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Missions, Nurses and Knowledge-Transfer: The Case of Early Colonial Malawi

Introduction: Colonial Malawi at the crossroads of missionary and imperial networks

This chapter explores nursing, knowledge-transfer and education in mission networks through a case study of early colonial Malawi.¹ It analyses the role of British Protestant missions in Malawi as important sites and nexuses where knowledge about nursing was made, transferred, negotiated and contested. The study focuses on nurses and nursing education in three key missions: Blantyre, Livingstonia and Universities' Mission to Central Africa (UMCA).

Medicine was a significant part of the Malawian mission field: the two Scottish Presbyterian missions (Livingstonia of the Free Church of Scotland and Blantyre of the Established Church of Scotland) and the English Anglican Universities' UMCA all established dispensaries and hospitals long before the colonial administration became seriously involved in medicine. Although medical missions in Malawi have been the subject of scholarly attention in recent years, rarely has the focus been on nurses and nursing. One notable exception has been Agnes Rennick's comparative study of medical work at the three missions from 1875 to the First World War.² Earlier studies of nursing

¹ Throughout this chapter the term Malawi is used to refer to the region that was known as the British Central Africa Protectorate from 1893 to 1907 and the Nyasaland Protectorate from 1907 to independence in 1964.

² C. M. Good, *The Steamer Parish: The Rise and Fall of Missionary Medicine on an African Frontier*, London: University of Chicago Press, 2004; M. Hokkanen, *Medicine and Scottish Missionaries in the Northern Malawi Region 1875–1930: Quests for Health in a Colonial Society*, Lewiston: The Edwin Mellen Press, 2007; A. Rennick, "Church and Medicine: The Role of Medical Missionaries in Malawi

elsewhere in colonial Africa have established the importance of questions of race and imperialism, alongside the metropolitan themes of class, gender and the professionalisation process.³ This chapter reassesses existing scholarship together with early colonial sources to explore mission nursing, knowledge-transfer and education in a colonial setting.

The importance of networks and mobility in the production of knowledge has been stressed within recent research.⁴ In the imperial age, knowledge was in many ways constructed and disseminated in transit between nations, imperial metropolises and colonies. Increased mobility of people, ideas and materials accelerated knowledge-production in the nineteenth and early twentieth centuries. Modern professionals, including medical professionals, doctors and nurses, were amongst the most mobile individuals. Medical missions connected these modern professionals with older and more far-reaching transnational missionary networks and groups. The modern missionary movement (at first dominated by evangelical Protestantism) grew into a truly global Christian endeavour over the course of the nineteenth century.⁵

1875–1914”, PhD thesis, University of Stirling, 2003; A. C. Ross, “The Scottish Missionary Doctor”, in D. A. Dow (ed.), *The Influence of Scottish Medicine: An Historical Assessment of its International Impact*, London: Parthenon Publishing Group, 1988.

³ S. Marks, *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession*, London: St. Martin’s Press, 1994, pp. 1–14; A. Rennick, “Church and Medicine...”, pp. 165–167.

⁴ See, for example, C. Hayden, *When Nature Goes Public: The Making and Unmaking of Bioprospecting in Mexico*, Princeton: Princeton University Press, 2003, p. 9; M. Hokkanen, “Imperial Networks, Colonial Bioprospecting and Burroughs Wellcome & Co.: The Case of *Strophanthus Kombe* from Malawi (1859–1915)”, *Social History of Medicine*, Vol. 25 (3), August 2012, pp. 589–607; D. J. Neill, *Networks in Tropical Medicine: Internationalism, Colonialism and the Rise of a Medical Speciality 1890–1930*, Stanford: Stanford University Press, 2012. For the study of networks in the making of British imperial world (with focus on economy), see G. B. Magee and A. S. Thompson, *Empire and Globalisation: Networks of People, Goods and Capital in the British World, c. 1850–1914*, Cambridge: Cambridge University Press, 2010.

⁵ D. J. Neill, *Networks in Tropical...*, pp. 2–3; D. L. Robert, *Christian Mission: How Christianity Became a World Religion*, Singapore: Wiley-Blackwell, 2009.

Many early to mid-nineteenth-century missionary projects were remarkably transnational: the German Lutheran missionaries Rebmann and Krapf, for example, operated as key agents for the English Anglican Church Missionary Society.⁶ As Andrew Porter has pointed out, the transnational nature of the modern missionary movement was one of the factors that distinguished Christian missions from political imperialism.⁷

Missionary organisations, institutions and networks were significant both for generating and for disseminating knowledge. Many missionaries contributed to science, scholarship and popular knowledge in Europe.⁸ In many ways, missions were also connected to secular national and transnational networks that constructed and transmitted knowledge and information – often through individual missionaries’ personal connections to universities, businesses or government institutions. For example, Scottish missionary connections facilitated the acquisition and appropriation of *strophanthus kombe*, a climbing plant used as arrow poison in Central Africa which was subsequently developed into cardiac medicine in Edinburgh.⁹ In their target regions in the majority world, missions aimed to transmit values, ideas and knowledge through proselytisation as well as education.

⁶ S. Paas, *Johannes Rebmann: A Servant of God in Africa before the Rise of Western Colonialism*, Milton Keynes: VTR/VKW, 2011.

⁷ A. Porter, *Religion Versus Empire? British Protestant Missionaries and Overseas Expansion, 1700–1914*. Manchester: Manchester University Press, 2004.

⁸ On missionaries and science, see, for example, S. Sivasundaram, *Nature and the Godly Empire: Science and Evangelical Mission in the Pacific, 1795–1850*, Cambridge: Cambridge University Press, 2005.

⁹ M. Hokkanen, “Imperial Networks...”, pp. 589–607.

In the late nineteenth century, South-Central Africa was at the heart of several missionary schemes. In the English-speaking world, the region around Lake Malawi had become firmly associated with David Livingstone and his expeditions. The first permanent mission settlement was established in 1875, and for a period missionaries comprised the bulk of the European population.¹⁰

Medical missionaries – whose primary practical function was to secure the health of their fellow missionaries – featured prominently in Scottish mission plans for South-Central Africa during the 1870s. Both Blantyre and Livingstonia employed a doctor and prioritised medical care for their missionaries. By contrast, the UMCA was slower to recruit doctors.¹¹

By the end of the nineteenth century, Malawi was a busy mission field: the Scottish and English missions had been joined by the Dutch Reformed Church from South Africa as well as the Catholic White Fathers and the Holy Ghost Fathers, all of whom undertook some medical work.¹² The Christian communities in the country diversified further with the establishment of Baptist and Adventist missions and independent African churches

¹⁰ J. McCracken, *A History of Malawi 1859–1966*, Woodbridge: James Currey, 2012; J. McCracken, *Politics and Christianity in Malawi 1875–1940: The Impact of the Livingstonia Mission in the Northern Province*, Blantyre: CLAIM, 2000 [first published Cambridge: Cambridge University Press, 1977]; I. Linden, *Catholics, Peasants and Chewa Resistance in Nyasaland 1889–1939*, London: Heinemann, 1974; T. J. Thompson, *Christianity in Northern Malawi: Donald Fraser's Missionary Methods and Ngoni Culture*, Leiden: Brill, 1995; A. C. Ross, *Blantyre Mission and the Making of Modern Malawi*, Blantyre: CLAIM, 1996.

¹¹ C. M. Good, *The Steamer Parish...*; A. Rennick, “Church and Medicine...”, pp. 58–59.

¹² M. King and E. King, *The Story of Medicine and Disease in Malawi: The 150 Years Since Livingstone*, Blantyre: The Montfort Press, 1997; R. Oliver, *The Missionary Factor in East Africa*, London: Longmans, 1952.

which had broken off from mission churches. Early colonial Malawi was thus connected with diverse Christian networks, of which British connections were just a part.¹³

The historical study of nursing and missions in the imperial era brings with it certain methodological challenges. Early nurses tended to leave fewer written records than did doctors; for this and other reasons the history of missionary medicine has been doctor-centric. Written sources relating to African nurses in the early missions are even more sparse and complicated. African nurses, and African women more generally, are almost invisible in the missionaries' sources. The history of early missions has been largely based on sources written by European male missionaries, and although there have been innovative studies that have used these sources, many essential problems, gaps and silences remain. Nevertheless, as many valuable studies have demonstrated, oral sources can provide a way of studying the experiences, ideas and actions of African nurses and midwives, particularly in the more recent period.¹⁴

The aims of this study are more modest. The experiences of nurses have been approached largely through the evidence written by male mission authorities although important sources by nurses have been consulted. These sources must be read carefully and critically, often "against the grain" and with an awareness of their gaps and silences.

Despite the challenges of the source material, it is possible to chart the networks of nurses

¹³ The Dutch Reformed Church mission began its training of African nurses in Mvera in 1909. M. King and E. King, *The Story of Medicine...*, p. 134. As noted below, Livingstonia mission employed a white South African nurse, Mrs Treu, in the 1920s.

¹⁴ See, for example, S. Marks, *Divided Sisterhood...*; N. R. Hunt, *A Colonial Lexicon of Birth Ritual, Medicalization and Mobility in the Congo*, London: Duke University Press, 1999; H. Sweet and A. Digby "Race, identity and the nursing profession in South Africa, c. 1850–1958", in B. Mortimer and S. McGann (eds.), *New Directions in the History of Nursing*, London: Routledge, 2005, pp. 109–124.

in the British missions, to locate and identify some of the Malawian and British nurses employed by the missions in the earlier period, and to discuss some of the possibilities and problems inherent in the study of nursing, knowledge and education in colonial and missionary contexts.

Approaches to nursing, missions and knowledge might benefit from further attention to the history of the body.¹⁵ With its emphasis on bodily practices of care, aspects of nursing and nurse training can be seen as transmissible through the silent methods of physical demonstration and imitation. This is to some extent true of medicine (and the lines between nursing and medicine can be blurred, of course), but arguably nursing, which in the early twentieth century was taught through apprenticeship in both Britain and Malawi, was a more purely bodily and intimate form of knowledge than medicine.

In this essay, nursing is explored as knowledge transferred in important ways through bodily imitation. The idea of imitation tied nursing education closely with more general missionary attempts to construct Christian womanhood as part of Christian society, largely through imitation of missionary women. However, it is argued that the inherent tensions and conflicts in missionary ideas and programmes for African women were also evident in nursing education.

Early British nurses in Malawi

¹⁵ On body history see, for example, E. M. Collingham, *Imperial Bodies: The Physical Experience of the Raj, c.1800–1947*, Cambridge: Polity, 2001; R. Porter, “History of the Body Reconsidered”, in P. Burke, (ed.), *New Perspectives on Historical Writing*, Cambridge: Polity, 2001.

In early twentieth-century Britain, nursing education focused on hospitals, where nurses were trained following an apprenticeship model. State registration for nurses in Britain took place relatively late, in 1919.¹⁶ The early British missionary nurses who arrived in Malawi came from disparate backgrounds, during a period in which nursing was undergoing profound changes. Their education and experience varied, arguably affecting the extent to which they would be involved in knowledge-transfer processes.

Although qualified doctors played an important part in the early Scottish missions in Malawi, it was some time before members of the nursing profession were recruited. Women missionaries, as independent agents, were not common within the early missions established in Africa. (By contrast, the importance of women in the Chinese and Indian mission fields had been apparent from the 1860s onwards; by the turn of the century, an exclusively female medical mission agency had been established in India.) The mission leadership largely viewed Central Africa as too dangerous and unhealthy to be endured by an unmarried woman. Within the Presbyterian missionaries, mission women were first and foremost wives. Although some women, including Mrs Laws (of Livingstonia), operated as significant mission agents through their work as teachers and lay nurses, the extent of women's contributions was often overlooked in mission publications.¹⁷

¹⁶ B. Mortimer, "Introduction: The History of Nursing: Yesterday, Today and Tomorrow", in B. Mortimer and S. McGann (eds.), *New Directions in the History of Nursing*, London: Routledge, 2005; A. M. Rafferty, *The Politics of Nursing Knowledge*, London: Routledge, 1996.

¹⁷ J. McCracken, "Class, Violence and Gender in Early Colonial Malawi: The Curious Case of Elizabeth Pithie", *The Society of Malawi Journal*, Vol. 64 (2), 2011. On female medical missions in India, see R. Fitzgerald, "Rescue and Redemption: The Rise of Female Medical Missions in Colonial India During the Late Nineteenth and Early Twentieth Centuries", in A. M. Rafferty, J. Robinson and R. Elkan (eds.), *Nursing History and the Politics of Welfare*, London: Routledge, 1997.

Nevertheless, the arrival of European women in mission stations facilitated new and important contacts with African women.¹⁸

Jane Waterston, as an independent woman missionary who had medical qualifications from London and Dublin, was a notable exception to the rule. However, Dr Robert Laws, the leader of Livingstonia, was reluctant to recognise her medical professionalism. Waterston's employment at Livingstonia was short-lived: she resigned from her position in 1880 after only a few months practice in Malawi (but later went on to establish a successful medical career in South Africa).¹⁹

Although this study focuses on professional nursing, medicine and missions, the work of lay missionary wives should be borne in mind. Their contributions could be integral to the everyday functioning of a mission station in an African community. After the initial pioneer period of the 1870s and early 1880s (which with its attendant dangers and high mortality rates had been regarded as men's work) the ideal of a married missionary couple supervising a mission station was at the heart of many Presbyterian missionary schemes. Marriage was seen as a means of securing the health and safety of men and women alike. In addition, the missionary couple would exemplify the values of Christian monogamous marriage and civilised family life for the local population. The missionaries and their wives would thus act as models to be imitated by African Christians.

Missionary couples were, in important ways, bodily models. They demonstrated their

¹⁸ C. M. Good, *The Steamer Parish...*, p. 17.

¹⁹ L. Bean and E. van Heyningen (eds.), *The Letters of Jane Elizabeth Waterston, 1866–1905*, Cape Town: van Riebeeck Society, 1983; H. McIntosh, *Robert Laws: Servant of Africa*, Carberry: Handsel Press, 1993. See also L. O. Macdonald, *A Unique and Glorious Mission: Women and Presbyterianism in Scotland*, Edinburgh: John Donald, 2000, pp. 120–133.

Christianity through physical action, manners, clothing, cleanliness and physical discipline,²⁰ patterns that have been discerned in Protestant missions elsewhere.²¹

However, the UMCA took a different approach from Blantyre and Livingstonia in their marriage policy. All UMCA agents, both male and female, were unmarried recruits and were required to remain single. Financial concerns largely underpinned this preference for celibacy in the Anglican mission. Unlike the salaried Presbyterian missionaries, the largely middle-class UMCA recruits were expected to cover their own costs.

Furthermore, women recruited by the UMCA had to be over thirty. The mission headquarters followed the logic that “middle-aged” women would not be so easily distracted from their vocational calling and dedication to Christian work by the prospect of marriage in the colonies.²²

The UMCA was the first mission in Malawi to recruit nurses. The first to be appointed, in 1888, was Sophia McLaughlin, former matron of Warneford Hospital in Leamington. Between 1888 and 1895, the UMCA employed four nurses, but it was not until 1896 and 1897 that professional nurses first arrived at Blantyre and Livingstonia respectively.

²⁰ M. Hokkanen, *Medicine and Scottish Missionaries...*, pp. 151–152, 462–463; M. Hokkanen, “‘Christ and the Imperial Games Fields’ in South-Central Africa: Sport and the Scottish Missionaries in Malawi, 1880–1914: Utilitarian Compromise”, *The International Journal of the History of Sport*, Vol. 22 (4), 2005; A. Rennick, “Church and Medicine”..., p. 168. On the importance of “Christian home” in the Anglo-American missionary movement, see D. L. Robert, “The ‘Christian Home’ as a Cornerstone of Anglo-American Missionary Thought and Practice” in D. L. Robert (ed.), *Converting Colonialism. Visions and Realities in Mission History, 1706–1914*, Cambridge: Wm. B. Eerdmans Publishing, 2008.

²¹ For example, in the study of Southern Tswana and the London Missionary Society missionaries, see J. L. Comaroff and J. Comaroff, *Of Revelation and Revolution, Vol. 1: Christianity, Colonialism, Consciousness in South Africa*, Chicago: University of Chicago Press, 1991; J. L. Comaroff and J. Comaroff, *Of Revelation and Revolution, Vol. 2: The Dialectics of Modernity on a South African Frontier*, Chicago: Chicago University Press, 1997.

²² A. Rennick, “Church and Medicine...”, pp. 56–58, 168–169.

According to Rennick, in the period before the First World War, Blantyre employed a total of 14 nurses, Livingstonia 9 nurses and the UMCA 22 nurses.²³

In terms of numbers of patients treated, Blantyre and the UMCA, which employed most nurses, were the two most effective medical missions in the early colonial period. By contrast, Livingstonia had more doctors on its staff, but many of them only practised medicine part-time. European nurses were crucially important for the establishment and operation of permanent mission hospitals. Their agency played a pivotal role in the professionalisation of missionary medicine in Malawi. The UMCA was particularly reliant on nurses. Between 1899 and 1927 the mission employed one doctor, who travelled between hospitals that were in practice run by a nurse. Nurses become increasingly important in Livingstonia from 1914 onwards: in 1922, for example, nurses were in charge of the medical work at three mission stations.²⁴

For the Presbyterian missions, nurses, as paid medical agents, were clearly less costly than doctors. In Livingstonia and Blantyre at the turn of the century, a qualified nurse was paid £120 pounds per year (about a third of the salary of a missionary doctor).²⁵

Charles Good has argued that the UMCA mission leadership practically exploited the

²³ A. Rennick, "Church and Medicine...", pp. 332–337.

²⁴ In the absence of resident doctors at the Loudon, Ekwendeni and Tamanda stations: *Report on Foreign Missions for 1922*; Laws to Ashcroft, 26 February 1924, National Library of Scotland (NLS), MS. 7887, 23; Livingstonia Mission Staff-Book, National Library of Scotland, Acc. 7548 D73; C. M. Good, *The Steamer Parish...*, pp. 294–297; A. Rennick, "Church and Medicine..."

²⁵ Chisholm, Letters to the Livingstonia Sub-Committee, 29 November 1907, NLS, Acc 7548, 29; A. Rennick, "Church and Medicine...", p. 171.

“health, good will, ingenuity and formidable skill” of its nursing sisters in its understaffed medical services.²⁶

Even during the early colonial period, most of the appointed nurses were already qualified and experienced at the time of recruitment. Gradually, full nursing qualifications became an official requirement. The UMCA recruited its nurses through the Guild of St. Barnabas in England. Of the 22 early UMCA recruits, at least 11 had training and experience in British hospitals, and two had been matrons. The UMCA nurses came usually from well-known English hospitals. Of the Livingstonia nurses, at least six had hospital experience or training, and ten of the fourteen nurses employed by Blantyre were trained.²⁷

However, some of the early nurses, those given the status of “honorary worker”, had little previous formal training. For untrained European nurses, work in mission hospitals provided practical vocational training. In 1900–1901 Livingstonia appointed three nurses, all of whom came from clerical homes: one was professional, two were honorary workers.²⁸ Blantyre employed two formally unqualified nurses between 1902 and 1904. They, however, had practical experience from caring institutions in Britain.²⁹

By 1906, as Rennick shows, the increasing demands of professionalisation were apparent in Blantyre mission recruitment policies. Some nursing candidates were encouraged to

²⁶ C. M. Good, *The Steamer Parish...*, p. 301.

²⁷ A. Rennick, “Church and Medicine...”, pp. 169–177; C. M. Good, *The Steamer Parish*, pp. 294–295.

²⁸ Livingstonia Mission Staff-Book, NLS, Acc. 7548 D 73.

²⁹ A. Rennick, “Church and Medicine...”, p. 172.

gain further practice at the Church of Scotland's Deaconess Hospital before their appointment. Furthermore, nurses who had already worked in the field were encouraged to study and train further in midwifery, dispensing and surgical nursing during their furloughs. Like the mission leadership, mission nurses themselves viewed their work in professional terms: at Blantyre hospital, one Scottish nurse's lack of wound-dressing skills were reported by her colleagues.³⁰

The independent professional agency of nurses conflicted with the Victorian missionary ideal of wives as domestic "helpmeets" for their husbands. In the Scottish Presbyterian mission tradition, women usually resigned when they married, but if they married missionaries (as many did), they were often expected to contribute to the work of the mission as unpaid and unofficial agents. Within the Scottish missions, marriage marked the end of many nurses' professional careers. Six of the fourteen Blantyre recruits had married missionaries by 1914. Of nine Livingstonia nurses, three married missionaries. However, two of these Livingstonia nurses continued to practise at their husbands' stations.³¹

Although the UMCA policy of celibacy had advantages for the mission, it also had its drawbacks. The only UMCA nurse to marry by 1914 was Nurse Minter, who married Dr

³⁰ A. Rennick, "Church and Medicine...", pp. 172–173.

³¹ A. Rennick, "Church and Medicine...", p. 158; McCallum to Smith, 29 January 1900, NLS, Acc. 7548 D69; for female Presbyterian missionaries and marriage, see L. O. Macdonald, *A Unique and Glorious Mission...*, p. 114.

Howard in 1909. Both Minter and Howard had to resign and so the mission lost two experienced medical workers at once.³²

UMCA nurses were expected to work for long periods without the support and supervision of doctors. On the main mission stations, nurses were in charge of hospitals with wards for African men and women, outpatient dispensaries and separate European wards. As Rennick points out, they were professionally isolated from their nursing colleagues. For many of them, the Guild of St. Barnabas seems to have provided a network of support and spiritual reflection, in Malawi as well as in England on furlough.³³

The spaces and locations of nurses' stations affected their positions and opportunities. In contrast to the independent agency of their UMCA colleagues, nurses in Blantyre and Livingstonia were mainly recruited to assist doctors in a clearly subordinate position. This was especially the case at the mission main hospitals, St. Luke's Hospital, Blantyre and the David Gordon Memorial Hospital (DGMH), Livingstonia, which were modelled after British teaching hospitals of the early 1900s. In more remote outposts, nurses sometimes undertook major medical and surgical tasks (such as setting fractured bones and carrying out amputations), but they tended to play down their achievements.³⁴

Early African nurses

³² C. M. Good, *The Steamer Parish...*, p. 294.

³³ A. Rennick, "Church and Medicine...", pp. 170–171.

³⁴ A. Rennick, "Church and Medicine...", pp. 173–175, 183, 201–202; Laws, "Women's work in the Livingstonia Mission", Malawi National Archives (MNA) 47/LIM/1/14, 208.

African women at early mission stations were often practically invisible in early mission reports and published accounts. Yet from their inception, the British missions attracted African associates – men, women and children – who settled in or near the mission stations. Early associates were often refugees, outcasts, or escaped or freed slaves – generally those in search of protection, food and shelter.³⁵ Those who remained with the missionaries usually worked for them, and their work ensured the viability of the mission stations. It was on the strength of predominantly African labour that houses and huts were built, gardens were cultivated, food was cooked, and goods and people were transported.³⁶

African women and men also played a part in the day-to-day running of the first mission dispensaries and hospitals. Being a patient at a mission station was one route to becoming a mission protégé. At the UMCA and Livingstonia stations, female patients were encouraged to cook for themselves and for male patients.³⁷ Following an extended stay at the UMCA Likoma Hospital, amputee patient Annette Chipyela was eventually employed as a cook.³⁸ Cooking for invalids was deemed an appropriate activity for women in both Malawian and British traditions.

³⁵ For early Livingstonia, see J. McCracken, *Politics and Christianity...*, pp. 78–86.

³⁶ For the study of early mission communities in East and Central Africa, see, for example, J. Wills, “The Nature of a Mission Community: The Universities’ Mission to Central Africa in Bonde”, *Past and Present* Vol. 140 (1), August 1993, pp. 127–154; L. White, *Magomero: Portrait of an African Village*, Cambridge: Cambridge University Press, 1987. Wills emphasizes the complex composition of mission communities: many of their members could be “marginal”, but importantly, in different ways.

³⁷ Medical Report for 1876–1877, Cape Maclear Journal 1875–1876, NLS, MS. 7908; A. Rennick, “Church and Medicine...”, p. 236.

³⁸ A. Rennick, “Church and Medicine...”, p. 247.

African women who worked in the early hospitals often remain anonymous. However, important traces of their presence do sometimes surface in missionary publications. Women patients could also act as advocates for missionary medicine. For example, UMCA missionaries maintained that their former patient, Duchess, was the single most important local advocate for the Likoma Hospital.³⁹

Before the introduction of formal nurse training programmes, African women were trained on the job at various mission stations. This early training of African nurses and male assistants would have been dependent on the initiatives of the European nurses and doctors who acted as teachers, as well as the availability and motivation of African recruits. However, such work-based training was rarely discussed in mission publications.⁴⁰ Throughout the early colonial period, individual apprenticeship was an important form of nursing training. For example, at the UMCA's women's hospital in Nkhotakota, Nurse Burr ridge trained an unnamed African woman, whose duties by 1915 included daily dressing of wounds and assisting Burr ridge during operations.⁴¹ At UMCA hospital in Likoma, Nurse Simpkin was assisted by the hospital cook in 1930.⁴²

The early medical training programmes in British missions focused on male medical assistants or dispensers. In Blantyre, Dr Neil Macvicar and Nurse Samuel pioneered the formal training of medical assistants in the late 1890s. Livingstonia followed suit in the

³⁹ *Ibid.*

⁴⁰ *The Free Church of Scotland Monthly Record (FCSMR)*, September 1903, 409; "Karonga Report for 1895" NLS, MS. 7879, 43; *The Livingstonia Mission Report for Year 1893–94; Annual Report for 1902*.

⁴¹ A. Rennick, "Church and Medicine...", p. 198.

⁴² M. King and E. King, *The Story of Medicine...*, p. 136.

early 1900s, and the UMCA began to train dispensers at Likoma in 1912.⁴³ The formal education of African women at mission stations was not only hampered by missionary values and schemes. Young women's agricultural, reproductive and caring responsibilities probably resulted in the reluctance of local communities to allow girls and women to undertake prolonged periods of training.⁴⁴

Despite the absence of African women from the earliest training schemes, some missionaries began to argue that nursing training for African women would be essential to the expansion of missionary medicine. It was assumed that European nurses would be responsible for such programmes. In 1903, James Henderson, the headmaster of Livingstonia's Overtoun Institution, argued that a trained European nurse-teacher could "multiply her power" by "developing a native agency".⁴⁵ Clearly the African women who worked at the mission stations had made a positive impression on Henderson (and others).

In 1901, Livingstonia missionary Donald Fraser, writing for *Women's Missionary Magazine*, described an unnamed Tonga "matron" at Bandawe:

There is one Atonga woman who is very conspicuous about the Bandawe station. Her women's class is the largest and most interesting. She is a matron at the dispensary and the temporary hospital...She is a widow, a great woman among her people. She was

⁴³ C. M. Good, *The Steamer Parish...*, pp. 325–326; Laws to Acting Commissioner 16 February 1906, NLS, Acc. 7548 D71, Letters to the Livingstonia Sub-Committee 1906, 36–42.

⁴⁴ A. Rennick, "Church and Medicine...", pp. 197–198; K. M. Phiri, "Some Changes in the Matrilineal Family System Among the Chewa", *Journal of African History*, 25, April 1983, pp. 257–274.

⁴⁵ Henderson 8 January 1903, NLS, Acc. 7548 D 70. Letters to the Livingstonia Sub-Committee 1903, 45–46.

*leader and initiator in the foul pagan ceremonies of her people. No one knew better than she the superstitions and the claims of their traditions. But to-day she is a mother in Israel, washed and made clean by the blood of the Lamb.*⁴⁶

In this missionary narrative, which was intended largely for female mission supporters, conversion to Christianity had thoroughly cleansed the powerful pagan widow and transformed her into a matron, teacher and (physical and spiritual) cleanser of local society. Such victories were rarely reported. Mission narratives often characterised elderly women as stubborn opponents of missionary medicine and staunch defenders of “pagan superstitions”. African midwives and birthing practices were repeatedly demonised in early twentieth-century mission discourse.⁴⁷

Although published missionary stories require careful and critical reading, there is further evidence that a capable and valued African nurse worked in the Bandawe hospital. Seven years later after Fraser’s account, the doctor at Bandawe reported that the hospital was staffed by a Medical Assistant and a Christian woman who had been taught to dress ulcers “and such like work”. She was deemed capable of running the hospital in the absence of the doctor and the assistant.⁴⁸

⁴⁶ D. Fraser, “The Women of Central Africa”, *Women’s Missionary Magazine*, 1, 1901, pp. 30–31.

⁴⁷ *The Livingstonia News*, April 1910, pp. 25–26; Brown 10 December 1906 NLS Acc. 7548 D71, Letters to the Livingstonia Sub-Committee 1907, 10; *Report of the Second General Missionary Conference, 1904*, p. 63. See also, C. M. Good, *The Steamer Parish...*, p. 349; M. Vaughan, *Curing their Ills: Colonial Power and African Illness*, Stanford: Stanford University Press, 1991, pp. 66–69.

⁴⁸ Robertson 7 September 1908, NLS, Acc. 7548 D 71, Letters to Livingstonia Sub-Committee 1908, 130–132.

Another notable Livingstonia nurse was Maria Chilimbano, an orphan and former slave who had been attached to the mission for some time, even though she had joined at a relatively advanced age. In addition to her work at the Overtoun Institution from the early 1900s, Nurse Chilimbano also attended evening classes and learned to read.⁴⁹ In 1907, Nurse Ballantyne argued that, given the opportunity of an education equal to that offered to African medical assistants, “she [Chilimbano] would be double their worth” for the hospital. However, as Rennick points out, it seems that Ballantyne was more concerned with appraising Chilimbano’s domestic competence (the cleaning of the hospital) rather than her caring skills.⁵⁰

Unlike the unnamed “matron” at Bandawe, Maria Chilimbano had been an outcast (as both orphan and a slave) rather than a respected member of her community. Nevertheless, she too forged a new career for herself in the mission service. Becoming nurses arguably allowed these two elderly women to assume roles similar to those played by respected African midwives in the local community.⁵¹

Gender, race and conflict in medical mission

Early missionary medical establishments, like British and colonial hospitals more generally, were profoundly hierarchical institutions, structured according to race, gender

⁴⁹ Laws to Prentice 10 and 13 October 1914, MNA 47/LIM/1/16, 47; W. P. Livingstone, *Laws of Livingstonia*, London: Hodder and Stoughton, 1921, p. 342.

⁵⁰ *Annual Report of the Livingstonia Mission for 1907*, 9; A. Rennick, “Church and Medicine...”, p. 200.

⁵¹ W. P. Livingstone, *Laws of Livingstonia*, p. 342; C. M. Good, *The Steamer Parish...*, p. 349.

and class. As Shula Marks has noted, the power relations of Victorian hospitals resembled those of the archetypal middle class family.⁵² The top-down hierarchy was particularly evident in the major mission hospitals: male European doctors, female European nurses, male African medical assistants and, finally, female African nurses.

However, this model could not always be realised in practice: although most doctors and nurses extolled the virtues of fully-fledged hospitals, missionary medicine was often practised in more modest institutions. This meant that the Western hospital hierarchy was not simply reproduced. For example, the potential for both European nurses and African hospital staff to exert more autonomy and agency was realised in UMCA hospitals that were largely run by English nurses and the agency of Malawian medical assistants in mission dispensaries.⁵³

Nevertheless, given the importance of hospital medicine to nursing practice and education, hospital hierarchy cannot be overlooked. Rennick has argued that, despite certain changes caused by pioneer conditions, “the powerful socialisation of doctors and nurses into their gender-specific professional roles preserved male medical power intact” in the three British missions during the period up to the First World War.⁵⁴ Professional hierarchies, with their attendant reinforcement of gendered roles, operated alongside images and presuppositions about race, and influenced medical practice and training in mission hospitals.

⁵² S. Marks, *Divided Sisterhood...*, pp. 3–4.

⁵³ C. M. Good, *The Steamer Parish...*; A. Rennick, “Church and Medicine...”.

⁵⁴ A. Rennick, “Church and Medicine...”, p.167.

Some European nurses were sceptical about African women's capacity for nursing (at least given existing educational standards). Perhaps the strongest scepticism and prejudice was expressed by Miss Dewar, a nurse from Blantyre, in a regional missionary conference in 1904:

*Let us now think for a moment of the possibility of training our native women as nurses. I fear we who have anything at all to do with Hospital work in Africa have often groaned over the seeming hopelessness of ever making anything of our women in this particular sphere. Even as ward-maids they come far short of what ought to be our standard for cleanliness in a hospital. The idea is still abroad that a nurse is born not made, but while even in the rawest native women we may find some of the qualities which go to make a good nurse, until she is possessed of a good education she is incompetent of grasping the most elementary part of the preliminary training.*⁵⁵

Dewar argued that, in the (distant) future, mission education with emphasis on “habits of observation, obedience, punctuality and cleanliness” would be a prerequisite for those Christian girls who wished to train as nurses. Although she maintained that older married women could not be trained as nurses, they could be taught the “common laws of health” and how to care for sick children.

⁵⁵ *Report of the Second General Missionary Conference held at The Church of Scotland Mission, Blantyre: British Central Africa. October 15–24, 1904*, edited by the Publication Committee, Blantyre: The Mission Press, 1904, pp. 70–72.

Dewar was particularly dismissive of African women's potential in the field of midwifery. In her view, "the raw native women" could not be trained "to manage even the simplest complicated case". However, she argued that Christian girls could be trained in midwifery as part of a three-year "hospital training" scheme, if a dedicated maternity ward was constructed.⁵⁶

No trace of existing African nursing in the mission can be found in Dewar's narrative, in which "the ward-maids", serve merely as an example of failure to meet hospital standards. This is in striking contrast to the earlier evidence from Livingstonia. African recollections of Dewar's time at Blantyre cast doubt on her effectiveness and, indeed, suitability as a nurse educator. A former Blantyre pupil, L. M. Bandawe, recalled in his memoirs that

*The missionaries were good and kind to the Africans and especially to anyone who was staying with them, with the exception of a lady missionary who was a nurse at the Mission Hospital. She used to call the boys and girls all sorts of names, such as rascals, fools, monkeys, etc. She used to slap them and at one time when a church bell was ringing a girl who was working with her at her house drew her attention to the fact that it was time for her (the girl) to go to church. The lady missionary said to her: "Jesus did not come on earth for black people." She once slapped her kitchen boy who got so annoyed that he pushed her down, took a knife and threatened to cut her throat. This incident was stopped by the intervention of the cook.*⁵⁷

⁵⁶ *Ibid.*

⁵⁷ L. M. Bandawe, *Memoirs of a Malawian*, edited and introduced by B. Pachai, Blantyre: CLAIM, 1971, p. 69.

The historian B. Pachai, the editor of Bandawe's memoir, identified the nurse in question as Miss Dewar. (It should be noted Bandawe had generally amiable recollections of Blantyre missionaries.)

Dewar's argument, that it would take years before the training of African women as nurses could be contemplated, can be viewed as rhetoric in defence of the professional status of European nurses at a time when the mission hospitals were emerging as more permanent organised institutions. In Britain, nurses were fighting to achieve professional status comparable to doctors through state-recognition and registration. In Dewar's view, rather than a "natural" sphere for all women, nursing was a prestigious profession accessible to European women on the merits of race, class and education. African women should first be educated as schoolgirls and then as Christian mothers. African women's membership of the nursing profession was, for Dewar, a distant prospect at best.

Other early British nurses had more positive views of African women and their potential. However, most also maintained that a caring attitude to patients, perceived as an essential part of nursing, was unknown amongst "pagan" African women. It was maintained that such an attitude could only be fostered through Christian change. As Lesley MacDonald has pointed out in her study of Scottish Presbyterian women missionaries, African women were seen as lacking in the nursing skills and instincts considered natural for Victorian women.⁵⁸ When an African woman asked for help for her friend, Margaret McCallum, one of the first Livingstonia nurses, remarked that this was a new

⁵⁸ L. O. Macdonald, *A Unique and Glorious Mission* ..., p. 8.

phenomenon.⁵⁹ Jessie Fiddes, also from Livingstonia, argued that the demonstration of sympathy by European nurses planted “the Christ in the consciousness” of African women.⁶⁰ For McCallum and Fiddes, African women were capable of sympathy and caring for sufferers, but they required European nurses to provide inspiration and a physical demonstration of kindly care.

As Rennick points out, “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.” Rennick quotes Dr Norris of Blantyre, writing in the *Central African Times* in 1903:

*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...there is no more potent means to that end than the work of European nurses in the native hospitals of this country.*⁶¹

Significantly, Christian nursing was demonstrated in a bodily manner, through gestures and touches, and it could be learned by imitation. In theory at least, nursing could be taught in ways that transcended linguistic barriers more easily than medicine or surgery.

⁵⁹ McCallum to Smith 9 August 1899, NLS, Acc. 7548 D 69, Letters to the Livingstonia Sub-Committee, 1898–1900, 89.

⁶⁰ Fiddes to the Livingstonia Sub-Committee 11 May 1905, NLS, Acc. 7548 D 71, 66.

⁶¹ *Central African Times*, 3 January 1903, quoted in A. Rennick, “Church and Medicine...”, p. 180.

However, missionary suspicion of African women hampered their inclusion in medicine and nursing. As Rennick notes, African women were often “perceived as unreliable and less than fully committed to the benefits of the new civilisation”. In UMCA missions, women’s participation in initiation dances, and their resorting to local medicinal “charms” to protect their children were viewed as strong evidence against the reliability of women.⁶² Victorian missionary hostility to dancing was based not only on religious grounds, but also on fear of “unhealthy passions”, particularly those of a sexual nature. Bodily control and discipline, through decent physical labour and suitable sports, were prescribed for African Christians and school pupils – however, these activities were aimed at men rather than women.⁶³

In Livingstonia, the education of women largely focused on preparing “good Christian” wives and mothers for their place in a “good Christian” family. It was difficult to adapt this scheme to incorporate the more independent role of nurse, although the traditional perception of nursing as the natural work of women afforded some room for compromise.⁶⁴

Notions of race and gender limited the roles and agency of African women in mission institutions and training. They also underpinned relationships between British nurses and African medical assistants. Whilst the nurses and assistants seem to have worked together

⁶² A. Rennick, “Church and Medicine...”, p. 198.

⁶³ M. Hokkanen, “ ‘ Christ and the Imperial...”

⁶⁴ See D. Gaitskell, “At Home with Hegemony? Coercion and Consent in African Girls’ Education for Domesticity in South Africa Before 1910”, in D. Engels and S. Marks (eds.), *Contesting Colonial Hegemony: State and Society in Africa and India*, London: Academic Press, 1994; J. L. Comaroff and J. Comaroff, *Of Revelation and Revolution, Vol. 2: The Dialectics of Modernity on a South African Frontier*, Chicago: Chicago University Press, 1997.

in relative harmony, occasional clashes and conflicts do come to the surface in unpublished mission records. In 1921, during the absence of a doctor, two assistants at the DGMH refused to take orders from a nurse. In 1926 a clash between an elderly assistant and a white South African nurse resulted in the summary dismissal of the assistant, who had reportedly refused to sleep in the hospital to watch over a patient. This left Nurse Treu, who had recently arrived from South Africa, in a difficult position: she was left alone in a hospital full of patients with whom she could not effectively communicate.⁶⁵

As Maryinez Lyons has pointed out, the gendered role of colonial African medical assistants could be ambiguous.⁶⁶ The assistants were practising nursing and medicine in a subordinate position to Europeans, and at the same time they belonged to a nascent Christian male elite, which was educated, ambitious and often aspired for greater recognition and agency. To some extent, the missions expected a medical assistant, as an independent worker in a dispensary and the male head of a Christian household, to take on a role similar to that of a missionary doctor.⁶⁷ Assistants were often taught by doctors and nurses, and both groups sought to transmit and transfer their own professional values and qualities to their students.⁶⁸

⁶⁵ Laws to Martin 14 December 1926, MNA 47/LIM/1/1/25 (a), 744; Stuart to Laws 26 August and 2 September 1926, MNA 47/LIM/1/1/36.

⁶⁶ M. Lyons, "The Power to Heal: African Medical Auxiliaries in Colonial Belgian Congo and Uganda", in D. Engels and S. Marks (eds.), *Contesting Colonial Hegemony: State and Society in Africa and India*, London: British Academic Press, 1994; see also 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 Southern African Studies*, Vol. 24 (4), 1998.

⁶⁷ M. Hokkanen, *Medicine and Scottish Missionaries...*, pp. 412–427; A. Rennick, "Church and Medicine...", pp. 212–213.

⁶⁸ A. Rennick, "Church and Medicine...", p. 213.

The increased agency of women in British missions caused some concern among the older generation of missionary doctors. In 1915, the Women's Foreign Missions Committee (WFM) of the United Free Church of Scotland took over financial responsibility for the salaries of the nurses employed at Livingstonia. Dr Laws, the head of the mission and its main hospital, was concerned that the WFM would in effect take over the mission hospitals. Laws demanded that the relationship between doctors and nurses should be clarified. The authorities in Scotland reassured him that the doctors would remain in charge.⁶⁹

Professionalisation and formal training schemes

Despite the problematic position for African women in missionary schemes and discourse, and the practical difficulties involved in educating women, nursing training continued. The first nurses' training scheme at Blantyre began in 1910. Nurse Hamilton taught her students bandaging skills, general nursing and dispensing. The first fully trained and certified nurse was expected to graduate in 1913.⁷⁰

By the 1920s there were further signs of the professionalisation of African nurses. The DGMH in Livingstonia employed three African nurses, who had their own distinctive uniform: an overall and apron worn over a khaki dress with a red trim. Although the formal training schemes in Livingstonia and Blantyre still focused on male assistants, there was now a distinct African nursing core, whose profession (and professionalism)

⁶⁹ Laws, "Women's work in the Livingstonia Mission", MNA 47/LIM/1/1/14, 208; Laws to Ashcroft 28 September 1914, MNA 47/LIM/1/1/14, 211; Ashcroft to Laws 1 December 1914, NLS, MS. 7861, 352.

⁷⁰ A. Rennick, "Church and Medicine...", pp. 198–199.

was signalled through their uniform.⁷¹ In the UMCA, according to Charles Good, African women were gradually admitted to the formal dispenser and dresser training scheme in Likoma. Women dispensers “proved themselves capable of high standards” during the five-year training period.⁷² In the mid-1920s, nurse training courses were reportedly organised at the hospitals in Khondowe, Mvera, Mlanda and Nkhoma.⁷³

The formal registration of nurses reflected developments in Britain, where, after thirty years of active lobbying, nurses were registered by the state in 1919.⁷⁴ By 1924 Dr Laws was calling for official recognition and registration for hospital-trained Livingstonia nurses. Laws strongly argued that nurses were as valuable to the local community as Hospital Assistants.⁷⁵ The General Medical Council of Nyasaland began to examine and register African medical staff in 1926.⁷⁶

In the same year, the Livingstonia Mission approved a formal training scheme for nurses at the DGMH. Designed by Nurse Patrick, the three-year course was to be taught in the vernacular, “supplemented by simple English”. To be accepted onto the course, candidates had to demonstrate “a certain proficiency” in reading, writing and arithmetic, be of good “character”, and secure the recommendation of their missionary teachers. In

⁷¹ Laws to Ross 14 February 1917, MNA 47/LIM/1/1/17, 842; W. P. Livingstone, *Laws of Livingstonia*, p. 365.

⁷² C. M. Good, *The Steamer Parish...*, p. 326.

⁷³ M. King and E. King, *The Story of Medicine...*, p. 135.

⁷⁴ B. Mortimer, “Introduction...”, p. 10. It should be noted that the history of professionalisation of nurses in the West is a complex issue. As Rafferty points out, female-dominated nursing does not fit easily into the historical patterns of “traditional”, male-dominated professions. Furthermore, as a field that developed in a subordinate position to medicine, the very “profession” of nursing can be questioned. A. M. Rafferty, *The Politics of Nursing Knowledge*, pp. 186–187.

⁷⁵ Laws to Attorney General 2 December 1924, MNA 47/LIM/1/24.

⁷⁶ M. King and E. King, *The Story of Medicine...*, p. 136.

their first year, the students focused on “Ward Work, Hygiene and Elementary Nursing”. The curriculum expanded in the second year to include anatomy and physiology, hygiene, and surgical and medical nursing. “Theatre Work and Midwifery” were added in the final year. All students were provided with board and uniform. In addition, final year students received a monthly salary of five shillings. Nurses who achieved more than 70 per cent in the final examination and received a good conduct report were certified. The monthly starting salary for a Certified Nurse was ten shillings per month, rising to fifteen shillings in due course. Those who passed but did not achieve the 70 per cent threshold became Assistant Nurses and received a lower salary (between six and ten shillings per month).⁷⁷

The introduction of two tiers of trained nurses in Livingstonia mirrored a similar structure in the training of male medical assistants and orderlies. One striking difference between the education of medical assistants and nurses was the decision to train nurses using a local language as the primary medium of education (probably chiTumbuka at the DGMH in the 1920s). English was usually the language used in medical training for men. This suggests that Nurse Patrick, in charge of nurse training, had a level of fluency in the vernacular. It also seems likely that chiTumbuka was already functioning as a language of work for nursing staff at the hospital before the formal training scheme was introduced. The choice to use vernacular instruction highlights also that female students at Livingstonia had received less English language education than their male counterparts. Unlike nurses, medical students had to pass Standard Six, the final year of primary instruction, before they could begin their training. Livingstonia nurses, like their British colleagues, were trained according to a hospital-based apprenticeship model.

⁷⁷ “Livingstonia Mission Course of Training for Certificated Nurses”, MNA 47/LIM/4/2.

Livingstonia's nurse training scheme was undertaken against a background of increased austerity. By the mid-1920s, some Livingstonia stations could no longer afford to employ mission-trained assistants. A lower grade male orderly was paid twenty shillings a month – substantially more than the highest grade Certified Nurse. Fully trained hospital assistants were, in fact, amongst the most highly paid Africans in Nyasaland, commanding salaries of up to three pounds per month. Nurses were clearly a cheaper source of labour than the well-paid (by local standards) male medical assistants. In the end, the more ambitious training schemes for medical assistants were gradually scaled down in the 1930s.⁷⁸

Located as it was at the centre of Nyasaland's colonial economy, during the interwar years Blantyre was able to overtake Livingstonia as the dominant Presbyterian medical training centre. In the 1930s medical education at Blantyre focused on nursing and midwifery training coordinated by the energetic Dr Janet Welch. By 1939, Blantyre was the key mission for Government medical cooperation.⁷⁹ During the interwar years, missions undertook more maternal and child welfare work, in which mission nurses played a key part.⁸⁰

⁷⁸ Laws to Rajpathak 13 October 1924, MNA 47/LIM/1/1/34; Minutes of the Mission Council July 1926, MNA 47/LIM/3/18; Laws to Ashcroft 23 December 1926, NLS, MS. 7889, 103; Overtoun Institution Senatus Minutes 20 January 1930, MNA 47/LIM/32; Todd to Young 15 January 1932, MNA 47/LIM/1/5/5 (see also M. Hokkanen, *Medicine and Scottish Missionaries...*, pp. 420–425).

⁷⁹ *Annual Report for the Nyasaland Protectorate 1939*: M. King and E. King, *The Story of Medicine...*, p.136.

⁸⁰ For UMCA, see C. M. Good, *The Steamer Parish...*, pp. 359–365. Although maternal and child welfare, as the site of encounters between European nurses and African women, has significance for the study of knowledge-transfer, it remains beyond the scope of this chapter.

Language, communication and knowledge-transfer

Questions of communication were crucial for knowledge-transfer in nursing education (whether specifically designed for African nurses or as part of a more general mission education of African women). How did mission nurses communicate their knowledge? How was this knowledge interpreted by the African women who were the intended recipients? And what kinds of exchanges occurred as part of this process? These are at once essential and frustrating questions given the context of the early colonial period in Malawi. Written missionary records of the period do not provide adequate information. The language skills of most missionaries cannot be judged retrospectively, although the evidence suggests that we might reasonably suppose that levels of proficiency in vernacular languages would have varied considerably.⁸¹

Nevertheless, it is significant that Livingstonia, at least, ran a formal training scheme in a vernacular language during the 1920s. By 1926, Nurse Patrick had spent five years working alongside African nurses at the DGMH, and so it seems safe to assume that the conditions for nursing education and transfer of knowledge were comparatively more favourable than those at mission stations with a high turnover of European and African staff. Similarly the UMCA nurses who spent long periods in Malawi and worked in remote hospitals may have developed sufficient fluency to undertake some form of nursing education.

⁸¹ A. Hastings, *The Church in Africa, 1450–1950*, Oxford: Clarendon Press, 1994, p. 303.

In principle, successful communication in the vernacular would also have enabled African nurses to educate Europeans about local medical ideas and practices, and the likely wishes and expectations of patients. Early mission hospitals did sometimes accommodate local ideas of illness and care. Notably, spaces were reserved for patients' relatives, who played an important role, not least by feeding the patients. Good reports that some UMCA hospitals responded to their patients' fears of leaving windows open at night, despite these fears being associated with belief in witchcraft or hostile spirits. In fact, hospitals were renovated so that windows could be closed at night without hampering ventilation of the wards.⁸²

When African and European medical staff worked well together, mission medicine undoubtedly became more accessible to the general population. Successful communication facilitated cooperation not only in nursing in hospitals and dispensaries, but also during tours. During the interwar period, European nurses from Livingstonia were sometimes accompanied on their village tours by African women who had been taught nursing and hygiene. According to oral testimony, the participation of Malawian women lessened the fear and suspicion of European nurses in the rural areas.⁸³ The increased mobility of nurses in the interwar period bolstered their agency and initiative: previously nurses had tended to stay in hospitals whilst doctors toured the countryside.⁸⁴

Conclusion: missionary nursing and bodily imitation

⁸² C. M. Good, *The Steamer Parish...*, pp. 297–298.

⁸³ Interview, Mrs L. H. Twea, Ekwendeni, 6 July 2004.

⁸⁴ A. Rennick, "Church and Medicine...", p. 182.

The silences and shortcomings of the available sources make the study of knowledge particularly challenging. One outcome of this study has been to highlight previously less well-known figures and connections. These initial findings about nursing and mission networks in South-Central Africa can serve as starting points for further enquiries based on oral histories and testimonies from nurses, other practitioners and patients.

Crucially, the evidence seems to suggest that nursing was also more easily taught in the vernacular African languages. By contrast, the teaching of Western medicine in Malawi was from its inception tied to the English language as the medium of higher education.

The element of bodily imitation involved in nurse training connected it with more general missionary ideas and programmes of gender and education. Livingstonia in the early colonial period certainly pursued a programme of holistic regeneration of people and society, a model based partly on the idea of African imitation of missionaries.

Missionaries were supposed to act as role models whose behaviour Africans should seek to emulate. The patterns of imitation themselves contained strong bodily elements: to be a Christian meant conforming to specific modes of dress, notions of cleanliness and ways of caring for the body.⁸⁵ Of course, one should not seek to minimise possible differences between missions. The UMCA's celibate agents obviously could not provide direct models of Christian marriage and family life.

Furthermore, it is crucial to note the differences between missionaries' models, and the reality of African encounters within mission Christianity, which were much more

⁸⁵ M. Hokkanen, *Medicine and Scottish Missionaries*...., p. 588–591 and *passim*.

complex. In the case of Livingstonia, I have argued elsewhere that the idea of imitation impacted most significantly upon missionaries and their families. There were many ways in which Africans could question, subvert or simply avoid missionary attempts to exert control and hegemony. Thus, whilst on the basis of missionary sources it is possible to analyse the missionaries' ideas, images and practices about nursing, we should remain cautious in drawing conclusions about local interpretations and responses to them.

With these caveats in mind, it can be argued that the idea of imitation was essential for European missionary nurses' perceived roles as models and educators. Many early British nurses doubtless shared this idea, as did the male-dominated mission leadership. Thus, the pattern of imitation at the core of the missionary agenda of holistic regeneration emerged in nursing both at the level of the image of the nurse and in her bodily practice. Nurses provided an exemplar of kind care. Proper nursing was to be taught through the bodily practice of repetition not only to African medical staff but also to recuperating patients, who were put to work to help others.

Knowledge of nursing was to be transferred largely orally or through physical demonstration and imitation. This was, of course, partly due to a practical lack of nursing textbooks, but the pattern also stemmed from Victorian and Edwardian ideas about nursing, and the British tradition of training nurses through apprenticeship. The early twentieth-century British view of nursing was based on notions of womanhood and feminine care that had a crucial gendered, bodily element. A nurse had to be a woman, and she had to embody proper nursing physically and through her behaviour. A good

nurse was kind and attentive. The “character” of a nurse, was difficult to define and largely revealed itself through corporal or physical qualities: gestures, looks, tone of voice and general *habitus*.

With the advent of professionalisation, these qualities and nursing knowledge were to be learned above all in the British hospitals, through formalised apprenticeship. Missionary nurses who had undergone this process would then replicate the apprenticeship pattern in mission hospitals worldwide. However, the professional strand of nursing had potential to come into conflict with the older idea of nursing as a natural sphere for all women.

Colonial settings in Malawi soon prompted questions about the extent to which nursing was connected to race and general education. In general, however, nursing was considered to be suitable for African women: this had been demonstrated by the early African nurses who had made significant contributions to the success of early mission hospitals.

The professionalism and knowledge of nurses could be shown arguably in more “modest” or subtle ways than those undertaken by doctors. When performed “properly”, meticulously and accurately, in a disciplined and effective way, activities that might be regarded as everyday routines (for example, feeding and bathing patients) could be transformed into demonstrations of female Christian practice. Although distinct (and increasingly in conflict), the images of a “good wife” and a “good nurse” converged on the virtues of cleanliness, meticulousness, kindness and (women’s) work ethic.

Elements of nursing knowledge and skills were arguably more easily transferrable in early colonial settings than many aspects of medical science. Relatively few resources were required, and certain practices could be demonstrated fairly effectively without extensive knowledge of vernacular languages. When nursing was taught, it could be taught in the vernacular as well as in English. Nursing practices also tended to be less jealously guarded than the medical knowledge of doctors. At the turn of the century, few Europeans saw any problem in the principle of teaching Africans nursing skills. By contrast, very few missionaries in Central Africa (with the notable exception of Neil Macvicar) openly envisioned the training and full qualification of African doctors.⁸⁶ As Rennick notes, early mission doctors could speak of “native nurses” but not of “native doctors” in a Western sense.⁸⁷

In this light, it seems almost surprising that early missionary medical education in Malawi placed so much emphasis on the extensive training of male medical assistants by mission doctors. The training of African nurses through work had been an ongoing process, but it received far less attention or resources (at least into the 1930s). In the early 1930s, Dr Agnes Fraser, of Livingstonia, lamented the backwardness of the mission’s education initiatives for women.⁸⁸

⁸⁶ In the 1880s, both Blantyre and Livingstonia rejected the offered medical services of black medical candidates (from West Indies and the United States). A. Rennick, “Church and Medicine...”, pp. 70–71. Neil Macvicar, who had studied alongside a West African medical student in Edinburgh, envisioned university-level education for Central Africans in the 1890s.

⁸⁷ A. Rennick, “Church and Medicine...”, p. 218. “Native doctor” in missionary parlance meant African “traditional” healer – but was not necessarily as derogatory as the term “witch doctor”.

⁸⁸ A. Fraser, *The Teaching of Healthcraft to African Women*, London: Longmans, Green and Company, 1932.

This seeming paradox can be understood through recourse to the profoundly gendered missionary programme of imitation. Certainly the male-dominated Livingstonia, and possibly to a lesser extent Blantyre and the UMCA, were slow to implement African nursing education because the idea of women as primarily Christian wives and mothers, to some extent, ran counter to the education and professionalisation of African nurses. Questions of race also played a part. However, at the same time, during the early twentieth century, the missions provided some space (which gradually increased) for the more independent and professional agency of both European and African women in the sphere of nursing. These conflicting tendencies were crucial to the contexts in which early knowledge-exchanges, knowledge-transfers and education in nursing took place in Malawi.

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