarial germ, African children developed a natural resistance to this disease.

Robert MacFarlane of Blantyre could therefore write in 1914:

Malarial fever appears to be the inevitable lot of the native everywhere. Almost every village child has to go through his painful struggle with the disease until he emerges, in most cases, successful and immune.⁸²²

Malarial theories provide an important early example of the philosophies of the new medical sciences overriding those of medical missionary discourse, which theorised that physical and moral degeneration was countermanded by physical and moral healing. Theories of the African’s contamination in his early childhood years were based almost entirely on physiological and biologically deterministic rationale. Regardless of the African child’s Christian conversion and education, these ideologies held out no possibility of regeneration from his diseased state. Segregation of the African child until, in direct response to the forces of nature, he had evolved into a less infectious state, was considered the single most effective means of ensuring the well being of Europeans in Africa.

The increasing influence of theories of the African’s inherent contagion is evident in the UMCA’s application of these policies. Rather than advocating living as an African in order to achieve the purest form of African Christian conversion, UMCA philosophies began to promote unparalleled degrees of segregation. In his account

⁸²¹ Annual Report, No.13, 1903.

⁸²² Medical Report for Lomweland, 1914, 86/Zom/2/8/1, M.N.A.

of these changes in 1904, Howard skilfully justified these new policies from a spiritual and professional standpoint. He wrote:

In the early days of the Mission it was thought necessary to live right among the people. Now, however, ideas have changed a good deal, and some degree of isolation from the village with its beer and dancing, and heathen life, is an advantage, even from the Mission point of view, and would probably now be advocated by most Missionaries; while from the sanitary and hygienic standpoint it is an unmixed benefit.⁸²³

Howard specifically identified within his report the perceived dangers to European health at each individual mission station. For example, the UMCA settlement near Nkhotakota was in close proximity to a town of approximately 5,000 inhabitants, which, according to Howard, threatened the purity of the mission's water supply. Howard observed: "The village is without any kind of sanitation. The natives use the lake shore and the beds of the streams as latrines."⁸²⁴ Moreover, the threat of dysentery was particularly strong in the dry season when water was obtained from dry water holes. From 1900, water for the Nkhotakota station was obtained from the hot spring, some distance away, which was guarded from pollution by the Collector. Water pollution was also considered a threat at the station at Mponda's, which incorporated an African village. Howard attached such significance to the perceived threat to European health at Mponda's that he recommended the replacement of its resident Europeans with African priests or deacons.⁸²⁵

In addition to this, as the UMCA, under the recommendation of its Medical Board, replaced its reed houses with permanent brick constructions, regulations developed which prohibited Africans from sleeping within them. It was considered that houses

⁸²³ Howard, *Five Years' Medical Work on Lake Nyasa*, p.75.

⁸²⁴ Howard, *Five Years' Medical Work on Lake Nyasa*, p.47.

⁸²⁵ Howard, *Five Years Medical Work on Lake Nyasa*, p.59.

occupied by Africans became infested with certain biting ticks or *nkufi*, which acted as a vector for the transmission of tick fever between humans. European fears of tick fever were compounded by the perception that Africans living in the proximity of the lake had become immune to the disease from childhood.⁸²⁶

The racially deterministic rationale, which underpinned the considered aetiology and transmission of tick fever, proved an emotive issue for certain medical missionaries. Brown of the Livingstonia Mission, a doctor who clearly prioritised the professional aspect of his role, documented his view of Africans as uncivilised and irresponsible in his annual report of 1912. He wrote:

Tick fever still seems to play most havoc with the native, and will continue to do so until they are properly housed and compelled to keep their houses clean. Advice is largely wasted on them. The native here should simply be told “you must”, and be made to know that there is authority behind the words.⁸²⁷

The Impact of Mission Medicine

I have described how germ theories, which were advanced by the field of tropical medicine, gradually supplanted views on the environmental causes of disease in the early years of the twentieth century. As these theories influenced missionary doctors and the practice of missionary medicine, the Africans who were closely associated with the missions, such as their educated employees and other Christian converts, experienced degrees of segregation. I have also described how African Christians were subjected to the missions’ attempts to socially engineer and manipulate traditional society. It is, however, important to note that whilst the

⁸²⁶ *Likoma Diocesan Quarterly Paper*, No.16, July 1907.

⁸²⁷ Annual Report, Livingstonia Mission, 1912, p.54.

missions endeavoured to effect the physical, moral and spiritual regeneration of Africans, before 1914, the numbers who were in regular contact with missionaries were a small fraction of the total African population. For example, Government estimates of the population levels in the districts surrounding the Blantyre mission for 1904 were as follows⁸²⁸:

Table 4: Estimated Population Levels in Blantyre and Surrounding Districts

	Men	Women	Children	Total
Blantyre	21,560	21,650	30,140	73,350
Liwonde	20,000	25,000	23,000	68,000
Mulanje	8,000	8,500	25,000	41,500
Zomba	8,390	9,960	9,550	27,900

By comparison, the total number of students on the Blantyre mission’s school roll in 1908 is listed in Table 5. However, the numbers of children who received a missionary education in some capacity was probably much higher than is demonstrated by these figures.⁸²⁹

Although the number of students who received a mission education was small, relative to the total population, as McCracken suggests, their influence was significant. By 1914, the educational impact of the Livingstonia Mission was beginning to shape the northern communities in substantial ways.⁸³⁰

⁸²⁸ *Life and Work*, Aug. 1904, *Total number of men, women and children*.
⁸²⁹ Church of Scotland African Mission Council, June 28 1908, Acc.9069, N.L.S. The numbers of students in regular attendance at mission schools were often only a small proportion of those listed on the school roll.
⁸³⁰ McCracken, *Politics and Christianity*, pp.171-195

Table 5: Total Number of Students on Blantyre Mission’s School Roll

	Boys	Girls	Total
Blantyre			
Institution & Boarding School	313	113	426
30 Village Schools	<u>1,142</u>	<u>296</u>	<u>1,438</u>
Total	1,455	409	1,864
Zomba			
Evening school	30	2	32
23 Village Schools	<u>420</u>	<u>84</u>	<u>504</u>
Total	450	86	536
Domasi			
Boarding School	169	45	214
19 Village Schools	<u>255</u>	<u>26</u>	<u>281</u>
Total	424	71	495
Mulanje			
Boarding School	161	19	180
13 Village Schools	<u>361</u>	<u>63</u>	<u>424</u>
Total	<u>522</u>	<u>82</u>	<u>604</u>
Total (89 Schools)	2,851	648	3,499

Table 6 demonstrates that the total number of people who received mission medical services was much larger than those who regularly attended school.

Table 6: Numbers of patients treated within the mission dispensaries.⁸³¹

	1902	1903	1904	1905	1906	1907	1908	1909	1910
Livingstonia Institute.	11,826	16,504	13,789	15,801	17,669	12,771	-	-	9,021
Blantyre central station	-	7,000	4,500	-	5,000	9,000	13,830	8,590	-
UMCA Likoma	-	10,835	-	-	-	-	-	-	-

N.B. figures for Livingstonia (all), for UMCA (1903) and for Blantyre (1908 and 1909) are ‘attendances’.

Figures for Blantyre for 1903, 1904 and 1906 are ‘new cases’.

Figure for Blantyre for 1907 is for ‘patients treated’

⁸³¹ Figures from Annual Reports, Livingstonia Mission; *Life and Work*, Jan. 1904, Jan. 1905, Jan-Feb. 1907, 1908, 1909 and Jan-April 1910; Medical Reports Likoma & St Michael’s College 1903-1904, 145/Dom/10/4/6, M.N.A.

However, before 1914, missionary medicine did not achieve the potential for change that was generated by a mission education. There were various reasons for this. As has been previously described, the patient incorporated missionary medicine within a plurality of healing systems, which enabled him to accept the medical treatment offered by the mission whilst rejecting the Christian doctrines and lifestyle that accompanied them.⁸³² This situation contrasts with the processes through which the African student was educated and incorporated within the new economy. Receipt of an education transferred to Africans skills, such as reading and writing, that were often alien to indigenous society. Furthermore, the pursuit of an education necessitated a prolonged, structured encounter with the mission through which the student was also exposed to Christian teachings and views on morality.

The medical assistants trained by medical missionaries made an essential contribution towards the increased uptake of western medicine. Indeed, up until 1914, the training of African healthcare personnel was arguably the most significant contribution that medical missionaries made towards the development and uptake of western medicine throughout the Protectorate. As Vaughan suggests, the administering of western therapies by Africans to Africans marked the process by which biomedicine was made “as ‘African’ as any other healing system.”⁸³³

However, although the contribution of medical assistants to the uptake of missionary medicine was highly significant, before 1914, only limited numbers of Africans were accepted for, and ultimately completed, missionary medical

⁸³² See Chapter 2.

⁸³³ Vaughan, *Curing Their ills*, p.25.

courses.⁸³⁴ By contrast all three missions under review trained African teachers from the pioneering years. In 1912, the Blantyre Mission could document that while there were 37 teachers, 2 pupil teachers and 347 acting teachers in training at the Henry Henderson Institute, only 10 students were undertaking medical studies.⁸³⁵ Africans who resided at a distance from the missions were therefore more likely to encounter western education delivered by an African teacher than missionary medicine administered by an African medical assistant.

In addition to this, the delivery and uptake of western medicine by Africans to Africans, independent of the missions, was frustrated by the reliance of medical assistants upon Europeans for their supplies of dressings, drugs and vaccinations. By contrast, it was possible for educated Africans to pass on their knowledge using only a bible as a reading book.

Between 1875 and 1914, the majority of Africans who experienced mission medicine would have done so as part of a campaign against smallpox or in the routine examination of Africans for sleeping sickness. However, since mission doctors frequently joined forces with those of the Administration as a means of maximising their efforts against the threat of epidemic disease, the majority of Africans would have been unable to perceive any real difference between mission medicine and that of the Protectorate Government. In taking responsibility for the provision of basic healthcare, a service which in other states would have been performed by the government, the Blantyre, Livingstonia and UMCA Missions operated at some level as an arm of the state.

⁸³⁴ See Chapter 4.

⁸³⁵ Blantyre Mission Council Minutes, Aug. 6 1912, Acc.9069, N.L.S.

Smallpox

The campaigns launched by medical missionaries for the control and prevention of smallpox provide a clear example of missionary medicine in its secular form. The sentiments maintained within the discourse of missionary medicine aimed over time, to (physically, mentally and socially) transform individual Africans. By contrast, successful vaccination campaigns necessitated only the briefest encounter between the healthcare practitioner and the patient and were those in which the largest numbers were inoculated over the greatest distances in the shortest possible time.

All of the three missions under review commenced vaccinating against smallpox as soon as they had sufficient resources. Howard of the UMCA initiated smallpox campaigns on both Likoma and the mainland soon after his arrival in the region in the late 1890's, while the doctors of Blantyre and Livingstonia administered vaccinations from as early as 1883 and 1889 respectively. In 1899, Howard documented a total number of 406 vaccinations administered.⁸³⁶

The success of mission-led vaccination campaigns was dependent upon the number of trained vaccinators available and the quantity and quality of the vaccine itself. When not frustrated by the lack of supplies of active vaccine, it was possible for some medical missionaries to vaccinate many hundreds of people. Prentice of Livingstonia vaccinated two hundred individuals in one day at Ekwendeni in

⁸³⁶ Medical and Surgical Reports, 1899, 145/Dom/10/4/7, M.N.A.

1904.⁸³⁷ John Bowie of Blantyre was reported to have vaccinated hundreds of Africans when smallpox broke out at Ndirande in 1890.⁸³⁸ Macvicar also vaccinated 254 people when smallpox appeared near Chiradzulu in 1899.⁸³⁹

In seeking to minimise the ravages of smallpox, medical missionaries were driven by a combination of humanitarian concern and Christian charity. However, some medical missionaries were also motivated by a desire to secure future European involvement in the Protectorate.⁸⁴⁰ There was, therefore, a need to control the epidemic diseases that threatened European settlement and African labour supplies, and compromised future financial investment in the Malawi Region.

As has been previously demonstrated, the doctors of the Blantyre Mission worked closely with European commercial agents for the control of epidemic disease and the smooth operation of European commerce in the Shire Highlands.⁸⁴¹ The mission doctors were usually highly involved in the campaigns launched against the threat of smallpox. For example, during an epidemic of the disease in 1899-1900, Macvicar of Blantyre organised a vaccination programme and instructed European employers to send to the mission those who had not been vaccinated. The doctor also routinely informed European employers of African labour of the areas in which smallpox was prevalent in order that they might avoid those regions when they recruited labour.⁸⁴²

⁸³⁷ Annual Report, Livingstonia Mission, 1904, p.29.

⁸³⁸ *Blantyre Mission Journal*, Sept. 16 1890, MS9218, N.L.S.

⁸³⁹ *C.A.T.*, Dec. 16 1899.

⁸⁴⁰ *Church of Scotland Home Foreign Missionary Record*, July 1 1890.

⁸⁴¹ See chapters 3, 4 and 5

⁸⁴² *C.A.T.*, Jan. 13 1900.

Furthermore, from as early as 1896, Macvicar, in initiating the training of African medical assistants who were capable of vaccinating against the disease, instigated the means through which increasing numbers of Africans were protected against smallpox in the first half of the twentieth century. *Life and Work*, noted in 1901 that the “largest number vaccinated at the Blantyre dispensary in a single day was six hundred and seventy.”⁸⁴³ In the same year, the planters’ newspaper wrote of the mission’s vaccination campaign: “During the last year the Mission native hospital assistants have vaccinated between 50,000 and 60,000 people.”⁸⁴⁴ Harry Kambwiri wrote from his Pantumbi Station:

we have of late been vaccinating as extensively as we could. A large proportion - probably about two-thirds of the whole native population is protected from small-pox either by vaccination or by previous attack.⁸⁴⁵

Life and Work also documented the Blantyre Mission’s desire for a partnership approach between the mission, the Administration and European commercial agents to control the disease. A correspondent in the mission’s journal reported of smallpox in 1899 that:

Dr Macvicar opened the campaign against it and various district medical officers of the administration also took the subject in hand. There is therefore every likelihood of the epidemic being speedily stamped out. At the present season when the demand for a large native labour supply is so clamant, the effect of an outbreak of small pox in our neighbourhood would be most disastrous. We hope the medical authorities will be warmly seconded by the various employers of labour in their praise worthy efforts to remove every source of infection and contagion from the district.⁸⁴⁶

The medical resources of the Protectorate Government reinforced the missions’ efforts to control smallpox. The public health campaigns launched by the

⁸⁴³ *Life and Work*, Jan.-March 1901.

⁸⁴⁴ *C.A.T.*, Dec. 7 1901.

⁸⁴⁵ *Life and Work*, Jan. 1900.

⁸⁴⁶ *Life and Work*, Dec. 1899.

Administration also aimed for the preservation and multiplication of the numbers of European settlers and African labourers and the promotion of European investment in the Protectorate. For example, it was documented in the annual report for the year 1902-3 that the European death rate for the Protectorate as a whole had fallen from 70 per thousand to 28.07 per thousand. It was then considered that the improved living arrangements of Europeans had been in part responsible for this reduction. The Administration could also report by 1903 that the incidence of smallpox had declined. They emphasised the effectiveness of mass vaccination campaigns of Africans, and highlighted the efforts of medical missionaries in this achievement, as was documented in the Annual Report of 1902-3:

Natives have been freely vaccinated, and although they are extraordinarily susceptible to the ravages of small-pox, it is satisfactory to note that there has been no epidemic of any consequence within the year...A tribute is due to the Mission Societies generally with regard to the useful work they have done during the year in the matter of vaccinating natives. This has been especially the case with the Church of Scotland Mission, who have spared no pains to vaccinate on a liberal scale, and during the past three years some 60,000 natives have been vaccinated in the Blantyre district alone by the mission medical staff, and to this is largely attributable the freedom of the Blantyre district from serious outbreaks of small-pox.⁸⁴⁷

Between 1903 and 1914, the Administration continued to document the considered reduction in the incidence of smallpox. In the annual report of 1906-7, the PMO, Dr. Hearsey, reported that:

Epidemics of small-pox, such as were common in the Protectorate some years ago, do not now occur. Sporadic or imported cases are at once reported, and measures immediately taken for their isolation and the vaccination of natives in the surrounding villages.⁸⁴⁸

⁸⁴⁷ Annual Report, 1902-3. No.13, p. 26.

⁸⁴⁸ Annual Report, 1906-1907, No.537, p. 50.

However, despite the medical officer’s confidence that the incidence of smallpox was reducing, a series of epidemics of the disease occurred in 1908-9. These led to the passing of the Vaccination Ordinance of 1908, which compelled every infant and adult who had not acquired natural immunity from smallpox to undertake vaccination from a public vaccinator. This Act also prohibited the traditional practice of inoculation. By 1913, it was considered that the Vaccination Ordinance had brought about a significant reduction in the prevalence of smallpox as was described in the Annual Medical Report of 1913.

There has now been no recurrence of small-pox in Nyasaland, in epidemic form, since the year 1909, when, after urgent representations, systematic vaccination of the general population was first adopted. Five years of freedom from a disease which hitherto was rightly regarded as the chief scourge among the natives, is something to have attained for a recurring outlay of about £200 per annum for the wages of Native Vaccinators, and an additional £100 for the purchase of lymph.⁸⁴⁹

The aggregate numbers of vaccinations performed annually between 1911 and 1913 are shown in table 7⁸⁵⁰

Table 7: Aggregate Vaccinations in Malawi Region 1911-1913

1911	1912	1913
107,687	132,992	143,502

In addition, 42,853 individuals were vaccinated during the smallpox epidemic of 1908-1909 in Central Angoniland alone.⁸⁵¹

Contrary to the PMO’s view that the reduction in the incidence of smallpox was a result of vaccination campaigns, there are other possible reasons for its apparent

⁸⁴⁹ Annual Medical Report. Dec. 31, 1913.
⁸⁵⁰ *Annual Medical Report*, Dec. 31, 1913.
⁸⁵¹ Pollock, *Nyasaland and Northern Rhodesia*, p. 474.

decline. For example, the epidemiology of the disease may have changed suddenly, possibly as a result of acquired herd immunity⁸⁵² or a less virulent strain of the disease may have developed.⁸⁵³ The data on which the suggested reduction in the incidence of smallpox is based is also open to challenge. Before 1914, it would not have been possible for the limited numbers of Europeans in the Protectorate to effectively monitor the health of Africans in rural areas or at a distance from European centres. In addition, the accuracy of the statistics of vaccinations administered is highly questionable. The Annual Medical Report of 1912 addressed this issue, stating:

Constant supervision by a staff of superintendents of vaccination would be required in order to ensure any degree of accuracy in the figures returned...The operations of the vaccinators extend over some fifteen or sixteen districts and sub-districts of the Protectorate, and while Medical Officers are under instructions to supervise their work it is not possible to exercise the constant supervision which is necessary for accurate returns.⁸⁵⁴

The problems encountered in the practical administering of the vaccine to the African population casts further doubt over the PMO's celebration of the success of the vaccination campaigns undertaken by his doctors and those of the missions. Constant anxieties existed over the maintenance and quality of lymph stocks. Medical missionaries continually reported that their supplies had become inactive before they could be utilised. Howard described the problem in 1900:

When small pox started here in June/99 I used all the glycerinated lymph without success, but working back thru' the stock got the last lot of human lymph, Dec/98 to take...I got some more from Blantyre Mission & did a lot of vaccinations, & stored a lot of lymph, then smallpox came to an end here.

⁸⁵² Herd immunity results where a critical number of people in a given society have acquired immunity to a particular disease. The offending germ dies since it cannot infect enough people in the society to maintain its critical rate of transmission.

⁸⁵³ M.H. Dawson, 'Socio-economic Change and Disease: Smallpox in Colonial Kenya, 1880-1920', in Feierman and Janzen (eds.), *The Social Basis of health and Healing*, pp.90-92.

⁸⁵⁴ *Annual Medical Report*, Dec. 31, 1912.

Two months later I wanted to vaccinate at Msumba & out of 50 tubes collected here I only got two that were still alive.⁸⁵⁵

There was also a problem of poor uptake of the vaccine. It was commonly reported that at times of outbreak, many hundreds of people would flock to the mission or vaccinator seeking immunisation. “When there is no small-pox scare there is considerable difficulty in getting the natives to come to be vaccinated, and, more especially, to return in a few days for inspection.”⁸⁵⁶

In many instances the vaccination programme must have appeared to Africans as just another compulsory measure of imperial rule. In 1903, the settlers’ newspaper printed an account of the on-going dispute between European employers of African labour and the Protectorate Government over whose responsibility it was to vaccinate African employees. The settlers maintained that the latter ought to arrange for these treatments to be administered by the Labour Bureau, through which the majority of migrants passed.⁸⁵⁷ Nevertheless planters gathered their workforces together in order for them to be subjected to systematic vaccination.⁸⁵⁸ Recommendations were also passed which stipulated that on the outbreak of smallpox or other infectious disease, employers of labour should have facilities for speedily isolating those affected.⁸⁵⁹

⁸⁵⁵ Howard to Travers, Dec. 3 1900, B2. UMCA Papers, R.H.L.

⁸⁵⁶ Annual Report, 1903-04.

⁸⁵⁷ *C.A.T.*, No. 29, April 18, 1903.

⁸⁵⁸ Cox to Blantyre Mission, March 22 1900, 50.BMC 2/1/29. The systematic vaccination of all African labourers in the encampments of the tenga tenga companies was just one aspect of the health service that Doctor Norris of the Blantyre Mission provided for subscribing companies. See *C.A.T.*, No. 20, Feb. 16 1901.

⁸⁵⁹ It should be noted that although various regulations were passed at this time the under funded Protectorate Government often struggled to enforce such measures.

The threat of violence remained real to Africans in the course of these smallpox campaigns and it is probable that they were associated with the demonstrations of physical force on the establishment of Protectorate rule in the early 1890's. For example, The *Central African Times* noted in 1899:

Dr Cross writes that at Ntonda all the genuine cases of smallpox have been gathered into the village behind Mr.Sinderam's house. Every house in which a case was found was burned and the natives compensated. A cordon of askari is on duty night and day. The same thing has been done at Chiradzulu where there are now three cases.⁸⁶⁰

Hearsey of the Administration noted in the Annual Report of 1906-7: "Cases of infectious diseases are isolated in temporary huts under a police guard, and these huts are subsequently burnt."⁸⁶¹ Elmslie of the Livingstonia Mission demonstrated a similarly aggressive approach to the control of smallpox in 1900:

Have been out all day hunting for a case of small pox which is being hid away by the people of the district & if the scourge gains a footing our workers will run away. I could not find him but everywhere the people were thwarting us. Dr. Innes & I burnt down several houses where we knew he had been, so the stupid people may begin to see their own interests & help us.⁸⁶²

In addition to this, the practical administration of the vaccine was frequently a painful experience for the recipient on account of the inferior skills of the medical assistant or the particular vaccination technique utilised. In 1909, the Resident of Nkhotakota discussed the possible precipitators of the severe ulcers found on the arms of those who had recently undergone vaccination.

But the native vaccinator (sic) himself stated that he was told by Dr. Norris in Zomba to vaccinate each native three times the size of half crown, that in itself I think, is sufficient to cause practicilly (sic) all the bad wounds which

⁸⁶⁰ *C.A.T.*, No.14, Dec. 30 1899.

⁸⁶¹ Annual Report, 1906-7, No.537, p. 57.

⁸⁶² Elmslie to Smith, Sept. 18 1900, MS7883, N.L.S.

have come before me...On George's arrival & before I sent him to work I inspected his scalpel, I found it very blunt & thickly incrustated with blood & dirt & he had intended using it in that condition, so that dirt or blood poisoning may have had a good deal to do with the wounds, of which the Asst. Resident Mgara complains.⁸⁶³

Therefore, despite the celebrated statistics for smallpox vaccinations from the turn of the century onwards, the problems of quality, uptake and administering of the vaccine could result in disappointing rates of achieved immunity from the disease. In 1913, the Annual Report for the Mlanje district stated that of 6,246 administered vaccinations, 3,879 were successful and 1,533 effected a 'modified' reaction, whilst 834 failed.⁸⁶⁴

The prevention of smallpox was initiated by missionary doctors in the pre-colonial period. The Blantyre, Livingstonia and UMCA Missions all instigated vaccination campaigns of varying sizes. This contribution to public health was recognised and appreciated by both European commercial agents and the Administration. However, this chapter has demonstrated that although the reduced incidence of smallpox was celebrated by government officials, statistics of the numbers of Africans who were successfully vaccinated are contentious.

Sleeping Sickness

Many Africans experienced missionary medicine as it supported the Administration's campaign against sleeping sickness. As has previously been described, before 1914, smallpox campaigns were often mission-led, with government doctors making a significant, but secondary contribution. By contrast,

⁸⁶³ Kota Kota Monthly Reports, Oct. 4 1909, NCK. 5/3/1, M.N.A.

⁸⁶⁴ Mlanje Report, March 31 1913, M1/2/1, M.N.A.

the campaign launched against this new disease was initiated and administered by government doctors, with missionary doctors relegated to the subordinate role.

Sleeping sickness, which was well known in the Congo and West Africa, appeared in epidemic form in Uganda in 1901, where it was transmitted from wild game to man via the *glossina palpalis* tsetse fly. The disease was caused by trypanosomes in the blood, which generated symptoms of fever, lassitude, coma and eventual death in humans. Livestock could also be infected. Between 1898 and 1906, the disease killed approximately 20,000 Africans in Uganda alone.⁸⁶⁵ As sleeping sickness spread southwards from Uganda, its progress was monitored closely by government officials, missionaries and European settlers, who feared this disease, the aetiology and cure of which evaded them.

Various environmental factors combined to exacerbate the impact and spread of sleeping sickness across east and central Africa in the early twentieth century. Settlement and cultivational patterns had altered significantly during the nineteenth century in response to the violence of the slave trade and the conquest of certain societies by aggressive immigrants. During this time, rather than practising dispersed cultivation, which controlled the growth of tsetse harbouring wild bush, individual African societies merged within larger fortified villages for protection, such that the bush reclaimed previously populated and cultivated land. In addition, the rinderpest epidemic, an animal disease that had been transmitted to Ethiopia by cattle imported from British Asia in 1888, decimated cattle and game stocks in the early 1890's. This enabled the wild bush to reclaim pasture land.

⁸⁶⁵ Pollock, *Nyasaland and North Eastern Rhodesia*, p.476.

These processes were exacerbated in the early twentieth century when violence, disease and labour migrations further reduced human populations, the density of cultivation and the potential for limiting the spread of the bush.⁸⁶⁶ The wild game that carried the sleeping sickness parasite, multiplied more quickly than cattle in the wake of the rinderpest epidemic and inhabited these extensive areas of bush. It is thought that the increased rate of transmission of the disease to humans in the early twentieth century resulted from a further alteration of the ecosystem as societies moved out of fortified villages and attempted to reclaim bush land. However, it is also speculated that the sleeping sickness of this period might have been of a more virulent strain of the disease to which people had reduced immunity.⁸⁶⁷

Although Nyasaland was initially unaffected by the disease, the authorities were concerned that the virus might be carried into the Protectorate by travellers from the Congo and Lake Tanganyika. This fear grew with the discovery in 1908 of a case of sleeping sickness in North Eastern Rhodesia. This case was transferred to an isolation camp at Dowa. Dr. Hardy of the Administration, who had been attending this first patient, was also infected and subsequently died within three months of his diagnosis. A medical inspection post for the examination of travellers was established at Karonga, whilst an investigation of the distribution of tsetse over the west and north west of Lake Nyasa was initiated.

⁸⁶⁶ J. McCracken, 'Colonialism, Capitalism and the Ecological Crisis in Malawi: A Reassessment', in D. Anderson and R. Grove (eds.), *Conservation in Africa: People, Politics and Practice* (Cambridge, 1987); J. Mackenzie, *The Empire of Nature*, (Manchester, 1988), pp.234-235.

⁸⁶⁷ J. Iliffe, *Africans. The History of a Continent* (Cambridge, 1995), pp.209-210.

Concern increased from 1910 as more instances of the disease were uncovered in parts of Central Angoniland, Marimba and South Nyasa districts, while in 1911, 35 cases of the disease were discovered in Nyasaland. The Epidemic and Contagious Diseases Ordinance of 1908 was utilised for the restriction of population movement between areas designated 'affected' and 'non-affected', as a means of limiting the spread of the disease.

At that time very little was actually known about the new disease. Its labelling as a 'plague' epitomized the perceived threat to the established order and the expectation for a speedy government-led response.⁸⁶⁸ Early detection and isolation of suspected cases was considered the most appropriate preventive measure. Since it was assumed that raised glands were a possible indicator of infection, missionary doctors joined with those of the Administration in routinely palpating the cervical glands of Africans. In October 1906, Doctor Murray of the Dutch Reformed Mission noted that approximately 60,000 people had been examined with no instances of infection discovered.⁸⁶⁹

However, by 1908 this diagnostic procedure was questioned as the majority of those with enlarged glands were later deemed unaffected. It was considered impossible and counterproductive to isolate people on the findings of a doubtful diagnostic process. *The British Central African Gazette* thus explained:

there would be the risk of sending absolutely healthy people to segregation camps; and secondly that segregation of Sleeping Sickness cases in the earlier stages of the disease would entail such hardship on the individual, and the enforcement of quarantine would have to be conducted on so

⁸⁶⁸ Hetherwick to Murray, Sept. 10 1910, 86/Zom/2/8/2, M.N.A.

⁸⁶⁹ V.L. Jhala, 'Human Sleeping Sickness in Nyasaland' (unpublished paper, 1985), p.3.

extensive a scale as to render the whole scheme impracticable; and this has been found to be the case in Uganda and East Africa.⁸⁷⁰

A more accurate means of ascertaining an individual's infectious status was through gland puncture. However, medical officers found this difficult to perform as villagers generally refused to consent to invasive medical procedures. In 1910, the glands of 11,000 Africans in the South Nyasa District were palpated while gland puncture was performed in only 56 instances.⁸⁷¹ Initially, gland palpation was focused on mission pupils and European-employed workers. Dr. Hardy wrote from Dowa.

As regards the villages I did not dare palpate, as these people are so timid & suspicious I have deferred that at present. Dr. Murray the Mission Doctor...will go through all the mission schools which are very numerous along the lake shore, and I am relying upon the large gangs of natives that come to the boma for work for palpation.⁸⁷²

However, as a greater sense of panic pervaded the Protectorate, a more aggressive approach was soon advocated. For example, Dr. Pask wrote from Dowa:

I am sending a Requisition to incur Expenditure for two askari in connection with Sleeping Sickness Investigation...Frequently I arrive at a village now & find all the inhabitants have taken their departure to the bush not to return till I have moved on to the next one. I think if I had two policemen it would greatly help in the matter, I could send one ahead to inform the villagers... The last ulendo I went (sic) I camped for three days in the centre of a large number of villages. One village I visited in person & waited to see the chief but he never came, I summoned him several times to come with his people to my camp...without result...I think he ought to receive some reminder about it...if he was imprisoned for some time it might be a good example to other villages which I might visit in the future.⁸⁷³

⁸⁷⁰ *Central African Gazette*, 1906.

⁸⁷¹ *Sleeping Sickness Bureau Bulletin*, 17,2, 1910

⁸⁷² Hardy to Norris, Jan. 24 1908, Medical Officer, Dowa, 1908-1911, M1/1/1, M.N.A.

⁸⁷³ Pask to Hearsey, undated, M.O. Dowa, 1908-1911, M1/1/1, M.N.A.

Africans continued to hide their sick; girls of marriageable age were concealed for fear that their dowry would be affected by their segregation. African non-compliance in the Sleeping Sickness Campaign was more formally addressed in 1912, when medical officers were “instructed to treat any and all cases of sickness they may encounter, in order to gain the confidence of the natives and thus place themselves in a better position to find cases than by following the more direct methods hitherto adopted, and which no doubt resulted in the concealment of a large number of sick persons.”⁸⁷⁴ Non-compliance in the Proclaimed Area of Dowa was managed through the employment of special police. Ultimately, medical officers were forced to appreciate that outwith the Proclaimed Area they had no legal authority to medically examine Africans against their will.⁸⁷⁵

Government doctors and officials expected missionary doctors to palpate the glands of their patients, perform microscopic inspections of blood specimens and, when required, remove infected cases to the isolation camp. Norris, acting in the capacity of P.M.O, informed Hetherwick of his expectations of the Blantyre Mission in the campaign against sleeping sickness in 1908. He wrote:

In Blantyre Native Hospital you will be able to do a great deal. I hope Dr. Caverhill will look upon the proposal carefully. I think mission medical men are in the best position to undertake gland palpation & puncture, & S.S is a common enemy we must all fight.⁸⁷⁶

However, while sleeping sickness made little impression on the Shire Highlands, the disease caused considerable concern in the north, particularly in the Kasungu area, where it had spread from the Luangwa Valley. Certain medical missionaries

⁸⁷⁴ Annual Medical Report, March 31, 1912.

⁸⁷⁵ Davey to PMO, Oct. 7 1912, M.O. Mlanje, 1913-1921, M1/2/1, M.N.A.

⁸⁷⁶ Norris to Hetherwick, Dec. 2 1908, 50.BMC.2/1/96, M.N.A.

of the Livingstonia Mission were, therefore, heavily involved in the government-led sleeping sickness campaign.

Chisholm, based at Mwenzo, was the first Livingstonia doctor to encounter the disease in 1907.⁸⁷⁷ Two years later, whilst working in the Chinsali district, he examined five hundred Africans for signs of infection.⁸⁷⁸ Dr. Innes was also involved in examining Africans for the disease at Karonga in 1911,⁸⁷⁹ whilst Dr. Brown, also of Livingstonia, undertook more detailed research on the disease from 1911.⁸⁸⁰ He described his investigations:

The S.S. Regulations for the Luangwa Valley first left the Fort-Jameson-Serenje road open, travellers by it being subject to examination at each end. This meant for me the examination of several hundred people at 2/6 per man. Later this road also was closed, which shut off a considerable source of income for the Mission. But I had still left the examination of men coming from the Congo who were going east. By and by this also ceased as they were sent east by routes other than Serenje... During the year an arrangement was made with the Principal Medical Officer for Northern Rhodesia whereby, if it was convenient, cases of S.S. should be sent here to be under my care in an isolation camp. As a matter of fact every case in the Serenje district had been under me. But this enabled me to transfer them from Serenje to where I could see them daily.⁸⁸¹

Dr Wigan of the UMCA also identified a case of sleeping sickness at Nkhotakota in 1913.

In the wake of the Ugandan epidemic, missionaries were acutely aware of the disease's potential to spread. Their principal role in the sleeping sickness campaign

⁸⁷⁷ Hokkanen, 'Doctors of Body, Soul and Society', p. 89.

⁸⁷⁸ *The Livingstonia News*, Aug. 1909, p. 55.

⁸⁷⁹ Annual Report, Livingstonia Mission, 1911, p. 36.

⁸⁸⁰ Fairly Daly to Brown, Nov. 6 1911, MS.7867, N.L.S.

⁸⁸¹ *The Livingstonia News*, April 1912, p. 28.

was to pressurise the government to establish the cause of the disease and to take action to limit its transmission.

In 1903, the *glossina palpalis* tsetse fly was identified as the vector which transmitted the trypanosomes parasite from animals to humans in the Ugandan epidemic of sleeping sickness. Since this fly did not exist in large numbers in Nyasaland, the Protectorate government adopted a 'wait and see' approach to the outbreaks of the disease in neighbouring territories.⁸⁸² However, the official labelling of *G.morsitans*, the common bush tsetse, as the vector of the rhodesiense trypanosoma raised concerns of the potential for the virus to spread throughout Nyasaland. Between 1909 and 1911, 42 new cases of the disease were diagnosed, while between 1908 and 1913, there had been 172 confirmed instances of sleeping sickness within the Protectorate.⁸⁸³

Although sleeping sickness did not reach the Shire Highlands, Hetherwick of the Blantyre Mission identified the possible detrimental effects of the epidemic on future investment and European settlement within the Protectorate and adopted the role of principal spokesperson in the campaign for a timely government-led response. He wrote:

Several native cases have been discovered in the same district [Central Angoniland] and so the whole situation is looking most serious for the country...Everyone here is anxious about the future if this disease is allowed to spread over the whole country as it seems likely to do. Then God help us all!! We are all alive to the gravity of the situation but it is well not to make a scare in the country or outside of it for it would be a great blow to all hope

⁸⁸² Pollock, *Nyasaland and North Eastern Rhodesia*, pp.476-480.

⁸⁸³ Jhala, 'Human Sleeping Sickness', p.15.

of commercial development if this Protectorate were known to be liable to the Sleeping Sickness.⁸⁸⁴

By 1910, a connection between the increasing numbers of wild game, tsetse fly and sleeping sickness had been identified, although the exact relationship between these factors was unknown. Hetherwick led the campaign to pressurise the government to effect the mass destruction of wild fauna. Prentice of Livingstonia, who was based at Kasungu, explained the rationale, which underpinned this appeal to the government. He wrote:

The protection of game and the consequent spreading of tsetse with sleeping sickness threatening this country is about as sane a policy as would be the protection of rats when bubonic plague is threatening a home community.⁸⁸⁵

In their campaign for the reduction in the wild animal population, the missionaries faced formidable opposition from the Protectorate Government and the game hunting community, who included the former Commissioner, Alfred Sharpe, amongst their numbers. This opposition called for further proof of any relationship between the disease and wild game before they would support a mass cull.

Hetherwick expressed his frustration at this opposition in a letter to Prentice.

But above all one felt that till Sharpe is out of the country one cannot touch this game question...it is a red rag to a bull...and he will not listen to anything that will even have the appearance of trying to do away with these game reserves or giving the natives the power to kill off game destroying their crops.⁸⁸⁶

⁸⁸⁴ Hetherwick to Burnett. Sept. 20 1910, 50.BMC.2/2/1, "M" Series, M.N.A. The panic and fear generated by this poorly understood disease has been likened to the crisis, which centred on the AIDs virus of present times.

⁸⁸⁵ Annual Report, Livingstonia Mission, 1907, p. 37; Mackenzie, *The Empire of Nature*, pp.236-240

⁸⁸⁶ Hetherwick to Prentice, 28 Feb 1910, 86 Zom/2/8 M.N.A.

On hearing of the infection of a European with the disease at Mvera in 1910, Hetherwick stepped up his campaign. He wrote:

I called the three un-official members of the Government together to consult on the situation and to send our views to the Government. Mr Kidney was going through to Zomba the following day and was to take our suggestions to the Governor for immediate action on three lines: ..

- (1) Increase of medical staff to make a thorough investigation of the District where the cases have occurred near Mvera:
- (2) Removal of all infected or suspicious cases to a non-tsetse infected District: and
- (3) Free killing off of game of all kinds in Central Angoniland District from the lat. 14.30 South to the Northern Boundry of the District and from the Shore of the Lake to the border of the Reserve. This includes all the places likely to be infected with the disease trypanosomes. A reward to be given for each head of eland and buffaloe killed .. these two species to be exterminated as quickly as possible for they are supposed by many authorities to be the host of the tsetse...The Governor is not so sure about the game question and the slaughter of all the animals in the suspected area .. but we have a meeting of the Chamber of Commerce next Tuesday called specially in view of this matter and they will no doubt urge the Governor to try this mode of meeting the plague.⁸⁸⁷

As has been described, Wigan of the UMCA observed patients for symptoms of sleeping sickness, but the UMCA played a less active role in pressurising the government to take decisive action to control the spread of the disease. By contrast, the missionaries of the Livingstonia Mission actively supported the action taken by Hetherwick. The work of the Livingstonia Mission in Northern Rhodesia had been seriously curtailed by the measures taken by the government to control population movement and the spread of the disease from the Luangwa valley, as Fairly Daly of the Home Committee informed Nurse Ballantyne:

Only Europeans can pass the border and carriers must be changed before passing from one district to another. All this is going to hamper very seriously the work of our mission, and Dr. Chisholm is earnestly asking for some modification of these rules, which will permit him or any other

⁸⁸⁷ Hetherwick to Murray, 10 Sept. 1910, 86 Zom/ 2/8 M.N.A

medical missionary to have some discretion given them on their responsibility as medical men.⁸⁸⁸

In 1911, the home committees of the two Scottish churches sent a Deputation to the Government calling for further action to be taken to control the spread of the disease. Fairly Daly informed Elmslie of the preparation for this:

The committee will on no account have Prentice as a speaker but we have asked him to prepare a paragraph of the medical facts to be incorporated in our printed statement. As an oral speaker he would simply spoil our case, but this is between ourselves. The Committee were quite emphatic about this.⁸⁸⁹

As a result of this Deputation, a Royal Commission, led by Sir David Bruce, was appointed to investigate the disease in 1911. In the same year the Elephant Marsh Game Reserve was abolished.⁸⁹⁰ However, the missionaries' proposal for the mass destruction of wild game in specified areas was not acted upon.

Ultimately, the rationale that the destruction of the wild game, which harboured the trypanosome infection, would reduce the incidence of the disease in humans was over-simplistic. When partially implemented in 1915, this policy accelerated the spread of the fly by scattering game into new regions.⁸⁹¹

However, it soon became apparent that the strand of the virus prevalent in the region was a less virulent type that would not reach epidemic proportions. More significantly, by 1913 it was observed at Nkhotakota that the disease's victims were

⁸⁸⁸ Fairly Daly to Nurse Ballantyne, 11 March 1911. MS 7867 N.L.S.

⁸⁸⁹ Fairly Daly to Elmslie, 11 Nov 1911. MS7867 N.L.S.

⁸⁹⁰ Mackenzie, *The Empire of Nature*, p.234.

⁸⁹¹ McCracken, 'Experts and Expertise in Colonial Malawi', *African Affairs*, 8, 322, 1982, p.107.

commonly the elderly and debilitated, who were already marginalized within the Protectorate's new commercial economy. The Resident documented :

the disease appears to have attacked only old or otherwise debilitated individuals and the Medical Officer further concurs with me in advising that no extreme measures such as the moving of villages be attempted for the present.⁸⁹²

The sleeping sickness campaign provides a striking example of the strengths and limitations of Western and particularly of missionary medicine. Fortunately the impact of the disease was comparatively mild in Nyasaland, but this had little or nothing to do with the application of Western medicine, which lacked remedies in this period that could be used against the disease. Although the aetiology of the disease had been established through the application of Western science, the key practitioners here were secular experts. Missionary doctors, by contrast, were marginalized within this process.

Missionary and Secular Medicine

This chapter has attempted to build upon chapter 3 of the thesis, which detailed the professional and spiritual influences that motivated and constrained the medical practice of individual missionary doctors. Despite the contrasting scientific and spiritual theories of disease causation and treatment advanced by individual medical missionaries, these ideologies often shared a practical end point. I have detailed the diverging views on personal and public hygiene and the treatment of ulcers as examples of this process. The science-based theories on the aetiology and prevention of malaria provide the first significant example of professional, secular

⁸⁹² Report for Kota Kota, Sept 1, 1913, NCK. 5/13/1, M.N.A..

medicine exerting its authority and influence over missionary medical discourse before 1914. Theories of the African child's inherent contamination could not be incorporated within this discourse.

The particular role of secular medicine in public health campaigns has been emphasised. These campaigns were indicative of their main motivation in servicing and preserving the settler economy.

Between 1900 and 1914, the Administration provided increasing medical services for Africans. The first Government doctor, Sorabji Boyce, had been appointed in May 1891. By 1910 the medical department was the second largest department of the protectorate Government.⁸⁹³ By 1914, the Administration was responsible for a range of hospitals and dispensaries across the Protectorate⁸⁹⁴.

As Table 8 demonstrates, this secular provision of medicine was confined very largely to the Shire Highlands and lower Shire River; the regions in which the settler economy and the Blantyre Mission operated. Virtually no medical services were provided by the Administration in the UMCA's sphere of influence and in the northern province, where the Livingstonia Mission was situated.

⁸⁹³ Baker, *The Government Medical Service in Malawi*, pp.296-299.

⁸⁹⁴ Annual Medical Report year ending 31 Dec. 1914. A hospital for Africans which would accommodate 10-12 beds was nearing completion at Blantyre at that point. The hospitals at Zomba included a general infirmary for Africans, a hospital for African troops and a separate institution for prisoners. There was also a dispensary for Africans and a camp dispensary.

Table 8: Administration Medical Provision within The Protectorate, 1914⁸⁹⁵

Station	Hospitals				Dispensaries
	European		African		
	Number	No. of Beds	Number	No. of Beds	
Port Herald	-	-	1	4	1
Mulanje	-	-	-	-	1
Blantyre	1	6	-	-	1
Zomba	1	6	3	46	2
Fort Johnston	1	2	1	6	1
Nkhota kota	-	-	-	-	1
Karonga	-	-	1	2	1
Total	3	14	6	58	8

It should be acknowledged that, before 1914, the total number of people in the Malawi Region who experienced western medicine provided by either government or missionary doctors was relatively small. However, throughout this period, the Blantyre, UMCA and Livingstonia Missions remained the principal sources of both curative and palliative western medicine for the African sick.

⁸⁹⁵ Annual Medical Report, 31 Dec. 1914.

CONCLUSION

Vaughan has demonstrated the effectiveness of missionary medical discourse in framing the British public's perception of the evangelising role of mission medicine in the late-nineteenth and early-twentieth centuries.⁸⁹⁶ The provision of medical care and treatment exemplified the perception of missionary doctors as benevolent agents in God's work. Those involved in missionary medical endeavours contributed, in their writing and statements, to this vision, linking the physical healing of the African to his spiritual salvation.

This discourse frequently portrayed the African patient as a grateful and needy recipient of care. By inference, and often in direct statement, traditional African society was presented as being unwilling or unable to provide care.

This study suggests the sub-themes within the discourse of missionary medicine were utilised as a means of justifying certain aspects of missionary endeavour. The role of white, Christian, female, nurses was contrasted with the suggested 'un-nurturing' attitude of non-Christian African females. Similarly, the discourse of the 'uncaring African' strengthened, for British supporters of mission, the importance of hospitals, both as a practical necessity and as examples of Christian charity.

Mission societies often portrayed the penetration of medicine into Africa in terms of a linear progression, with rising numbers of dispensaries and mission hospitals reflecting the increasing effectiveness of mission medicine and of the growing demand from the African sick for western medicine. However, rather than usurping

⁸⁹⁶ Vaughan, *Curing Their Ills*, pp.55-76.

indigenous medicine and traditional healers, missionary medicine was incorporated within a plurality of healing systems from which Africans would draw. Often, patients would only turn to Western medicine once other healing methods had failed or if they were denied or excluded from traditional family support systems. Furthermore, only a minority of patients self-referred to the hospital. The majority were directed to the infirmary by 'referring agents', including influential family members, teachers, medical assistants or European employers.

Before the advent of antibiotics it is debatable whether missionary medicine was any more effective than indigenous healing systems. New research on the treatment and prevention of malaria and blackwater fever did have a significant effect in lowering death rates amongst European personnel. Missionary doctors also undertook simple operations and orthopaedic procedures, such as setting broken bones, but only a tiny proportion of Africans benefited from these services.

Vaughan emphasises the spiritual aspects of missionary medicine, contrasting it with secular colonial medical services.⁸⁹⁷ However, this study suggests that all mission doctors, to differing extents, balanced their spiritual beliefs and medical duties, with many prioritising the professional aspect of their role; seeing the practice of medicine as an end in itself, rather than merely as a route to saving the African's soul. This study has also demonstrated that the treatments administered by certain medical missionaries were motivated by more practical issues such as professional and economic concerns and the promotion of European investment and

⁸⁹⁷ Vaughan, *Curing Their Ills*, pp.56-57.

settlement in the region. The term ‘medical missionary’ – presenting mission doctors as a homogeneous group, fails to acknowledge this diversity of approach.

This thesis further contends that the evident professionalising and related secularising of mission medicine from 1900 onwards, was advanced by those medical missionaries who prioritised the professional rather than the spiritual aspect of their role. It is also suggested that the secularisation of mission medicine was initiated around the late 1890’s at the time of the development of the hospitals within missions and Administration-led public health campaigns.

The advance and secularisation of mission medicine were most pertinent at the Blantyre mission. By the start of the Great War, the Central Blantyre Hospital operated as a teaching institution for the training of African medical assistants and female nurses, while medical facilities were also available at its sub-stations. The mission’s medical departments also serviced the health needs of the African labourers who converged on the Shire Highlands – the principal site of European commerce within the Protectorate. It is argued that the evident health needs of the African migrant labourer, in conjunction with the expectations of European commercial agents, in part, required the Blantyre Mission to professionally organise its provision of medicine earlier than the two other more northerly missions.

However, although more distant from the influence of the settler economy, both the UMCA and Livingstonia missions made their own unique contributions to the development of medical services in Malawi. Although hindered by the lack of medical personnel, funding and the vast geographical scale of its diocese, the

UMCA developed hospitals and dispensaries at each of its principal stations by 1914 and could account for the treatment of thousands of patients annually within its dispensaries. The Livingstonia Mission made similar achievements, with particular focus on dispensary rather than in-patient provision.

There can be no question that many, although not all, of the doctors and nurses who accepted the privations of missionary life in Central Africa in the late nineteenth and early twentieth century were motivated by a strong sense of religious conviction which was reflected in their relations with their patients. However, this study has suggested that to focus too narrowly on the discourse of missionary medicine is to ignore much that is important concerning the motivations of these individuals and the development of early mission medical services. It therefore argues that it is only by looking at wider influences, from increasing medical and nursing professionalism, scientific advances and the expansion of the settler economy, that we can understand the different approaches to medical provision adopted by the medical missionaries of the UMCA, Blantyre and Livingstonia Missions.

European Health Record: Likoma Diocese, UMCA & Livingstonia

Deaths and Invalidings of European Staff at the UMCA (Likoma Diocese) and Livingstonia Missions

Year	UMCA ¹			Livingstonia ²		
	No. of Staff#	Deaths	Invalidings	No. of Staff	Deaths	Invalidings
1900	n/a	n/a	n/a	24	1	0
1901	n/a	n/a	n/a	n/a	0	0
1902	n/a	n/a	n/a	n/a	1	0
1903	n/a	n/a	n/a	n/a	0	0
1904	39	0	2	25	0	0
1905	39	0	2	n/a	1	1
1906	45	2	1	n/a	0	0
1907	43	0	1	n/a	0	0
1908	46	1	0	25	0	0
1909	42	0	0	n/a	0	0
1910	37	1	0	n/a	0	0
1911	37	1	2	n/a	0	0
1912	41	1	-	27	0	0
1913	n/a	0	0	n/a	0	0
1914	n/a	0	3	24	0	0

#Includes staff on furlough, but not wives, except for Dr Fraser. There were 13 Livingstonia wives in 1904; 13 in 1908; 17 in 1912 and 15 in 1914. (Livingstonia Mission Annual Reports)

¹ European Health Record, Vol. II, 145 Dom/10/4/1 M.N.A.

² D. Fraser, *Livingstonia*, (Edinburgh, 1915).

Record of Doctors Employed at the Livingstonia, UMCA and Blantyre Missions³

Livingstonia Mission Doctors

	Name	Joined	Left
1.	<u>Rev. Robert Laws</u> M.B. (Aberdeen)	1875 (Mission Head from 1877)	-
2.	<u>Rev. William Black</u> M.B., C.M. (Glasgow)	1875	1877 (Died)
3.	<u>Rev. James Stewart</u> (Glasgow)	1876	1878
4.	<u>Jane E. Waterston</u> (Glasgow/Dublin)	1879	1880 (Resigned)
5.	<u>Rev. Robert Hannington</u> M.B, C.M.	1881	c.1882 (Invalided)
6.	<u>William Scott</u> M.B., C.M. (Aberdeen)	1883	1886 (Resigned/ Invalided)
7.	<u>Rev. Walter A. Elmslie</u> M.B., C.M. Ordained 1897 in Aberdeen	1884	-
8.	<u>Rev David Kerr Cross</u> M.B., C.M. (Glasgow) Resigned to join Administration	1885	1896 (Resigned)
9.	<u>Rev. George Henry</u> M.B., C.M.	1887	1893 (Died)
10.	<u>Rev. George Steele</u> M.B., C.M. (Glasgow)	1890	1895 (Died)
11.	<u>Rev. David Fotheringham</u> M.B., C.M. (Glasgow)	1890	1893 (Resigned)
12.	<u>Rev. George Prentice</u> L.R.C.P. (Edinburgh) Ordained 1899 at Peebles Diploma of Tropical Medicine – 1912	1894	-
13.	<u>Rev. J.C. Ramsay</u> L.R.C.P. (Edinburgh)	1896	1898 (Invalided)
14.	<u>A.W. Roby-Fletcher</u> M.B., C.M. (Edinburgh)	1897	1898 (Died)
15.	<u>Robert Scott</u> M.B., C.M. (Glasgow)	1898	1900 (Resigned)
16.	<u>Rev. Frank Innes</u> M.B., C.M. (Aberdeen) Ordained in Aberdeen 1903 Diploma of Tropical Medicine	1899	-

³ D. Fraser, *Livingstonia*, (Edinburgh, 1915). Figures taken from Livingstonia Mission Staff Book, Acc7548, D73, N.L.S.; *Life & Work, Central Africa*; Letters of the Secretary of the Church of Scotland, 1887-1918.

17.	<u>Rev. James Chisholm</u> L.R.C.P. (Edinburgh) Ordained 1905 in Inverness Diploma of Tropical Medicine – 1906	1900	-
18.	<u>Ernest A Boxer</u> L.R.C.P. (Edinburgh)	1900	1905 (Resigned)
19.	<u>Agnes Fraser</u> M.B., C.M. (Glasgow) Not formally appointed as a doctor. Status remained that of missionary's wife.	1901	-
20.	<u>Alexander Brown</u> M.B., Ch.B., D.T.M. (Aberdeen/Liverpool)	1905	1912 (Resigned)
21.	<u>Berkeley Robertson</u> M.B., Ch.B. (Glasgow)	1906	1910 (Resigned due to ill health)
22.	<u>Rev. William Turner</u> M.A., M.B., Ch.B. (Glasgow) Diploma of Tropical Medicine – 1912	1906	-
23.	<u>Hubert Wilson</u> M.B., C.M. (Cambridge) Grandson of David Livingstone. Diploma of Tropical Medicine.	1913	

UMCA Mission Doctors

	Name	Joined	Left
1.	<u>John Edward Hine</u> MRCS (London), M.D. (Oxford) Bishop of Likoma (1896-1901) Bishop of Zanzibar (1901-1908) Bishop of N. Rhodesia (1910)	1889	-
2.	<u>Frederick Augustine Robinson</u> L.R.C.P., M.R.C.S.	1893	1894 (Invalided)
3.	<u>Robert Howard</u> M.A., B.M., B.Ch. (Oxford) M.D. – 1906 Entered Government service on Pemba in 1918.	1899	1910 (Transferred to Zanzibar Diocese)
4.	<u>William Cecil Wigan</u> L.R.C.P., M.R.C.S. War Service between 1916-1918.	1911	-

Blantyre Mission Doctors

	Name	Joined	Left
1.	<u>Thomas T. Macklin</u> M.B. (1876), Glasgow.	1876	1879
2.	<u>William Kerr Peden</u> M.B., C.M. (Glasgow – 1879)	1880	1883
3.	<u>James Henry Dean</u> M.B, C.M., L.R.C.P. (Edinburgh – 1881) Returned ill in 1882 and severed contact with mission in 1883.	1881	1883
4.	<u>George Milne</u> , M.B., C.M. (1884) Educated at Aberdeen University Resigned due to ill health. Died aged 31 in 1890.	1885	1889
5.	<u>John Bowie</u> M.B., C.M. (1882) (Edinburgh)	1887	1892 (Died)
6.	<u>William Affleck Scott</u> M.A. (1883), C.M. (1888) (Edinburgh)	1889	1895 (Died)
7.	<u>Henry Scott</u> M.A. (1886), L.R.C.P., L.R.C.S. (Edinburgh) Ordained 1890. Transfer to Kikuyu Mission in 1907.	1890	1907
8.	<u>George Robertson</u> L.R.C.P. (Edinburgh), L.R.C.S (Edinburgh), L.F.D.S. (Glasgow 1890) Resigned from Mission to work at the Blantyre European Hospital.	1891	1895
9.	<u>Neil Macvicar</u> M.B., C.M. (1894) (Edinburgh).	1895	1900
10.	<u>Samuel K. Norris</u> M.B., C.M. (Edinburgh) 1897 Resigned from the Mission to work for the Administration.	1899	1903 (Resigned)
11.	<u>Austin Caverhill</u> M.B., Ch.B. (Edinburgh 1902) Diploma of Tropical Medicine in 1908.	1903	1914 (Resigned)
12.	<u>J. Bell Walker</u> Employment terminated after public fist fight with Reverend Anderson.	1904	1905
13.	<u>Robert M. Macfarlane</u> M.B., Ch.B. (Glasgow) Liverpool School of Tropical Medicine: Diploma of Tropical Medicine – 1905.	1905	-
14.	<u>Dr Wilfred Macfarlane</u> Appointed 1914 but did not commence work at the mission until after the war.	1914	-

Mission Medical Facilities: 1906-1912 – From the Government Blue Books

N.B. Some of the statistics vary slightly from those held by individual missions

1906

Mission	Hospital	No. of Beds	Total No. of Patients Treated	Number of Inmates	Remarks
Church of Scotland					
Blantyre	1	62	12,000 (in & out patients)	494	Funded from Scotch Churches local subscription, donations, fees. Government pays £20 per annum for support of two beds.
Zomba	1	22	5,200 (in & out patients)	17	Funded from local voluntary contributions Government pays £50 per annum for support of five beds.
Total	2	84	17,200	511	
UMCA					
Likoma	1	20	n/a	20	Funded by special subscriptions from England and General Mission Funds.
Kota-Kota	2 (1 Native + 1 European)	n/a	n/a	24	As above
Malindi	1	n/a	n/a	18	As above
Total	4	n/a	n/a	62	
Livingstonia Mission					
Mwanzo	1 + Dispensaries	6	n/a	n/a	Funded from European and native medical fees; gifts. Balance from Livingstonia Committee of United Free Church of Scotland Local subscriptions: £61:15:0
Karonga	As above	n/a	15,502	n/a	Funded as above. Medical Fees, Europ'n: £20:4:0
Livingstonia*	As above	16	15,922	n/a	Funded as above. Local subscriptions: £75:18:0
Ekwendini	As above	n/a	n/a	n/a	Funded as above. Native medical fees: £4:17:0
Loudon	As above	8	n/a	n/a	Funded as above. Local subscriptions: £35:18:5
Bandawe	As above	n/a	3,545	n/a	Funded as above. European medical fees: £1:12:9
Kasungu	As above	n/a	n/a	n/a	
Livingstonia	Overtoun Missionary Inst' & School for Blind	n/a	n/a	216 resident + 123 apprentices	
Total	7 + Dispensaries	n/a	n/a	n/a	

*Temporary hospital only
n/a – not stated

Mission	Hospital	No. of Beds	Total No. of Patients Treated	Number of Inmates	Remarks
Church of Scotland					
Blantyre	1 + 9 Dispensaries	62	5,000	726	Funded from Scotch Churches: £250; local subscription, donations, fees: £200. Government pays £20 per annum for support of two beds.
Zomba	1	22	Not stated	Not stated	Funded from local voluntary contributions. Worked by Government part of year.
Total	2 + 9 Dispensaries	84	n/a	n/a	
UMCA					
Likoma	2 (1 European + 1 Native)	43	6,000	259	Funded by special subscriptions from England and General Mission Funds
Kota-Kota	2 (1 Native + 1 European) + Dispensary	27	3,500	95	Funded as above.
Malindi	2 (1 European + 1 Native)	17	2,000	87	Funded as above.
Mponda's	Dispensary		3,000		
Total	6 + 2 Dispensaries	87	14,500	441	
Livingstonia Mission					
Karonga	Dispensary	n/a	13,462	n/a	Funded from European and native medical fees; Gifts. Balance from Livingstonia Committee of United Free Church of Scotland
Livingstonia*	1 + Dispensary	16	12,771		Funded as above.
Ekwendini	As above	8	2,167		Funded as above.
Loudon	As above	8	834		Funded as above.
Bandawe	As above	16	19,912		Funded as above.
Kasungu	Dispensary	n/a			Funded as above.
Livingstonia	Overtoun Missionary Inst' & School for Blind			220 resident + 98 apprentices	Funded as above.
Total	4 + 6 Dispensaries	n/a	49,146	n/a	

*Temporary hospital only

n/a – not stated

Mission	Hospital	No. of Beds	Total No. of Patients Treated	Number of Inmates	Remarks
Church of Scotland					
Blantyre	1 + 9 Dispensaries	62	16,150 (including returns for treatment)	397	Funded from Scotch Churches; local subscription, donations, fees; &c. Government pays £20 per annum for support of two beds.
Zomba	1	22	278 (In) 3,158 (Out)	n/a	Worked by Government past year.
Mlanje	1	4	n/a		
Total	3 + Dispensaries	88	19,586	n/a	
UMCA					
Likoma	2 (European + Native) + Dispensaries	63	6,500	380	Funded by special subscriptions from England and General Mission Funds.
Likoma	Isolation Hosp.	10			
Kota-Kota	2 (Native + European) + Dispensary	27	4,000	95	Funded as above
Malindi	2 (European + Native) + Dispensary	27	2,000	100	Funded as above
Mponda's	Dispensary		3,000		
S.S. Chauncey Maples	Dispensary		2,000		
Total	6 + Dispensaries	127	17,500	575	
Livingstonia Mission					
Karonga	Dispensary	n/a	n/a		Funded from European and native medical fees; Gifts. Balance from Livingstonia Committee of United Free Church of Scotland
Livingstonia*	1 + Dispensary	16	7,167		Funded as above
Ekwendini	As above	8	n/a		Funded as above
Loudon	As above	8	2,543		Funded as above
Bandawe	As above	16	6,081		Funded as above
Kasungu	As above	16	4,091		Funded as above
Livingstonia	Overtoun Missionary Inst' & School for Blind			242 resident pupils of whom 146 receive industrial training	Funded as above
Total	5 + 6 Dispensaries	n/a	n/a		

* Temporary hospital only

n/a – not stated

Mission	Hospital	No. of Beds	Total No. of Patients Treated	Number of Inmates	Remarks
Church of Scotland					
Blantyre	1 + 10 Dispensaries	62	10,000 (including returns for treatment)	484	Funded from Scotch Churches; local subscription, donations, fees; &c. Government pays £20 per annum for support of two beds.
Zomba	1	22	242 (In) 2,993 (Out)		Funded by Government Grant. Worked by Government past year.
Mlanje	1	8	n/a		Funded from Scottish Church Fees
Domasi	1	12	130 (In) 9,814 (Out)		Funded from Scottish Church Fees
Total	4 + 10 Dispensaries	104	n/a	484	
UMCA					
Likoma	2 (1 European + 1 Native) + Dispensaries	63	6,500	380	Funded by special subscriptions from England and General Mission Funds.
Likoma	Isolation Hosp.	10			
Kota-Kota	2 (1 European + 1 Native) + Dispensary	27	4,000	95	Funded as above.
Malindi	2 (1 European + 1 Native) + Dispensary	27	2,000	100	Funded as above.
Mponda's	Dispensary		3,000		
S.S. Chauncey Maples	Dispensary		2,000		
Total	6 + Dispensaries	127	17,500	575	
Livingstonia Mission					
Karonga	Dispensary				Funded from European and native medical fees; Gifts. Balance from Livingstonia Committee of United Free Church of Scotland
Livingstonia*	1 + Dispensary	25	10,892		Funded as above.
Ekwendini	As above	8	2,832		Funded as above.
Loudon	As above	8	2,410		Funded as above.
Bandawe	As above	16			Funded as above.
Kasungu	As above	16	3,336		Funded as above.
Livingstonia	Overtoun Missionary Inst' & School for Blind			152 resident pupils of whom 70 receive full & 82 partial industrial training	Funded as above.
Total	5 + 6 Dispensaries	73	19,470		

* David Gordon Memorial Hospital opened at Livingstonia Mission, August 1911
n/a – not stated

Church of Scotland Mission Nurses

Name	Training	Recruitment/ Controlling Body	Age at Appointment	Appointment/ Arrival Date	Departure Date	Marriage
Jessie Samuels	Western Infirmary, Glasgow	F.M.C.		c.1896		Dr Neil Macvicar
Nurse Farquar	Aberdeen Hospital	F.M.C.		1899		Rev. Anderson 1905
Jessie Dewar	Gained experience in fever hospitals before nursing in Deaconess	W.A.F.M.	29	1901		Mr Burnett 1905
Nurse Richardson	In consumptive women's ward, but not professionally trained.	W.A.F.M.	23	1902		
Nurse Aikman	Experience in maternity care.			1903	1905	
Nurse Lorimer	Well trained but not technically qualified.			c.1904		Dr Macfarlane 1909
Nurse Cullen	Trained in the Deaconess Hospital	W.A.F.M.		1905	1908 Resigned before being dismissed	
Nurse Hamilton				1905	c.1913/1914	1914 Mr Currie
Henrietta Priest	A fever nurse who had also worked in nursing homes.		35	c.1906	1913 Invalided.	

⁴ D. Fraser, *Livingstonia*, (Edinburgh, 1915). Figures taken from Livingstonia Mission Staff Book, Acc7548, D73, N.L.S.; *Life & Work, Central Africa*, Letters of the Secretary of the Church of Scotland, 1887-1918.

Nurse Liddell					1907	1915 Took a nervous breakdown, but returned to mission in 1917	
Name	Training	Recruitment/ Controlling Body	Age at Appointment	Appointment/ Arrival Date	Departure Date	Marriage	
Nurse Low				1907			
Nurse Janet Muir Lewis	At time of recruitment she was nursing privately in Glasgow.	F.M.C.		1909	1914	c.1914 Mr Boyce on Z.I.M.	
Nurse Isa Mackenzie	Had been in residence at the Deaconess Hospital.	W.A.F.M.		1911			
Nurse McManus		W.A.F.M.					
Nurse Bathia F Davidson	From Aberdeen. Nursing experience gained in the City Hospital of Aberdeen. She was a sister in a Cambridge Sanatorium. A superintendent nurse in East Poor House Hospital Aberdeen and a night superintendent at the Old Mill Hospital Aberdeen with 24 nurses under her.	F.M.C.	38	c.1914/1915			

UMCA Nurses

Name	Training	Recruitment/ Controlling Body	Age at Appointment	Appointment/ Arrival Date	Departure Date	Marriage
Sophia McLaughlin	Matron of Warneford Hospital Leamington			1888	Retired 1893	
Florence Turner				1890	1893	
Nurse Whitbread				1892		
Nurse Alice Rees	Worked at a London Hospital and Stockwell Fever Hospital was matron under the Metropolitan Board and at the Fever Hospital, St Albans			1895	Retired 1897	
Miss Gardiner	Trained at a London hospital. Had teaching experience.			1896	1897	
Miss Kathleen Minter	Trained at University College Hospital.			1899	c.1909	Dr Howard 1909
Nurse Lyons				1899	Died 1902	
Nurse Newton				1900	Retired 1915	
Nurse Glover				1900	1901	
Nurse Matthew				1903	1905 Invalided	

Name	Training	Recruitment/ Controlling Body	Age at Appointment	Arrival Date	Departure Date	Marriage
Nurse Mary Armstrong				1901		
Nurse Alice Sophia Murton	Wanted to do midwifery training whilst on furlough			1901	1914	
Nurse Williams				1902	1915	
Nurse Ether Parsons	At St George's Hospital for 6 years before going to the mission.			1906		
Nurse Constance Thompson	Fully qualified			1907	1912	
Nurse Ada Fielding	4 yrs training at Queens Hospital, Birmingham. Then worked in Sussex County Hospital, Brighton and Upton on Severn Infirmary. She had been private nursing since 1905.			1908	1913	
Nurse Ethel Burridge	Trained at Ormesby Hospital, Middlesbrough. Private Nursing for 3 years.			1909	1916 Died	
Nurse Spindler	Trained nurse from Wales. Had been a district nurse.			1911		
Nurse Elsie Maud Griffin	Had been a massage and electrical sister for 6 months in Bradford Royal Infirmary.			1913	1915	

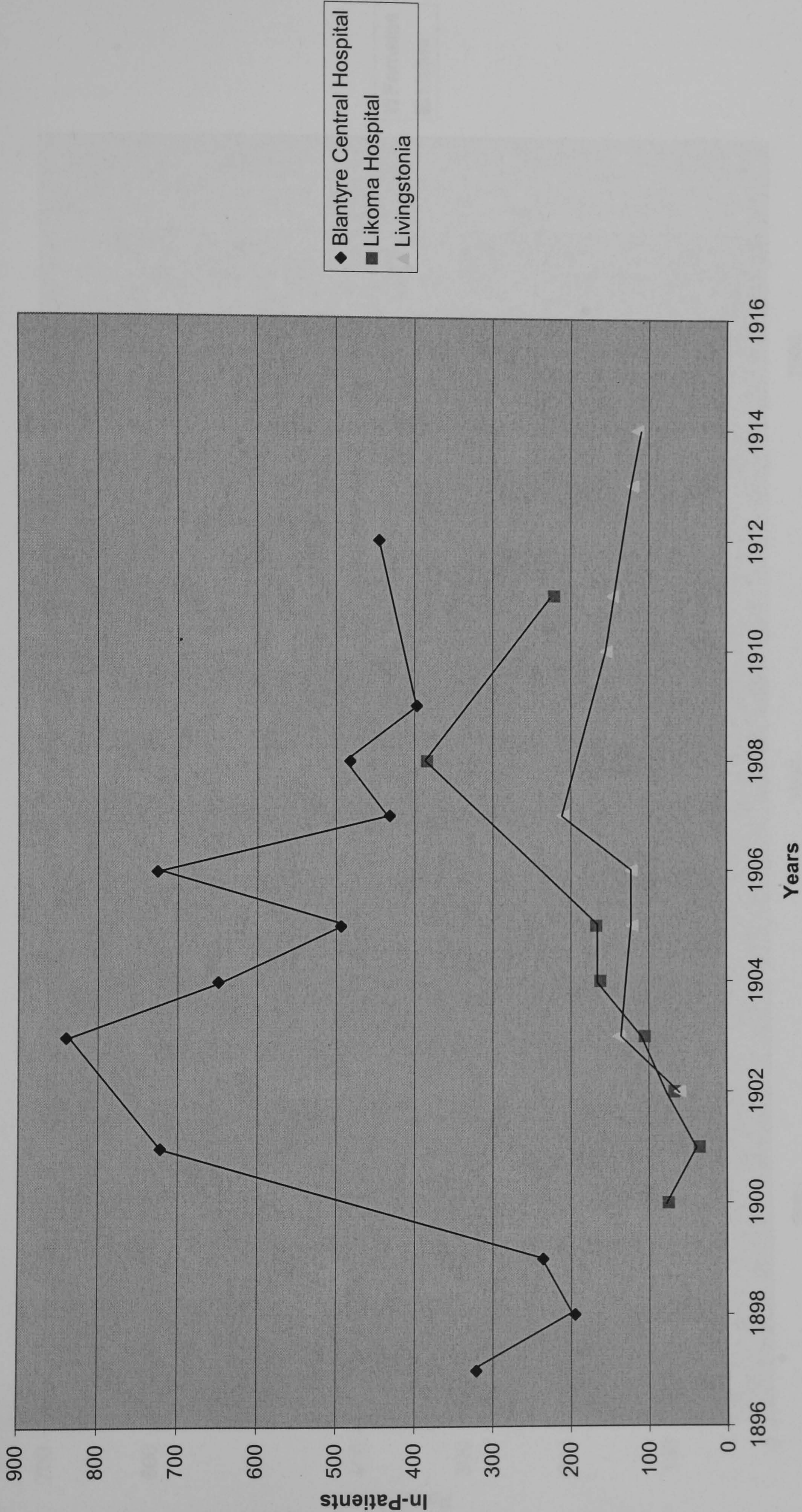
Name	Training	Recruitment/ Controlling Body	Age at Appointment	Appointment/ Arrival Date	Departure Date	Marriage
Nurse Alice Simpkin	Certified Nurse and Gold medalist. Trained at St Bartholomew's Hospital. A ward sister since 1908.			c.1914		
Nurse Florence S Johnson				1914	1916	
Nurse Grace Day	Trained for 3 years at Marylebone Infirmary			1915		

Livingstonia Nurses

Name	Training	Recruitment/ Controlling Body	Age at Appointment	Appointment/ Arrival Date	Departure Date	Marriage
Nurse Margaret McCallum	Previously nursed contagious & infectious diseases.		31yrs	1897		1900 to Charles Stuart
Nurse Maria Jackson	Qualified Nurse. Worked at Glasgow's Royal Infirmary		28yrs	1897		1900 to Malcolm Moffat
Nurse Mary J. Fleming				1900	1905 due to ill health	
Nurse Jessie Martin	Qualified honary nurse – worked at Miss de Broen's Belleville Mission in North Paris			1900	1909 Retired	
Nurse Winifred Knight	Honary Nurse			1900	1905 Dies	1903 to Dr Boxer
Nurse Mary Ballantyne	Worked as a nursing sister at Edinburgh's Royal Infirmary		31yrs	1905		
Nurse Mary Henderson			26yrs	1907		
Elizabeth B. Cole	Trained in medicine and surgery at Glasgow Western Infirmary. Worked in London's Fever Hospital.			1909		
Nurse Ruth Livingstone-Wilson	Certified Hospital Nurse. Training in midwifery.		31yrs	1913		

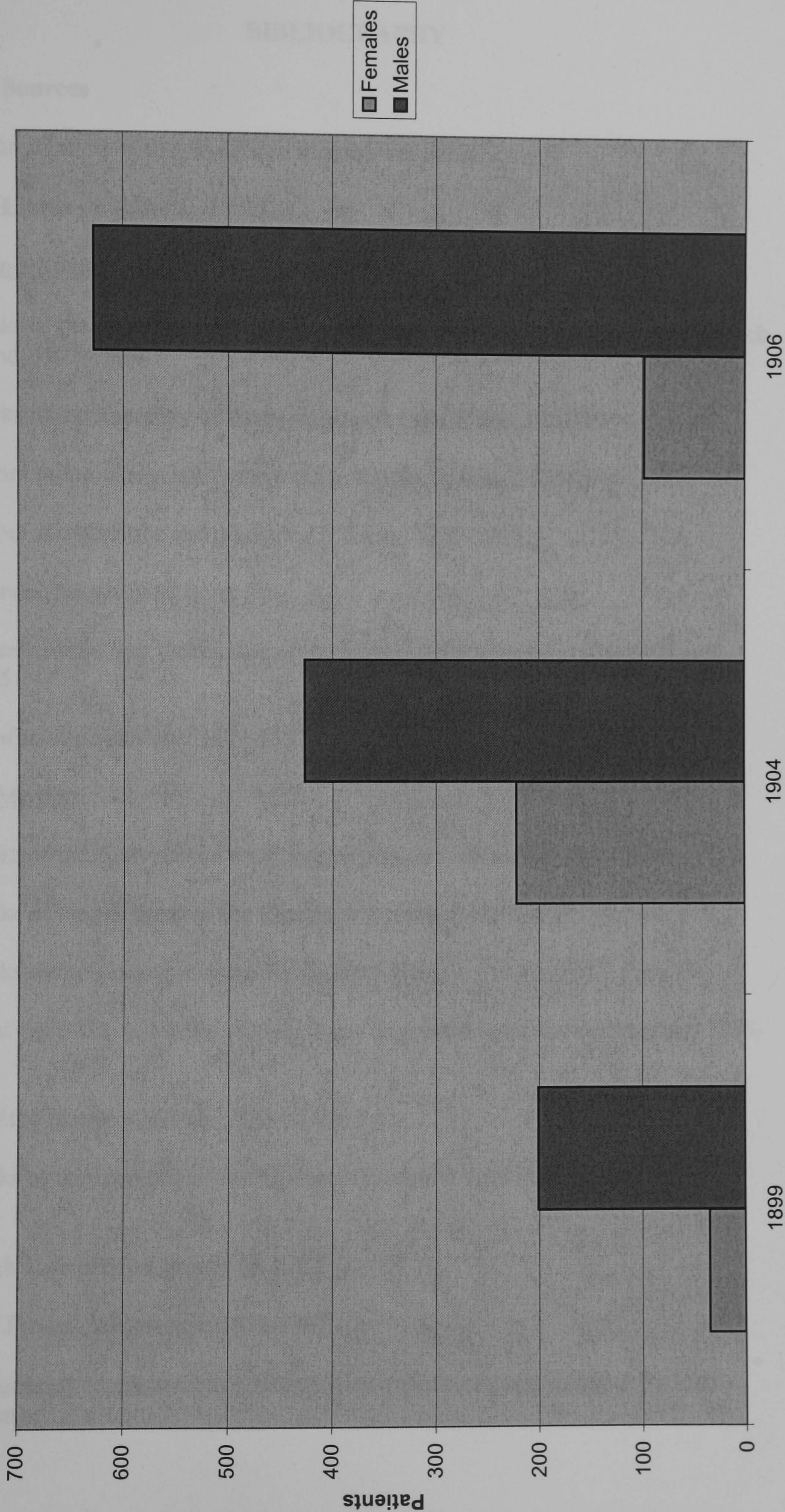
Annex 5: No. of In-Patients Treated at Central Hospitals (Blantyre, Likoma & Livingstonia)

Sources: *Life and Work*; UMCA Annual Report 1990-1901 and *Central Africa* ; Annual Reports Livingstonia Mission.



Annex 6: Blantyre Central Hospital Patients By Gender

Source: *Life and Work*



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