

## *Missionaries, African Patients, and Negotiating Missionary Medicine at Kalene Hospital, Zambia, 1906–1935*

WALIMA T. KALUSA  
(University of Zambia)

*Until recently, European medical missionaries in the nineteenth and twentieth centuries were often portrayed as all-powerful heroes who plied their craft without being soiled by the cultural commerce of the people they encountered in imperial contexts. Such histories often cast colonial subjects as beneficiaries of missionary medicine who, none the less, routinely contested the medical authority and power of missionary medics. This article casts a shadow on these analyses. It insists that scholarship informed by the dominance–resistance debate obfuscates how missionary healers and their African interlocutors minimised their ontological differences of healing so that each party incorporated idioms and practices from the other’s medical system(s). As a corollary, the missionary and local medical systems came to coexist, enabling African patients to move easily between these systems of healing as they sought cures to their ills. Mission doctors, on the other hand, practised their medicine in ways that were culturally meaningful to their patients. The encounter between them and Africans thus resulted in cultural and intellectual exchange that has long been glossed over by historians who project the encounter as a site of endless confrontation.*

### **Introduction**

Sometime in the 1920s, a hilarious verbal exchange involving a Lunda-speaking malaria patient and Elsie Burr, a British missionary nurse under the Christian Missions in Many Lands (CMML), took place at Kalene Hill Mission Hospital in modern Zambia’s Mwinilunga District. Having given a few tablets of aspirin and quinine to the patient, the nurse advised him to swallow them with water. However, as she moved on to treat the next man, the malaria patient tied the pills to his forehead with a bark-rope. Irritated that the patient had ignored her prescription, the missionary ordered him to swallow the tablets. But the patient refused. ‘*Ndona* [madam]’, he replied adamantly, ‘the pain is in my head, not in my tummy; if I swallow the tablets, when will they reach my head?’<sup>1</sup>

This was not an isolated exchange. A few months later, the nurse faced a similar situation when she gave a tiny pill of calomel to a sick chief and some other larger tablets to one of his followers. Rejecting the pill, the chief angrily wondered why the nurse had given him so small a tablet that he could hardly see it and yet gave bigger pills to ‘his slave’. Tactfully, Burr quickly gave the irate Lunda chief a solution of some bigger innocuous tablets with which ‘he was pacified’.<sup>2</sup> Anecdotes of this nature similarly fill the diaries of Dr Walter Fisher, the British surgeon who founded Kalene Hospital in 1906. The diaries show that his patients and their hospital escorts routinely refused to take some of his medicine, demanded

1 Elsie Burr, *Kalene Memories: Annals of the Old Hill* (London, Pickering and Inglis, 1956), p. 67.

2 *Ibid.*, p. 68.

injections and drugs with specific colours, smell and sizes, or simply refused to submit to his surgical knife.<sup>3</sup>

The regularity with which these incidents occurred in colonial/mission hospitals has convinced some social and medical historians that the medical encounter between coloniser and colonised spawned forces of domination and resistance.<sup>4</sup> Yet, as Nancy Rose Hunt astutely observes, such incidents suggest that these encounters were also characterised by negotiation and (mis)communication between Africans and European medics over healing.<sup>5</sup> Recent studies indeed convincingly show that colonisers and colonised actively engaged in complex conceptual and practical negotiations to minimise the ontological gulf between them. The tactful way in which nurse Burr 'pacified' the chief, for example, is indicative of the fact that medical missionaries in Africa came to appreciate that they could not successfully treat local patients in isolation from existing culture. Nor were missionaries oblivious to the importance of assimilating pre-existing knowledge of healing into their medical practice in order to popularise their medicine.<sup>6</sup> Thus, scholarship that depicts Africans as little more than passive patients on whom all-powerful European doctors unproblematically inscribed Christian versions of disease and medicine obscure the cultural negotiations and exchange that attended the encounter between the two parties.<sup>7</sup>

Included among academics who share this perspective are those operating within neo-Foucauldian paradigms.<sup>8</sup> Neo-Foucauldian scholars particularly privilege European doctors' power over and above the important question of cultural negotiation and exchange that characterised white-black relationships in imperial Africa. They assume that since white missionary doctors enjoyed greater social, economic and political power than Africans, they

3 Anna and Walter Fisher Diaries, No. 17 (undated), National Archives of Zambia (hereafter NAZ), HM8 F1 2/1/1, CMML, *Echoes of Service*, April 1913, pp. 155–6.

4 For recent studies that question this perspective, see Glen Neube, 'The Making of Rural Healthcare in Colonial Zimbabwe: A History of the Ndanga Medical Unit, Fort Victoria, 1930–1960s', PhD Thesis, University of Cape Town, 2012; Julie Livingston, 'Productive Misunderstandings and the Dynamics of Plural Medicine in Mid-Twentieth-Century Bechuanaland', *Journal of Southern African Studies*, 33, 4 (2007), pp. 801–10. I am grateful to an anonymous reviewer who drew my attention to these insightful works. For another study that impressively deals with the question of ontology in a different context, see Joost Fontein, 'Graves, Ruins, and Belonging: Towards an Anthropology of Proximity', *Journal of the Royal Anthropological Institute*, 17, 4 (2011), pp. 706–27.

5 Nancy Rose Hunt, *A Colonial Lexicon of Birth Ritual, Medicalization and Mobility in the Congo* (Durham and London, Duke University Press, 1999).

6 I am grateful to an anonymous reviewer who stressed the importance of this viewpoint. See also Walima T. Kalusa, 'Language, Medical Auxiliaries, and the Reinterpretation of Missionary Medicine in Colonial Mwinilunga, Zambia, 1922–51', *Journal of Eastern African Studies*, 1, 1 (2001), pp. 57–78, and 'Medical Training, African Auxiliaries, and Social Healing in Colonial Mwinilunga, Northern Rhodesia (Zambia) 1945–1964', in Ryan Johnson and Amna Khalid (eds), *Public Health in the British Empire* (New York and Abingdon, Routledge, 2012) pp. 154–70.

7 For works that eulogise colonial and missionary medicine in Africa, see four works by Michael Gelfand: *Tropical Victory: An Account of the Influence of Medicine on the History of Southern Rhodesia, 1900–1923* (Cape Town, Juta, 1953); *Livingstone the Doctor: His Life and Travel, A Study of Medical History* (London, Basil Blackwell, 1957); *Northern Rhodesia in Days of the Charter: A Medical and Social History* (Oxford, Basil Blackwell, 1961); *Godly Medicine in Zimbabwe* (Gwelo, Mambo Press, 1988). See also Lewis H. Gann and Peter Duignan, *Burden of Empire: An Appraisal of Western Colonialism in Africa South of the Sahara* (Stanford, Hoover Institution Press, 1967), p. 283.

8 Examples of these scholars' approach include Roy M. McLeod and Milton J. Lewis (eds), *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion* (London and New York, Manchester University Press, 1988); Maryinez Lyons, 'Sleeping Sickness, Epidemic and Public Health in the Congo', in David Arnold (ed.), *Imperial Medicine and Indigenous Societies* (Manchester, Manchester University Press, 1988), pp. 105–24. See also her *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900–1940* (Cambridge, Cambridge University Press, 1992); Daniel R. Headrick, *The Tools of Empire: Technology and European Imperialism in the 19<sup>th</sup> Century* (New York and London, Oxford University Press, 1981); Maynard Swanson, 'The Sanitation Syndrome: Bubonic Plague and the Urban Native Policy in the Cape Colony, 1809–1909', *Journal of African History*, 18, 3 (1977), pp. 387–410; John Farley, *Bilharzia: A History of Tropical Medicine* (Cambridge, Cambridge University Press, 1991). See also Deepak Kumar, 'Unequal Contenders, Uneven Ground: Medical Encounters in British India', in Andrew Cunningham and Bridie Andrews (eds), *Western Medicine as Contested Knowledge* (Manchester, Manchester University Press, 1997), pp. 170–90.

did not practise medicine in ways that resonated with the expectations of the latter. Backed by colonial regimes, white medics reportedly emasculated local medical systems and underlying belief systems and practices, thereby contributing toward the constitution and maintenance of colonial power and culture. This assumption is reinforced by the fact that missionaries, like imperial doctors, endorsed colonial policies, including labour migration, racial segregation and the policing of subject populations on medical grounds.<sup>9</sup>

Academics who maintain that colonial/mission medicine in extra-European locations was contested knowledge have done little to illuminate the complex ways in which western medical practitioners and colonial subjects renegotiated modern medicine to reduce the ontological gulf between them.<sup>10</sup> To such academics, the coloniser–colonised relationship involved unequal contenders and transpired on uneven ground since white doctors allegedly enjoyed the full backing of colonial regimes.<sup>11</sup> Deepak Kumar, for example, who subscribes to this view, emphatically maintains that although colonial subjects contested the authority and power of European medical practitioners, their contests occurred on the fringes of a discursive space dominated by the latter. Kumar insists that subject populations' responses to western medicine therefore amounted to no more than rumours, suspicions, and hostility. These responses were, however, too ineffectual to prevent European medical authorities from imposing an overwhelming dominance over non-western healing systems. Kumar concludes that indigenous medical systems in colonial settings thus became 'so marginalised that they sought survival more in resistance than in collaboration'.<sup>12</sup>

This article distances itself from scholarship informed by dominance–resistance debates. Driven by an awareness that missionary medicine was a potent site of cultural negotiation, the article insists that conflicting ontologies of disease and medicine between missionary healers and African patients scarcely prevented mutual healing interactions from taking place.<sup>13</sup> Such healing interactions were the consequence of active intellectual and cultural negotiations in which both camps participated almost daily. In these negotiations, the article argues, each party wittingly or unwittingly incorporated into its medical system(s) the other's healing idioms, images and practices. This minimised the divisions between local and Christian healing, consequently bridging the ontological gulf between the two parties. This in turn enabled European medics to ply their trade in ways that were culturally meaningful to their African interlocutors. This perception calls for a rethinking of the ways in which missionary medicine in colonially dominated contexts has until now been conceptualised.<sup>14</sup>

The article is divided into three sections. The first section unravels the hegemonic medical discourse that initially marked mission medicine in British Mwinilunga. The second examines how Lunda-speaking patients reacted to hegemonic discourse. It argues that Lunda patients embraced elements of missionary medicine through selectively integrating Christian images and ideas into their own existing medical systems. The third section demonstrates that, as Lunda reaction confounded the efforts of CMML missionaries to undermine local

9 See Randall M. Packard, *White Plague, Black Labor: Tuberculosis and the Political Economy of Disease in South Africa* (Berkeley, University of California Press, 1989); H. Khekshus, *Ecology and Economic Development in East Africa: The Case of Tanganyika, 1850–1950* (Berkeley and Los Angeles, University of California Press, 1977).

10 These studies include Richard Waller and Kathy Homewood, 'Elders and Experts: Contesting Veterinary Knowledge in a Pastoral Society', in Cunningham and Andrews (eds), *Western Medicine as Contested Knowledge*, pp. 69–93. In the same volume, see Deepak Kumar, 'Unequal Contenders, Uneven Ground: Medical Encounters in British India', pp. 170–90.

11 For a study that impressively questions this view, see Hunt, *A Colonial Lexicon*.

12 Kumar, 'Unequal Contenders', p. 185. For a study that depicts western and western-trained doctors in Africa as more powerful than local patients, see G. Jansen, *The Doctor–Patient Relationship in a Tribal African Society* (Assen, Van Gorcum Group, 1973).

13 This perspective is informed by Livingston, 'Productive Misunderstandings'.

14 For a stimulating recent collection of articles pointing in this direction, see Johnson and Khalid (eds), *Public Health in the British Empire*.

medicine, the missionaries reworked their medical discourse to incorporate existing local idioms and practices into their own medical repertoire to popularise their medicine. In so doing, medical missionaries in Mwinilunga reduced the ontological gulf between them and the Lunda interlocutors.

It should be stressed that African patients appear in the historical record as fleeting figures. This is partly because nearly all that they said or did while seeking treatment at the colonial and mission hospitals derives from the diaries, letters, and annual reports of European medics who in their early days often poorly understood local languages and/or denigrated their patients' medical views.<sup>15</sup> Even though these documents graphically describe the diseases patients brought to mission hospitals for treatment and the 'miraculous' cures that reportedly ensued, they rarely identify the patients by name, age, gender, or place of origin. Moreover, these sources paint the encounter between African patients and white doctors as a one-sided affair dominated by white doctors and nurses, while describing African patients in terms of their perceived 'heathenism', 'ignorance', 'irrationality' and 'loathsomeness'.<sup>16</sup> African escorts, who routinely accompanied sick relations to hospitals, do not escape similar epithets. Like patients, they are cast as no more than an obstacle in the smooth running of colonial and mission hospital regimes.<sup>17</sup> The very fact that the authors of these accounts routinely portrayed Africans in these terms, however, suggests that the relationship between the two parties cannot be fully appreciated in the context of domination–resistance models within which most medical histories have been conceived and nurtured.<sup>18</sup>

### Early Missionary Medical Discourse

When Walter Fisher opened Kalene Hill Mission Hospital in 1906, debates in both metropolitan and colonial circles over the importance of western medicine to imperial and evangelical projects in Africa were still unsettled.<sup>19</sup> Within CMML, a loosely organised society of fundamentalist believers founded in nineteenth-century England,<sup>20</sup> non-medical missionaries objected to the use of medicine as a means of Christian evangelisation.<sup>21</sup> Critics of the 'Gospel of the syringe' in the CMML insisted that sickbed conversions in non-western societies produced converts with superficial faith, a fear that was shared by many evangelists in several other missionary movements.<sup>22</sup> Medical enthusiasts, however, perceived modern

15 Missionaries' poor command of African languages compelled medical doctors in mission hospital to rely on local medical auxiliaries as interpreters between the doctors and patients. For details on this topic, see Kalusa, 'Language, Medical Auxiliaries'.

16 Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford, Stanford University Press, 1991).

17 *Ibid.* See also E.W. Doell, *Hospital in the Bush* (London, Christopher Johnson, 1957), and W.H. Watson, 'Eheu, Fugaces Labuntur Anni: Medical Experiences in Nyasaland', *Central African Journal of Medicine*, 1, 2 (1955), pp. 54–61.

18 My insight here derives from Khalid and Johnson, 'Introduction' in Johnson and Khalid (eds), *Public Health in the British Empire*, pp. 1–31. See also Jansen, *The Doctor–Patient Relationship*.

19 For details on this topic, see W.T. Kalusa, 'Christian Medical Discourse and Praxis on the Imperial Frontier: Explaining the Popularity of Missionary Medicine in Mwinilunga, Zambia, 1906–1935', in P. Harries and D. Maxwell (eds) *The Spiritual in the Secular: Missionary Knowledge about Africa* (Grand Rapids, MI/ Cambridge, UK, Eerdmans, 2012), pp. 245–266.

20 For fuller details on the CMML, see F. Roy Coad, *A History of the Brethren Movement: Its Origins, Its Worldwide Development and Its Significance for the Present Day* (Exeter, The Paternoster Press, 1968); Frederick A. Tatford, *That the World May Know: Light over Dark Continent*, Vol. 6 (Bath, Echoes of Service, 1984); Robert I. Rotberg, 'Plymouth Brethren and the Occupation of Katanga, 1886–1907', *Journal of African History*, 5, 2 (1964), pp. 285–97; W.T. Stunt, A. Pulleng, A. Pickering, G.P. Simmons, D.K. Boak, S.F. Warren, *Turning the World Upside Down: A Century of Missionary Endeavour* (Eastbourne, Upperton Press, 1972).

21 NAZ HM8 F1 2/1/1, Walter Fisher to Singleton Darling, 5 June 1915.

22 See Linda Beer, 'The Development of Medical Missions: The Brethren in Kasempa District, Northern Rhodesia, 1906–1954', Working Paper No. 2, presented in Basel, Basler Afrika Bibliographien, 24 October 1995; Vaughan, *Curing Their Ills*, p. 58.

medicine, and the path-breaking scientific advances it scored towards the end of the nineteenth century, as a God-given tool they could wield in their crusade to convert subject populations to Christianity. Through healing colonised bodies, they no less hoped to demonstrate God's compassion for the sick to the 'heathen' than to propagate European ways of seeing and being. This could in turn rid imperialised societies of supposedly irrational, superstitious medical and religious ideologies that Europeans regarded as a barrier to the conversion of the colonised to Christianity.

Dr Walter Fisher subscribed to this discourse. Born in 1865 in England and trained in scientific medicine at Guy's Hospital in London in the early 1880s, he was heir to the professionalisation of medicine that vested medical authority exclusively in bio-medically trained doctors. Dr Fisher attributed what he saw as cultural, mental, and spiritual degradation in Africa to existing medical belief systems. He maintained that only after Africans had jettisoned 'pagan' cosmologies underlying local medicine would they 'make a clean cut with everything connected with superstition' and thus 'advance all round, not only mentally but also spiritually'.<sup>23</sup> To him this conceptual transformation could best be accomplished through demonstrating to sceptical Africans the power of modern medicine, undermining their therapeutic beliefs, and converting them to Christianity.

It is not surprising, then, that the surgeon placed a high premium upon medical evangelism. To him, evangelical medicine possessed the power not just to cure the ills of African societies but also to weaken their medical belief systems, which he regarded as an obstacle to Christian proselytisation. Like other enthusiasts of medical evangelisation within and without the CMML, he therefore regarded medicine as a means to fulfil a much larger project: the conversion of Africans to Christianity. Fisher hoped that patients treated successfully at Kalene Hospital would easily embrace the new religion. Upon returning to their villages, the patients-cum-converts would commend their new faith to their 'heathen' kinsfolk. Healing at the mission hospital would thus transform them into agents of evangelisation, thereby assisting missionaries to transmit the new faith beyond the mission enclave.<sup>24</sup>

In this discourse, Christian medicine was a vehicle for transforming African society through the conversion of individual patients, irrespective of their culture or social relationships. Each patient treated at Kalene Hospital would follow a linear progression from embracing the mission's therapeutic system, with its Christian ideology, to abandoning existing medicine together with its associated beliefs and practices. As remarked elsewhere, this discourse left no space for cultural exchange between missionary and African healing systems.<sup>25</sup> For missionaries in Mwinilunga and beyond perceived their medicine as the only rational means of confronting human disease and suffering. To them, too, Christianity was the only true religion. Unsurprisingly, they were as eager wholly to override local constructions of disease, religion and medicine as they were to replace them with biomedical understandings of health.

This hegemonic missionary discourse enjoyed the warm endorsement of successive colonial states: first the British South African Company (BSAC), which ruled the territory between 1890 and 1923, and later the government formed in the colony by the Colonial Office in London. Understaffed and governing the territory on a shoestring budget,<sup>26</sup> the

23 Extract from Anna and Walter Fisher Diaries, No. 17 (undated), NAZ HM8 F1 2/2/2/1. See also William Fisher and Julyan Hoyte, *Ndotolu, The Life Histories of Walter and Anna Fisher of Central Africa* (Ikkelenge, Lunda-Ndembu Publications, 1992, first published in 1948), pp. 176–82.

24 Extract from Fisher Diaries, No. 17, NAZ HM F1 2/2/2/1.

25 Kalusa, 'Language, Medical Auxiliaries', p. 62; and W.T. Kalusa, 'Disease and the Remaking of Missionary Medicine in Colonial North-Western Zambia: The Case of Mwinilunga District, 1902–1963' (PhD dissertation, Johns Hopkins University, 2003), p. 96.

26 This observation is informed by Sara Berry, 'Hegemony on a Shoestring: Indirect Rule and Access to Agricultural Land', *Africa*, 62, 3 (1992), pp. 327–55.

company–government welcomed the establishment of the CMML hospital in Mwinilunga. It regarded missionary medical work and presence in the district as indispensable to ‘pacifying’ the area, as well as for demonstrating to unwilling Africans the benefits of acquiescing in European rule.<sup>27</sup>

The BSAC’s support of medical evangelism at Kalene Hill found concrete expression in growing co-operation between the company and missionaries as they endeavoured to suppress indigenous medicine. For while CMML medics perceived such healing systems as a major barrier to African evangelisation, company officials saw them as a rival source of political power. Thus, in 1906 BSAC officials, with the warm support of missionaries at the hospital, enacted the Anti-Witchcraft Ordinance, which criminalised divination and spiritual healing. African diviners and healers convicted under the law were liable to a fine of £25, corporal punishment, and/or one year’s imprisonment with hard labour.<sup>28</sup> In subsequent years, Dr Walter Fisher actively helped the company to enforce the anti-witchcraft ordinance. He often instigated the arrest and imprisonment of Lunda ‘traditional’ healers who contravened the legislation in one way or another.<sup>29</sup>

The co-operation between the BSAC and the CMML further extended to the campaign to combat debilitating epidemics ravaging the district, especially before the First World War. For example, to rid the district of epidemic smallpox and thus make it safe for recruiting cheap African labour for emerging capitalist mines and farmers in southern Africa, the company’s tiny health department occasionally supplied the anti-smallpox vaccine to the mission hospital between 1908 and 1914.<sup>30</sup> With the vaccine, Dr Fisher carried out an extensive smallpox campaign in Mwinilunga, vaccinating hundreds of people in the area by the outbreak of the war in 1914. This reportedly reduced the danger that the loathsome disease posed, especially in the north-western corner of the district. This considerable achievement was the consequence not only of the vaccine that the BSAC periodically supplied to the surgeon. The BSAC also provided policemen to rein in Africans who opposed the vaccination campaign, which the Africans probably perceived as the company’s attempt to extend its oppressive rule into their colonised bodies.<sup>31</sup>

But while the BSAC was keen to co-operate with CMML to undermine local medicine, and to combat epidemic diseases that threatened incipient capitalist interests in southern Africa, it fell short of financially assisting missionaries. Until the company–government surrendered political reins to the Colonial Office in London in 1923, it remained chronically insolvent. Its medical department was thus inadequate and too poorly funded to grant fiscal aid to medical missionaries in the colony, including those at Kalene Hill. Without state funding, Kalene Mission Hospital exclusively relied on the material and monetary donations of philanthropists in England, which were far from adequate.<sup>32</sup> This situation persisted until the mid-1920s, when the colonial state that succeeded the BSAC established a much more robust medical service in the territory through the provision of grants-in-aid to selected medical missions. Such missions were in turn legally obliged to treat government employees and prisoners, vaccinate Africans against epidemic afflictions, and oversee the work of

27 Mwinilunga District Notebook (hereafter MDN), 1906–1964, NAZ KSE4/1; Annual Report for the Year Ending 31 March 1910, NAZ KSE6/1/1; Annual Report for the Year Ending 31 March 1911, NAZ KSE6/1/1; Annual Report for the Year Ending 31 March 1915, NAZ KSE6/1/1.

28 P.C.G. Adams, ‘Disease Concepts among Africans in the Protectorate of Northern Rhodesia’, *Rhodes–Livingstone Journal*, 10 (Cape Town, Oxford University Press, 1950), p. 50.

29 Quarterly Report for July, August, and September 1912, NAZ KSE6/1/2. See also Burr, *Kalene Memories*.

30 NAZ/MDN, KSE4/1.

31 David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley, University of California Press, 1993).

32 Walter Fisher to Singleton Darling, 14 June 1907, NAZ HM8 F1 2/1/1; Tatford, *Light over Dark Continent*; Stunt *et al.*, *Turning the World Upside Down*.

African medical auxiliaries who increasingly staffed state clinics and dispensaries.<sup>33</sup> Under this arrangement, the mission hospital began to receive an annual subsidy of £120 in 1926, and two years later an additional £30, specifically for training African medical personnel.<sup>34</sup> Henceforth, CMML missionaries were both theoretically and practically absorbed into the colonial medical service. This situation ended their chronic underfunding, enabling them to build a modern hospital in the 1920s, equipped with state-of-the-art medical technologies.

Owing to the lack of funds before the 1920s, the first CMML hospital at Kalene Hill was hardly a sanitised healing space, nor was it a potent emblem of colonial/missionary medical power and authority. Until after the Second World War, the hospital itself was little more than a grass-thatched, mud-and-pole dwelling built on the summit of the hill. Constructed to no specific plan due to the rocky nature of the site, the so-called hospital possessed neither an operating theatre nor isolation wards, and patients with infectious diseases freely roamed the hospital grounds.<sup>35</sup> Dr Fisher conducted surgical operations on a kitchen table on the veranda of the hospital, often without chloroform, which was in chronic short supply.<sup>36</sup> Moreover, the majority of the dwellings at the hospital were huts that also served as 'wards'. These overcrowded huts were hastily constructed either by in-patients themselves or by their hospital escorts.<sup>37</sup> The latter not only shared the 'wards' with patients but, in the absence of trained nurses in the hospital's early days, also cooked food for the sick, washing, feeding and nursing them. Even after its relocation to more spacious environs at the foot of hill in the 1920s, the hospital continued to be severely overcrowded with patients, traders, state officials on tours of duty, and pupils attending the mission school close to the hospital.<sup>38</sup> Such overcrowding was a recipe for contagious diseases, notably tropical ulcers, tuberculosis, pneumonia, hookworm and, during the First World War, devastating Spanish influenza. In the 1920s and 1930s, hookworm alone infected 80 per cent of the people living at the hospital, both black and white.<sup>39</sup> The CMML hospital at Kalene was not a sanitised healing space, and thus hardly a foreign institution that foisted itself upon local imaginations. Rather, it was an institution whose life and activities were effectively colonised by Lunda patients, their escorts, and the community in which it operated.<sup>40</sup> At Kalene Hill the healing environment hardly diverged from that under which Lunda traditional healers plied their trade.

### Negotiating Missionary Medicine at Kalene Hill

Studies that explore how African patients selectively embraced various elements of colonial medicine open a window on to the creative manner in which Lunda people appropriated the

33 For a fuller treatment of this topic, see Kalusa, 'Language, Medical Auxiliaries'.

34 Walter Fisher to Singleton Darling, 29 October 1926, NAZ HM8 F1 2/1/1; Walter Fisher to Secretary of Native Affairs, 30 August 1928, NAZ ZA1 9/1/28/2/1. On the same file, see Provincial Medical Officer Livingstone to Secretary of Native Affairs, 6 October 1928, and Secretary of Native Affairs to Principal Medical Officer, 10 October 1928.

35 Burr, *Kalene Memories*, p. 73.

36 Walter Fisher to Singleton Darling, 14 June 1907, NAZ HM8 F1 2/1/1; Fisher and Hoyte, *Ndotolu*, p. 145; Monica Fisher, *Nswana – The Heir: The Life and Times of Charles Fisher, a Surgeon in Central Africa* (Ndola, Mission Press, 1991), p. 52.

37 Fisher and Hoyte, *Ndotolu*.

38 Burr, *Kalene Memories*.

39 MDN NAZ KSE4/1; Annual Report for the Year Ending 31 March 1921, NAZ KSE6/6/1/4; Annual Report on Native Affairs for the Year Ending 31 March 1937, NAZ SEC 2/133; H.S. de Boer, Report on Conditions in Northern Rhodesia (1933), NAZ ZA7/6/7; A.E. Fulton, *From Forest Track to Tar Mac (1925–1967 in Zambia)* (Bala, Dragon Books, 1972), p. 12.

40 Sean Lang, 'The Control of Birth: Pupil Midwives in Nineteenth-Century Madras', in Johnson and Khalid (eds), *Public Health*, p. 34.

mission's therapeutic system at Kalene Hill Hospital.<sup>41</sup> Although missionaries and colonial officials hoped to weaken African medical knowledge and praxis, Lunda people's response to the new medicine was anything but straightforward. In the early years of the hospital, medical missionaries at Kalene observed that local patients were eager to be treated with modern medicine only if they were accompanied to the hospital by their kin and kith.<sup>42</sup> To the dismay of the medics, both patients and their escorts insisted on taking part in diagnosing and treating ailments. 'Nursing patients', lamented nurse Elsie Burr, 'was not always easy, for they were usually accompanied by one or two, if not a whole horde of relations, and these, particularly grannies, did not see eye to eye with us over the matter of the patient's treatment'. According to Burr, grandmothers in particular would clandestinely remove pneumonia patients from the warm hospital to wash them in a nearby stream before returning them.<sup>43</sup> During the First World War, when Mwinilunga was hit by a devastating epidemic of tropical ulcers for which there was no scientific cure,<sup>44</sup> 'uncooperative grannies' reportedly frequently packed local herbs into the gaping ulcer sores of their indisposed relatives at Kalene Hill.<sup>45</sup> Most of the patients also demanded to be treated with white pills but rejected red ones, sometimes accusing medical missionaries of witchcraft when treatment failed at the hospital.<sup>46</sup>

CMML evangelists initially dismissed these reactions as a reflection of local mystification of modern medicine. Yet the missionaries themselves could ill afford completely to disregard African responses to Christian medicine and its underlying belief system. To popularise his medicine, Dr Walter Fisher routinely welcomed his patients and their escorts into his hospital, for their presence increased the number of potential converts to Christianity and gave him a chance to introduce them to his microbial and Christian salvation theories. The surgeon spent time daily explaining to his patients and their escorts alike scientific disease causation and medicine.<sup>47</sup> He also reportedly engaged them to dispel their beliefs regarding witchcraft as causation of disease and misfortune.<sup>48</sup> Most importantly, Dr Fisher always sought the permission of his patients' relatives before carrying out surgical operations, including minor ones.<sup>49</sup>

In engaging with each other over discourses of healing at Kalene Hill, CMML doctors and Lunda people located missionary healing within the local social milieu and medical culture in which healing involved the healer, the patient, and the patient's therapy management group.<sup>50</sup> To Lunda patients and their escorts, therefore, diagnosis and treatment were not a preserve of medical missionaries. By engaging local people in matters of healing, missionaries at the hospital routinely operated within the context of Lunda culture, in which both the healer and the patient (*muyejji*) played an important part in the diagnosis and treatment of disease. Furthermore, in this cultural context, healing marked a step towards the calling of healing,

41 A good example of such works is Ncube, 'The Making of Rural Healthcare'.

42 Burr, *Kalene Memories*.

43 *Ibid.*, p. 17.

44 Walter Fisher to Singleton Darling, 13 January 1916, NAZ HM8 F1 2/1/1; MDN, NAZ KSE4/1; Quarterly Report for the Quarter Ended 31 December 1915, NAZ KSE6/2/1.

45 Burr, *Kalene Memories*.

46 CMML, *Echoes of Service*, February 1918, p. 48.

47 Fisher and Hoyte, *Ndotolu*.

48 H. Julian Hoyte, 'Kalene Jubilee', *Echoes Quarterly Review*, 1, 2 (1959), p. 4; Walter Fisher to Singleton Darling, 5 September 1915, NAZ HM8 F1 2/1/1.

49 See Fisher and Hoyte, *Ndotolu*.

50 For widely read classics on Lunda medical knowledge and practices, see Victor Turner, *Forest of Symbols: Aspects of Ndembu Ritual* (Ithaca, NY, Cornell University Press, 1967); *Schism and Continuity in an African Society: A Study of Ndembu Village Life* (Manchester, Manchester University Press, 1957); *The Drums of Affliction: A Study of Religious Processes among the Ndembu of Zambia* (Oxford, Clarendon Press, 1968). I borrow the phrase 'therapy management group' from John M. Jansen, *Quest for Therapy in the Lower Zaire* (Berkeley and London, University of California Press, 1978) and his 'Therapy Management: Concept, Reality, Process', *Medical Anthropological Quarterly*, 1, 1 (1987), pp. 68–84.

with former patients eventually becoming healers themselves.<sup>51</sup> It is thus little wonder that some of Dr Walter Fisher's early patients saw themselves as healthcare givers after being cured at the hospital. Indeed, some of the ex-patients permanently settled at Kalene Hill, forming the nucleus of the first African Christian community in Mwinilunga. From among their offspring, too, would later emerge the first generation of medical auxiliaries trained by missionaries in the territory.<sup>52</sup>

Conceptually, African comprehension of missionary medicine was eased by its cultural translation, a task in which Lunda speakers and CMML missionaries mutually participated. The two parties came to depend heavily on indigenous medical terms to translate scientific concepts in modern medicine and hence establish a communicative foundation between themselves.<sup>53</sup> In this process, local medical terms, some of them taken from Lunda ritual and healing discourses, were mutually appropriated to gloss scientific medical terms. For example, *nyitumbu*, *musongo* and *muyeji* were appropriated from existing medical vocabulary to express the meaning of the English terms 'medicine', 'disease' and 'patient', respectively.<sup>54</sup> In using these and other similar concepts as means of communication, Lunda and their European healers read the meanings embedded in Lunda medicine into western medicine, with local people comprehending the latter as a variation of the former.

Seen from this perspective, the medical encounter involving Africans may be read as a site of cultural and intellectual exchange. Through this exchange, missionary medicine was reinterpreted by patients, their escorts, and missionaries alike, in a manner that enabled them to create a conceptual bridge across which to communicate, and, of course, sometimes miscommunicate. This cultural reinterpretation of missionary medicine allowed Africans in Mwinilunga to filter Christian medicine, with its technologies, through pre-existing medical culture, logic and grammar. With medical missionaries in tow, they infused into missionary therapeutics local medical meanings, thereby familiarising the new system of healing without necessarily jettisoning their therapeutic beliefs and associated practices.<sup>55</sup> Africans fine-tuned missionary medicine, using it in conformity with their own medical criteria and practices. Missionary involvement in cultural translation meant that CMML evangelists found a common language with local hosts in which they mutually communicated, occasional misunderstandings between the two camps notwithstanding. In Mwinilunga, evangelical medicine scarcely crossed its western cultural frontier intact.

Since patients and those who accompanied them to the hospital were in socially and politically weaker positions than Europeans, it is tempting to dismiss their responses to western medicine as both ineffectual and devoid of power. Indeed historians operating within domination–resistance paradigms have unwittingly fallen into this temptation. They have depicted colonised patients as having been too powerless to exert any influence on local understandings or use of modern medicine.<sup>56</sup> It is, however, perhaps more productive to examine the missionary–African encounter as more than simply an arena of conflict and resistance. Mission hospitals were not always scenes of contestation between white doctors and black patients, even though missionaries depicted them as such. They were also sites of social and cultural creation and exchange, which missionaries seldom documented. Nor were sick Africans completely without social and cultural bargaining power. The patients' power

51 *Ibid.*

52 For more details on this topic, see Kalusa, 'Language, Medical Auxiliaries'.

53 Kalusa, 'Language, Medical Auxiliaries'.

54 For a fuller treatment of this topic, see *ibid.*

55 My analysis here is informed by Pier M. Larson, "'Capacities and Modes of Thinking": Intellectual Engagement and Subaltern Hegemony in the Early History of Malagasy Christianity', *American Historical Review*, 102, 4 (1997), pp. 969–70.

56 See, for example, Kumar, 'Unequal Contenders, Uneven Ground'.

at Kalene Hill manifested itself in myriad but often unobservable forms of behaviour. Such power lay not only in their ability to reinterpret and to deploy missionary medicine in ways that missionaries often inadvertently endorsed: it lay also in the patients' mischief, their selective embracing of mission medicine, laughing at white doctors' prescriptions, smuggling patients and drugs out of the mission hospital, and incorporating Christian images and idioms into their own medical practices and beliefs.<sup>57</sup>

In their eagerness to demonstrate that colonial and missionary doctors enjoyed greater authority over Africans, and in stressing local resistance to colonial and mission medicine, academics operating within domination–resistance models negate the significance of cultural or intellectual cross-pollination that defined encounters between imperial rulers and ruled.<sup>58</sup> It is indisputable that CMML doctors and nurses at Kalene Hill were in much more powerful social and political positions than Africans, thanks to their connection to colonial power. But no matter how well politically connected, missionaries needed to redirect their medical practice through locally accepted ways of comprehending and managing disease. This had vital implications in terms of how CMML missionaries came to practise their medicine in the district. Acutely aware of their inability to mould African apprehensions of either modern medicine or Christianity, they rethought their hegemonic medical discourse and searched for more effective ways to influence local perceptions of mission medicine and its ideology.

The imperative to reconstitute the hegemonic discourses underlying missionary medicine at Kalene Hill was perhaps best expressed in *Thinking Black*, a bestseller written by Dan Crawford in 1912.<sup>59</sup> A leading CMML educator, philosopher, linguist, and colleague of Dr Fisher, Crawford argued that the failure of western evangelists in Africa to shape indigenous reception of western Christianity and other institutions derived from missionaries' own 'policy of make-believe', which indiscriminately condemned local customs and practices without understanding their cultural and moral logic.<sup>60</sup> Crawford dismissed this policy as a 'hollow one'.<sup>61</sup> A keen believer in the essential unity of humanity, the missionary insisted that Africans were not intellectually inferior to other races. Some of their social institutions and practices were based on solid moral and intellectual foundations, and thus not incompatible with western institutions, including Christianity. Dan Crawford insisted that Africans could best embrace European religion through their own existing institutions and practices. Local ways of praying and healing, such as singing, incantations and dancing, could therefore be 'consecrated to the Lord'.<sup>62</sup> As such, they could be used to spread western Christianity, and presumably understandings of disease and healing. To this end, the missionary challenged other evangelists to steep themselves in local religions, medicine, languages and idioms so that they could deploy them to instil into host societies European versions of religion, medicine, and other ways of life.<sup>63</sup>

It is most unlikely that Crawford, the CMML's philosopher, abandoned common assumptions in missionary circles that African institutions, customs and practices were backward. Nor does he seem to have questioned the notion that such customs and practices were the locus of the reproduction of heathenism in Africa. But he does seem to have been

57 My insight here is informed by Hunt, *A Colonial Lexicon*.

58 This point is informed by Frederick Cooper, 'Conflict and Connection: Rethinking Colonial African History', *American Historical Review*, 99, 5 (1994), pp. 1516–45. See also Bryan Thomas Callahan, 'Syphilis and Civilization: A Social and Cultural History of Sexually Transmitted Disease in Colonial Zambia and Zimbabwe' (PhD dissertation, Johns Hopkins University, 2001), p. 6.

59 Daniel Crawford, *Thinking Black: 22 Years Without a Break in the Long Grass of Central Africa* (London, Morgan and Scott, 1912).

60 *Ibid.*, p. 416. See also Kalusa, 'Disease and Remaking Missionary Medicine'.

61 Crawford, *Thinking Black*.

62 *Ibid.*, p. 55.

63 Much of this data derives from Kalusa, 'Christian Medical Discourse' pp. 245–66.

convinced that such institutions and practices could be emptied of their pagan elements, and be effectively pressed into service of the Gospel, and perhaps even of western medicine.<sup>64</sup> From this standpoint, what Crawford advocated was a religious and medical replica of indirect rule. If British authorities hoped to govern their colonial subjects in Africa through local political institutions, the CMML thinker believed that Africans could be more effectively drawn to western religion and medicine through their own institutions and practices.

As would be expected, not all medical missionaries agreed with Crawford; indeed, some of them 'equated thinking black with thinking evil'.<sup>65</sup> However, Crawford's call to redefine missionary discourse seems to have struck a responsive chord among medical missionaries at Kalene Mission Hospital, including Fisher, who regarded Crawford as the most gifted thinker in the CMML.<sup>66</sup> In the aftermath of the publication of *Thinking Black*, Fisher and other medical missionaries at the hospital increasingly redirected their medical practice into ways they believed resonated with Lunda perceptions of disease and healing. Consequently, they sometimes acted in ways that were unthinkable to most western doctors in the metropole. They routinely sang and prayed before administering modern drugs to patients, and they engaged African patients and escorts in debates on witchcraft and healing to secure their compliance with mission treatment.<sup>67</sup> They also endlessly involved themselves in local discussions on witchcraft, with Dr Fisher often collecting and burning witchcraft paraphernalia at the hospital.<sup>68</sup>

In all this, missionaries reinvented Lunda healing ordeals. Their practice of medicine at Kalene Hill thus came not to be a private affair involving mission doctors and patients alone. Rather, CMML evangelists embraced local medical idioms and practices in which the treatment of disease took place on several fronts, with missionaries taking part in anti-witchcraft ordeals. Missionary medicine at Kalene therefore became a ritualised affair, drawing together mission healers, their patients, and patients' therapy management groups.<sup>69</sup> Indeed, by the 1920s, healing prayers, singing healing hymns, invoking the supernatural healing power of God, and other rituals that defined Lunda medicine, had indeed become defining features of medicine at the mission hospital, at least in the eyes of local people.<sup>70</sup>

In sum, it may be reiterated that interactions between Christian medics and Africans in colonial Mwinilunga were not a one-way phenomenon dominated by CMML evangelists, nor was management of therapy their exclusive monopoly. Even though they were in a more powerful position than Africans, and the latter stood at the lowest level of the hospital hierarchy, the missionaries could ill afford to dispense their medicine without locating its practice in existing social and cultural milieux to make it locally comprehensible. The imperative to do so arose partly from the unexpected manner in which their African patients embraced missionary medicine. By incorporating Lunda medical ideas and practices into their own, CMML evangelists reduced the alien nature of their medicine, easing its acceptance by the local patients and their hospital escorts. It is little wonder, then, that African patients moved easily between their own medicine and mission medicine. Some

64 Crawford, *Thinking Black*.

65 See Hunt, *A Colonial Lexicon*, p. 135.

66 M. Kitty Fisher, *Lampposts to Searchlights: The Brighter Side of Missionary Life: Memories of M.K. Fisher in Central Africa* (Ikkelenge, Lunda-Ndembu Publications, 1994).

67 Interviews with: Hildah Wadsworth, retired nurse matron, Kalene Hill Hospital, 7 January 2001; Thomas Brighton Sameta, retired medical orderly, 7 January 2001.

68 Fisher and Hoyte, *Ndotolu*.

69 For details on African healing practices in Mwinilunga, see Victor Turner, 'Lunda Rites and Ceremonies' and his 'Chihamba, the White Spirit: A Ritual Drama of the Ndembu', *Rhodes-Livingstone Paper 33* (Manchester, Manchester University Press, 1962). See also his *The Forest of Symbols; Drums of Affliction*; and *Schism and Continuity*.

70 For a detailed examination of this topic, see Kalusa, 'Disease and Remaking Missionary Medicine'.

indeed regarded the latter as a variation of the former. Others, as late as the mid-1930s, continued, in the exaggerated view of a colonial functionary, to regard missionary medicine as no more than 'advanced witchcraft'.<sup>71</sup>

## Conclusion

This study distances itself from academic scholarship that locates the missionary–African interaction at mission-controlled healing centres in imperial Africa in dominance–resistance paradigms. Rather than seeing the encounters between western doctors and their African patients as involving one party dominating the other, this article suggests that it is more revealing to explore how missionaries and Africans forged ontological bridges to reduce the binary divisions in their medical knowledge and practices. The article maintains that, through complex cultural and intellectual negotiations, colonised subjects and their western healers adapted each other's ontologies of disease, medicine and healing, resulting in what an upcoming scholar aptly describes as 'productive misunderstandings'.<sup>72</sup> Through such misunderstandings, medical missionaries and their African interlocutors medically and culturally accommodated each other. The historical record and missionary iconography, however, depict mission doctors as heroes who acted upon the prostrating, passive African sick. Scholars who have uncritically relied on such sources have duplicated this image in their portrayal of the encounter between mission doctors and subject populations in colonial contexts as a one-way affair dominated by missionaries.

It is true that in their early years in Africa most European evangelists cast themselves as cultural conquistadors out to annihilate local medical beliefs and practices that they dismissed as tall barriers to the evangelisation of their host communities. A close study of missionary work at Kalene Hill mission hospital, however, shows that medical missionaries needed to rethink this hegemonic approach to healing. For the Africans they sought to convert to the Christian faith selectively embraced mission-based medicine, appropriating and using it in ways that accorded with their existing medical knowledge and practice. Faced with this local reaction to their medicine, CMML missionaries engaged local people in Mwinilunga in cultural terms. This led to complex cultural negotiations with Lunda-speaking people, in which existing medical concepts and practices came to be mapped on to Christian medicine. This exchange enabled mission practitioners to ply their trade in ways that were comprehensible to local patients. In turn, this enabled patients to embrace new systems of healing in terms that were culturally meaningful and practically akin to how Lunda medicine was dispensed in Mwinilunga.

WALIMA T. KALUSA

*Department of History, University of Zambia. E-mail: [chamakalusa@yahoo.co.uk](mailto:chamakalusa@yahoo.co.uk)*

71 H.S. de Boer, *Medical Report Following Tour through North-Eastern and North-Western Portions of Northern Rhodesia* (Lusaka, Government Printer, 1934), p. 31.

72 Livingston, 'Productive Misunderstandings'.