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Language, Medical Auxiliaries, and the Re-interpretation of Missionary Medicine in Colonial Mwinilunga, Zambia, 1922–51[1]

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ABSTRACT *Until recently, African medical auxiliaries employed in missionary-owned hospitals in colonial Africa have been thought of as little more than agents who both imbibed the imperial ideologies of their European masters and planted those values beyond the confines of mission enclaves. From this standpoint, auxiliaries are seen as having undermined African medical beliefs and praxis. Implicit in this view is the assumption that medical auxiliaries appreciated the Euro-Christian values of their employers and translated missionary medicine in ways that resonated with the expectations of missionary doctors. African auxiliaries were, however, more than the simple creations of white colonial masters. Through an examination of the concepts used by Lunda-speaking auxiliaries to translate mission medicine at the hospital run by the Christian Missions to Many Lands in Mwinilunga, from 1922 to 1951, this article argues that auxiliaries translated missionary medicine in ways missionaries could neither imagine nor control. To express, domesticate, and hence familiarise missionary medicine, auxiliaries appropriated concepts from pre-existing Lunda secular and ritual vocabulary through which indigenous medicine in the district was expressed, debated and internalised. Consequently, Christian medicine in Mwinilunga came to be understood as if it were a variation of Lunda medicine – which CMML healers dismissed as no more than a citadel of paganism. In translating mission medicine in this way, African auxiliaries not only confounded their employers' ambition to undermine local medical beliefs, but they also demonstrated that they were self-motivating actors who joined mission employment for reasons often at odds with the expectations of their employers.*

Autochthonous medical auxiliaries employed in European-controlled hospitals on the imperial periphery in the nineteenth and twentieth centuries have long been imagined as agents of 'medical imperialism'.[2] It is alleged that although such auxiliary employees as ward attendants, orderlies and nurses sometimes contested colonial medical hegemony, they, nonetheless, deeply appreciated the superiority of Western medicine over 'traditional' therapy because of their training in scientific medicine. As admirers of the new medicine, auxiliaries reportedly internalised the Euro-Christian bourgeois values that Western doctors attached to their medical intervention on the colonial frontier. They thus regarded themselves as the legitimate spokesmen of the Western therapeutic system,

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signalling that 'they stood with progressive elements of society against [local] customs that were entwined with religion and superstition'.[3]

From this standpoint, non-Western practitioners of colonial/missionary medicine in Africa and beyond championed their employers' crusade against 'traditional' medical culture and praxis. They helped in undermining local cosmologies of disease and healing perceived by colonial and mission doctors, respectively, as a stumbling block to their imperial crusade and as a barrier to evangelical efforts to win for Christ the hearts and souls of the subjects of empire. It is further argued that besides 'persuading recalcitrant patients and sceptics of the superiority of western medicine',[4] auxiliary workers were as instrumental in planting Euro-Christian values on the African soil as they helped in disseminating those values beyond the confines of colonial/mission enclaves.[5] They thus bolstered their masters' efforts to suppress pre-existing belief systems, to 'civilise' the 'Dark Continent' and, above all, to convert its people to Christianity, the *raison d'être* of medical evangelisation.

Histories that cast African employees in European health institutions as mere agents of cultural annihilation have been shaped by the long-standing but now fast fading perception of colonialism as an all-crushing, monolithic and coherent force under which all forms of non-Western culture crumbled.[6] These studies specifically derive their inspiration from the writings of Michel Foucault that place a premium on the centrality of medical knowledge and power in the construction of culture and of social control.[7] Neo-Foucauldian studies have admittedly opened significant avenues for exploring linkages between medical knowledge and the creation of imperial culture and hegemony outside Europe. They have shown how European doctors operating in colonial arenas used their knowledge of medicine to further imperial expansion, constitute and maintain colonial power, undermine local belief systems, and, lastly, construct the colonised as the governable Other.[8] These works, therefore, aptly demonstrate the extent to which Western medicine, the bulk of which consisted of missionary medicine, served both as a practical and symbolic arm of Western hegemony in imperialised societies.

Academic scholarship modelled on readings of Foucault is undoubtedly crucial to our appreciation of the contribution of modern medicine to the rise of imperial power on the fringes of the Western empire in the last few centuries. However, as Richard Waller and Kathy Homewood recently remarked, scholarship that underscores biomedical power in imperial settings has too frequently been written from the perspective of European agents, rather than that of colonial subjects.[9] It thus essentially explores the goals, intentions and expectations of Western doctors on the colonial frontier in the nineteenth and twentieth centuries, and skirts the important question of how people at the periphery of the European empire at whom colonial medical interventions were directed received or comprehended Western medicine.[10] By sidelining this question, the scholarship under review obscures the meanings non-European societies read in imperial medicine, and does not illuminate the extent to which they utilised the new system of healing to come to terms with colonial afflictions, to recreate their own medical conceptions and to reconfigure their social relations, identity and power. This underestimates the capacity of the colonised to shape their own medical reality, let alone to circumvent the hegemonic intentions of European medics and paramedics.[11] Scholarship that ignores this question is a forceful reminder of underdevelopment theories that once maintained that the colonised world was 'organized in a manner functional for Euro-centered capitalism', a

point that Pier Larson makes most powerfully in his appraisal of African reception of Christianity in nineteenth-century Madagascar.[12]

Studies that project auxiliaries as agents of cultural imperialism mask their ability to redefine European-authored discourses in a manner that fitted the discourses into non-Western cultural logic. Proponents of this scholarship over-simplistically assume that because colonisers enjoyed greater social, political and material power over auxiliary employees, the former successfully inscribed their own constructions of medicine and treatment upon the latter.[13] But white doctors in extra-European contexts often lacked a ready-made language through which they could articulate or meaningfully convey their medical and religious thought to their colonial interlocutors. Thus, regardless of how powerful they were relative to the subjects of colonialism, white doctors outside Europe could neither define the terms of local understanding of colonial/missionary medicine nor dictate how imperialised societies practised it. This handicap largely issued from the fact that European medics on the fringes of the Western empire seldom mastered local languages well enough to communicate effectively with the people they encountered away from Europe.

This language constraint was reinforced by disparities between Western and non-Western notions of disease and healing. This profoundly confounded European medics' intention to convey scientific values, concepts or beliefs across the social, cultural and language barriers that separated colonial rulers from the ruled. As a corollary, white doctors outside Europe came to depend indispensably on local medical auxiliaries to translate Western medicine and its allied concepts and technologies into vernacular languages. The doctors assumed that since their employees spoke local languages more fluently, they could more effectively interpret scientific medicine and technologies into vernacular concepts. European practitioners of medicine envisaged that vernacular translations would be drained of 'pagan' connotations and loaded with Western notions of medicine and disease. The medics were, therefore, convinced that local translations could effectively be used to express modern medical concepts and technologies, thereby making Western medicine more meaningful, more comprehensible and more acceptable to its recipients in colonies.

In abdicating the task of translation to auxiliary personnel, however, colonial healers unwittingly rendered their medicine vulnerable to (re)interpretation in ways that they could neither imagine nor control. Evidence suggests that auxiliaries (re)interpreted Western medicine through familiar or familiarised terms ironically appropriated from 'pagan' grammar, vocabulary, and ritual discourse – rather than from biomedical discourse. Auxiliaries thus invariably filtered colonial/missionary medicine through existing medical culture, logic and meaning. They consequently imbued the new medicine and its allied discourse with values associated with 'heathen' culture of disease and healing, resulting in evangelical medicine being locally appropriated on indigenous terms, as opposed to those dictated by Western doctors. This not only obscured the distinctiveness of the scientific meanings the doctors wanted to convey to local converts and patients but circumscribed the potential of Western medicine and that of its local dispensers to act as an effective arm of cultural suppression.

Indigenous medical workers in colonial hospitals were more than translators who crafted languages through which Western medicine came to be expressed or understood. They also became its principal dispensers who, from the 1920s onward, increasingly outnumbered European medics and enjoyed greater contact with patients.[14] Further-

more, they invented their own rituals critical to the smooth running of colonial and mission hospital regimes.[15] In undertaking all these functions, auxiliary employees played a more critical role than white doctors in shaping how the afflicted experienced colonial and mission-based medicine, even though auxiliaries enjoyed far less medical authority and power than their European masters.

This paper, focusing on the encounter between the missionaries who established Kalene Hill hospital in Zambia's Mwinilunga district under Dr Walter Fisher of the Christian Missions in Many Lands (CMML) in the early twentieth century and Lunda-speaking auxiliaries trained at the hospital from 1922 to 1951, questions academic discourse that casts auxiliary practitioners of Christian medicine as agents of cultural destruction. Without denying that auxiliaries' cultural translation of mission medicine was crucial to the construction of a communicative process that enabled CMML healers to transmit their hegemonic intentions and goals to Africans in Mwinilunga, the paper maintains that the foundation upon which this communicative process rested was a fragile one. In crafting this foundation, medical auxiliaries, the paper argues, extensively drew on Lunda grammar, vocabulary and etiologies associated with the 'pagan' healing culture that the local employees were ironically commissioned to obliterate. Auxiliary employees thus intentionally or unintentionally filtered evangelical medicine with its allied discourse through local medical logic. This not only unavoidably infused the new medicine with 'heathen' ideas, beliefs and meanings but constrained missionaries' efforts to impose their Christian version of modern medicine on Africans through evangelical healing. As a corollary, missionary medicine in Mwinilunga came to be comprehended in ways that were analogous with what its local recipients already knew about disease, medicine and treatment.[16] In this manner, auxiliaries unwittingly subverted the ideological grounds of evangelical medical hegemony, constraining what Rafael Vicente perceptively refers to as 'the universalising assumptions and totalising impulses of a colonial-Christian order'.[17]

This paper further questions the axiom that indigenous auxiliaries on the colonial periphery turned into devotees of 'medical imperialism' who faithfully jettisoned 'traditional' medical beliefs, warmly embraced European bourgeois values and enthusiastically conveyed them beyond colonial and mission enclaves. While acknowledging that auxiliary employees sometimes drew on CMML medical discourse to manage their own cultural and political concerns, the paper asserts that African auxiliaries at Kalene hospital were neither simple creations nor victims of *Pax Brittanica* but self-motivating actors who joined mission work for reasons that all too often were at odds with the expectations of their employers.[18] As such, African medical staff were not incapable of exerting their own influence on local reception and practice of mission-based medicine, notwithstanding that they were employed to operate on the margins of Christian medicine.

'The Gospel of the Syringe'

When the CMML led by Dr Walter Fisher established their medical mission at Kalene Hill at the inception of the twentieth century in what soon became Zambia's Mwinilunga district under the British South Africa Company, debates on the role of medicine in the overall missionary enterprise were still unsettled in most missionary societies. Opinions on the topic were deeply fragmented, with some critics of the 'gospel of the syringe' within the CMML itself dismissing medical evangelisation as a devil-inspired affair that

hindered proselytisation of 'pagan' societies.[19] The detractors, among whom were the editors of *Echoes of Service*, the movement's two-weekly journal published in Bath, England, insisted that medical evangelism produced converts with skin-deep faith. They thus discouraged bio-medically trained missionaries from going overseas. But their opponents countered that modern medicine gave the Christian missionary not just a unique opportunity to carry on the healing ministry began by Christ but to convince 'pagan' societies of His undying love and hence attract them to Christianity.[20]

In the nineteenth century, the influence of the enthusiasts of medical evangelism within the CMML blossomed, thanks to the scientific breakthroughs in European medicine in the latter part of the century. This influence was further encouraged by the nature of the movement itself. Founded in Britain and Ireland in the early decades of the nineteenth century by a small but growing group of middle-class believers who vehemently opposed institutionalised religion (with its rituals) and strictly adhered to the literal interpretation of the Bible, the CMML was a loosely structured missionary agency. Unlike most other agencies, it was devoid of a distinct policy on how non-Western societies could best be converted to Christianity, possessed no central policy-making organ or headquarters, and, other than the Bible, no book of regulations for its followers to observe. CMML clerics in Africa or elsewhere were consequently at liberty to craft their individual evangelical discourses and to pursue their strategies, or change them without direction from above. Unsurprisingly, the CMML had by the closing decades of the nineteenth century turned into the hunting ground of the individualistic. Some of these missionaries successfully used their scientific knowledge of healing to rise to eminence and to convert people to Christianity.[21]

Dr Walter Fisher, the founder of Kalene mission hospital, was one of those eminent figures. A medical missionary par excellence, Fisher was born in 1865 in a middle-class family in England. An heir to the major advances that occurred in Western medicine in Europe in the second half of the nineteenth century, Walter Fisher graduated with a gold medal in surgery in 1887 from Guy's Hospital in London. He first gained practical experience in Morocco and Angola, before he relocated his medical mission to Kalene Hill in Mwinilunga, Zambia, at the inception of the twentieth century. Dr Fisher strongly endorsed the Christianisation of extra-European societies through biomedical healing. He shared the universally held view that Africa's cultural, spiritual, material backwardness largely stemmed from the continent's 'irrational' beliefs linked to disease and healing. However, unlike other missionaries who felt that they could overcome this obstacle through exposing Africans to Western education, the surgeon saw the epoch-making advances in bacteriology, protozoology and entomology of the nineteenth century as a God-ordained weapon that he and other missionaries in Africa could wield to overcome the 'heathenism' of the 'Dark Continent'.

The missionary doctor believed that unless Africans came to appreciate disease as a matter of physical dysfunction engendered by germs rather than a product of imbalances in social relations, as they did, they would never give up their deeply entrenched 'pagan' beliefs in ancestral/witchcraft affliction.[22] Unless this obstacle was removed, the doctor often argued, the African mental world would continue to be 'crammed with hideous fears', fuelled by other 'irrational' beliefs and related practices that stood in the path of African conversion to Christianity. To Fisher, these beliefs had to be dispelled not only because they were an embodiment of 'heathenism' but also because they encouraged converts in Africa to backslide into 'pagan' healing rituals in times of affliction, thus

marring their faith in Christ.[23] The missionary hoped that by demonstrating to sceptical Africans the power of evangelical medicine over disease, he would undermine their 'superstitious' medical beliefs, enhance their receptivity of Christianity and set them on to the path to civilisation and modernity.[24] Claiming universal validity for his medicine and speaking with the authority of science, the surgeon sought to occasion a profound conceptual transformation in local cosmologies and practices as a way to refashion the African society in his own image.

As conceptualised by the surgeon and other missionary healers, medical evangelism therefore entailed that African patients would follow a teleological progression from embracing the Christian variety of scientific medicine to abandoning their 'heathen' culture, along with its underlying belief systems. This discourse, of course, left no room for ambiguity, syncretism or cultural exchange between European and local medical systems. Its architects were as passionately convinced that their medicine was the only rational way of combating human affliction as they believed in its power to purge the non-Western world of 'pagan' beliefs and to plant Christianity, civilisation and modernity there. In sum, 'the gospel of the syringe' was an integral ingredient of the wider Western 'civilizing mission', which construed all pre-Christian forms of medical knowledge and religion as its 'primitive Other', in dire need of reconstructing in European image.[25]

Linguistic Obstacles in Medical Evangelism

The political environment in which Dr Fisher launched his 'civilising mission' in Mwinilunga could not have been more favourable. Eager to 'pacify' the district and increase European presence in North-Western Zambia as a whole, the British South Africa Company (BSAC) government quickly routed slave traders from the area in order to make it safe for Christian evangelisation. The BSAC further joined hands with the CMML in harassing and imprisoning local healers and diviners, whom missionaries at Kalene Hill regarded as their ontological foes who competed for the same clientele.[26] Despite this spirited support from the colonial government, refashioning the Lunda society according to missionary precepts and values proved more difficult than the CMML evangelists had anticipated. Although Dr Walter's hospital at Kalene had by the 1920s become a model Christian medical centre for other mission hospitals in the territory, it produced far fewer converts than patients.[27] His patients, as the surgeon himself often lamented, displayed keen interest in the curative benefits of his medicine, but they were less interested in his microbial explanations of disease causation, let alone the Christian theories of salvation to which patients at the hospital were routinely exposed.[28] Colonial authorities, who periodically inspected the mission hospital between the 1920s and 1950s, equally observed that for every patient admitted to Kalene hospital, half a dozen or so gave it a wide berth. According to the officials, some ex-patients continued to seek divination in nearby Angola or the Belgian Congo, where anti-witchcraft legislation either did not exist and the enforcement of similar legislation was reportedly or more lax than in colonial Zambia respectively.[29]

Particularly worrying to the CMML as a whole was the tenacity of local etiologies of disease and the obstructive persistence of related practices among early Lunda Christian converts. Sixteen years after the inception of medical evangelism in the district, a Kalene-based missionary expressed this concern when he despairingly told the readers of the *Echoes of Service* that 'The fear of witchcraft with these people is ever present and even the

native Christians cannot rid themselves wholly of it.'[30] A few years later, another cleric at the hospital reiterated the complaint to a visiting colonial functionary, noting that Lunda patients and ex-patients regarded mission medicine as if it was another form of witchcraft and that in times of sickness, 'the first thought of the native [was] not whether a dose of Epsom salts would cure him, but which of his ancestral spirits must be appeased with offerings and incantations'.[31]

Many factors may explain why Africans in Mwinilunga were slow to embrace missionary medicine on the terms of its European dispensers. The most important of these factors, however, lay in the language constraints coupled with the linguistic diversity CMML evangelists encountered in the district, which hampered their efforts to express mission medicine meaningfully to the local people. While the Christian emissaries themselves communicated in English, their African interlocutors spoke languages as diverse as Chiluba, Silozi, Kaonde, Chokwe, Mbunda, Luchazi, Luvale, and Lunda.[32] These languages, save for Luvale and Lunda, were phonetically and morphologically as dissimilar as Provincial English is from Scottish.[33] This linguistic situation constituted a formidable obstacle to exchange between missionaries and Africans seeking mission treatment. But the earliest doctors at Kalene were ardent believers in the translatability of all human languages, as we shall see. Unsurprisingly, they at first endeavoured to learn all the languages spoken in the area. By the 1910s, however, such efforts had proved impractical, compelling the CMML healers to concentrate on studying Lunda, the most widely spoken language in the district.

But learning Lunda itself turned out to be a no less daunting task. This was not least because the language occurred in three distinct dialects with some words spoken in one dialect completely missing in others[34] but because the dialect spoken in Mwinilunga was fraught with its own obstacles. These difficulties, aptly chronicled in the linguistic works published in the 1940s by Dr Walter Fisher's son, William Singleton Fisher and Singleton's wife, largely arose from the nature of the dialect.[35] Not only were the dialect's strange phonetic characteristics bewildering to the English ear but the complicated workings of the dialect made the mastery of even such basic features such as verbs, prepositions, spellings and formatives highly problematic. As the linguistic couple observed, some Lunda verbs, for example, were/are inclusive in meaning and thus need(ed) no supporting words to make them complete (e.g. *tama*, 'be bad' or *waha*, 'be good', in both of which the English 'be' was/is included). Other verbs included meanings of prepositions (e.g. *tenteko*, 'put down', *tala*, 'look at', *dila*, 'cry for').[36] Compounding the challenge needed to master these demanding grammatical rules was that when some Lunda prefixes and suffixes were added before or after a stem or root of a word, they form(ed) tenses, indicate(d) persons or things, or all together alter(ed) the application of the verb. Moreover, some Lunda words spelt in the same way but spoken in different tones conveyed entirely different meanings (e.g. *manùñu*, 'knees' and *manúñu*, 'pots'), while minor shifts in the speaker's tone sometimes conveyed changes in tense (e.g. *wa kàta*, 'he was ill' and *wa káta*, 'he is ill').[37]

The complicated workings of the Lunda dialect meant that knowledge of its grammar and vocabulary was not sufficient for one to become proficient in the language, and its English student had to constantly 'train his ears for inflexions, neat turns of speech, and new words'.[38] For most missionaries at Kalene Hill, however, many years of such strenuous efforts produced poor results. Elsie Burr, an English nurse who worked at

Kalene hospital from the 1920s to the 1950s, observed that even after a prolonged period of studying the Lunda language spoken in Mwinilunga

> one can still sit and listen to village women talking among themselves [in Lunda] and not even get the gist of what they are saying. In meetings one can pick out heaps of words and yet not get the drift of the message. At Kalene, woe betide a new young missionary who appeared at the meeting without a notebook and pencil dangling round her neck. The strain of listening, listening, all the time, picking out what one thinks is a new word and writing it down, only to be told afterwards that it is composed of the latter half of one word and the front half of the next! One wrestles with prefixes and suffixes and locatives, etc.[39]

Confronted with such an exacting language, the majority of CMML missionaries unsurprisingly 'acquired just a smattering of the language'.[40] Some doctors, to be sure, improved their command of spoken Lunda in later years. However, literacy in Lunda continued to elude them, as is borne out by the fact it took Christian evangelists at Kalene Hill more than two decades to translate the New Testament, and not less than fifty years the whole Bible.[41]

Rising language proficiency in spoken Lunda among missionaries in later years did not necessarily reduce the linguistic gulf between Europeans and the local people. Christian healers in Mwinilunga soon discovered that their ability to speak Lunda was not a passport to meaningful dialogue between the two parties, for the local language lacked concepts equivalent to those in which Western medical evangelists articulated their Christian and their scientific medical beliefs. Thus, for example, translating such Christian terms as the 'Holy Spirit' and 'God' through the respective the Lunda words for ancestral spirits (*akishi*) and 'Creator' (*Nzambi*) spawned entirely new unexpected comprehension of Christianity among local converts and patients, igniting furious misunderstandings between Africans and missionary medics, as well as within evangelical circles in the district.[42]

Even more challenging for CMML Christians was to find local terms to interpret scientific, medical and technological concepts. This turned out to be a particularly difficult task because of the lack of resonance between Western and Lunda medical and technological conceptions arising from the conflicting worldviews associated with Western and local medical culture and knowledge. Missionaries in Mwinilunga from early on thus encountered insurmountable barriers as they tried to convey the scientific implications loaded in Western terms like 'disease' 'medicine' and 'germs' across the linguistic and cultural boundary that separated the medics from the Lunda-speaking people. Interpreting biomedical technologies such as the microscope, X-ray and the stethoscope that lacked equivalents in the local healing culture or vocabulary proved even more difficult.[43]

These language nightmares militated against conceptual and linguistic transfer between Christian missionaries and their Lunda-speaking converts and patients. Consequently, the two parties essentially brought to their medical engagement conflicting sets of values and meanings, leading to endless misunderstandings and mistranslations in their daily interactions. Apart from preventing the CMML clerics from transmitting their religious and medical ideas to the indigenous population, this situation meant that the missionary

society could hardly dictate the terms on which missionary medicine and technologies were locally accepted, popularised or internalised.

Translating Mission Medicine and Contracting Christian Medical Hegemony

Faced with these language hiccups and with expanding demand for mission medicine in the district in the early 1920s, Dr Walter Fisher began to train medical auxiliaries at the hospital in March 1922.[44] How missionaries trained auxiliaries in colonial settings has lately been a subject of growing concern to academics in recent decades.[45] For the purpose of this study, it will suffice to merely explain why Walter Fisher, who dominated African medical training at Kalene hospital until his death in 1935, came to place a premium on producing local nurses, midwives, ward attendants and medical orderlies.

From the outset of the training programme at Kalene Hill, the surgeon made it clear that the central goal of the exercise was to imbue a small number of Africans with microbial theories. This training could inscribe on auxiliaries biomedical comprehension of disease and treatment and convince them of the rationality, efficacy and superiority of scientific medicine over 'pagan' therapeutic knowledge and practices.[46] Unable to recruit a qualified medical tutor, establish a modern medical school or equip it with teaching gadgets due to fiscal limitations, Fisher settled for instructing his trainees in elementary physiology, anatomy and entomology.[47] But the mission doctor placed greater emphasis on teaching them about the moral duty and virtues incumbent upon every Christian convert.[48] His training programme was therefore an amalgam of scientific training and moral preaching. To the missionary, this elementary course taught in English was sufficient to erase 'pagan' medical beliefs from the minds of its recipients, creating a slate upon which the surgeon could then craft biomedical constructions of disease causation and treatment. In Dr Walter Fisher's own metaphorical terminology, the training could liberate African auxiliaries 'from the terrible bondage of [their] belief in witchcraft' so that they would assimilate scientific conceptions of disease, while simultaneously appreciating Christ as the Great Healer 'who overcame death and in so doing defeated all the powers of Hell'.[49] To the surgeon, transformation in the etiological conceptions of local auxiliaries was a short step to their acceptance of Jesus Christ as the ultimate Healer.

Fisher aimed at more than transforming medical auxiliaries' etiological beliefs. Like other missionaries, he also wanted to socialise his trainees in European values and modes of behaviour. The doctor endeavoured to awaken in the auxiliaries a deep appreciation for such European middle-class values as diligence, literacy, reliability, nuclear family life, time-keeping, subordination to superior authority, strict discipline and Christian moral codes. In the apt phrase of one of the medical orderlies whom the missionary doctor trained at Kalene hospital in the late 1920s, Ndotolu, as Fisher was affectionately known in Mwinilunga, 'wanted to turn his students into black Englishmen', who, apart from internalising the values of the Western way of life, would forsake their own medical and belief systems.[50] The missionary saw these bourgeois values as critical to the reconstruction of the African character as they were central to the maintenance of the standards and integrity of Western medicine, which African auxiliary personnel were expected to faithfully uphold.[51]

The medical training Africans at Kalene hospital received may, in short, be construed as a significant element of the wider Western social engineering project across the continent that entailed no less than etching new social, cultural and medical identities on

a privileged few. These lucky individuals, paternalistically referred to as 'progressives' in colonial/mission terminology, were to be in the frontline of their employers' crusade to demolish the evil forces of 'paganism' in order to bring light to the 'Dark Continent'.[52] In addition to making a complete break with their 'pagan' past and deferring to Western values, auxiliaries were to carry their newly acquired values and identities beyond the confines of Kalene hospital, living as role models in their villages. There, they were to demonstrate the superiority of Christian medicine over 'traditional' therapeutic system, undermine the ontological power of the 'traditional' healer, inscribe their new identities upon their fellow Africans and, ultimately, draw them into modern ways of seeing and being.

Although the CMML recognised the centrality of indigenous workers to the evangelical endeavour to reconfigure the African society, the training the agency offered them was too elementary. This training could at best only produce humble, faithful servants who would operate on what a leading scholar perceptively refers to as 'the fringe of modern medicine'.[53] Auxiliaries trained and employed under the CMML were thus not to be drawn into dialogue on the basis of equality with missionaries. Much as their training was designed to turn them into the vanguard of cultural reconstruction, Kalene-trained graduates were expected to be subservient assistants. In this way, they, like their counterparts elsewhere in Africa, could not acquire 'an easy confidence in their own powers', and thereby pose a threat to the medical authority of their European masters.[54] The ideal auxiliary employee was to be an adjunct in the CMML's *mission civilisatrice*, recognised by his/her meagre authority that would neither approximate nor threaten the authority of the European doctor or nurse.

The decision to deny African medical practitioners the authority enjoyed by white medics and paramedics was calculated to reduce the former to performing menial jobs ranging from nursing patients, taking their temperatures and preparing them for operations to administering simple medications, sterilising surgical equipment, treating minor illnesses and dressing wounds. More fundamentally, this decision was intended to ensure that auxiliary personnel at Kalene were humble interpreters who could translate Christian medicine in conformity with the dictates of their missionary employers. Yet *how* exactly medical auxiliaries would translate evangelical medicine so that it turned into an instrument of cultural domination was a question CMML evangelists rather assumed than seriously addressed. Adherents to the literal interpretation of the scriptures, Christian missionaries in Mwinilunga believed that the translation of Western medicine with its underpinning belief system into African languages would be a God-inspired affair and hence unproblematic.

As Birgit Meyer shows, this simplistic assumption, which was universally shared in Protestant circles, derived from the Christian myth that made connections between the Old Testament account of the Tower of Babel and the New Testament discourse on the gift of the Holy Spirit at Pentecost.[55] According to the myth, all human beings once spoke a common language and worshipped one God. But because people challenged God's power by trying to reach Him through building the tower, He punished them by both destroying the building and dividing humanity into various ethnicities. Each ethnic group, the myth went, developed its own language and forms of worship that degenerated over time, distancing people further from the true God. However, at Pentecost when Christ's disciples spoke in foreign tongues through the Holy Spirit, God not only demonstrated the translatability of all human languages, He also mandated all

Christian believers to learn languages in distant lands so that they could preach the Good News across the world and hence reunify all races in the worship of the Christian God.[56]

As already noted, CMML evangelists in Mwinilunga subscribed to this myth despite their faith in medical science. They therefore saw Lunda and all the other African languages they encountered in the area as potentially translatable. They believed that these languages possessed word forms, terms or concepts adequate for the expression of Christianity, as well as for the interpretation of Western medicine. To this end, CMML emissaries at Kalene hospital expected African translators, over whose work of translation missionaries endlessly beseeched God's guidance, to interpret missionary medicine in ways that were linguistically correct and scientifically accurate, reflecting the clerics' own medical beliefs and expectations rather than those of the local interpreters.[57]

The missionaries' prayers seem to have been seldom answered. Auxiliaries' command of English, the language through which they were trained, seems to have been as limited as their employers' mastery of Lunda. Generations of colonial medical doctors who periodically inspected Kalene hospital between the 1920s and 1950s routinely attributed the lack of English competence among medical auxiliaries to what the inspectors regarded as the gross neglect and subordination of African education by the CMML to medical work.[58] This criticism may not have been unfounded. As late as the 1940s, the highest level of education obtained by medical students at Kalene did not go beyond Standard Three.[59] Most of the students enrolled at Kalene thus possessed just a stammering knowledge of English, or none at all. Such insufficient command of the language frustrated their efforts to translate complicated scientific concepts and technologies into vernacular. This obstacle was deeply compounded by the lack of African terms through which the local interpreters and missionaries could express modern medical terms.[60]

In view of the elementary training the auxiliaries received and of their lack of proficiency in English, the employment of auxiliary workers at Kalene hospital did not fundamentally erode their pre-Christian etiological beliefs or transform them into pliable agents of missionaries. Dr H. S. de Boer, the colony's Deputy Director of Medical and Sanitary Services, who visited the mission hospital in 1933, confirmed this observation when he remarked that despite their training in medical science, African auxiliaries at the hospital continued to adhere to 'traditional' notions of healing and regarded European medicine as no more than 'advanced witchcraft'. The Deputy Director lamented that the ubiquity of such beliefs among African auxiliaries at Kalene and beyond reflected their poor knowledge of medical science. This, the doctor added, prevented missionaries and the government from building a satisfactory medical practice in the colony.[61] Dr de Boer probably underestimated the auxiliaries' knowledge of modern medicine, for both oral and mission accounts unanimously agree that bio-medically trained auxiliaries appreciated microbial theories of disease causation, with many of them becoming highly adept at identifying disease-causing bacteria using the microscope.[62] Nonetheless, de Boer's sentiments underscore the fact that despite such an appreciation, auxiliary personnel employed at Kalene Kalene Hill did not completely turn their back on 'pagan' notions of disease and medicine, even after a lengthy period of patient training at the feet of the CMML.

This observation was most poignantly confirmed by a piece of fascinating research carried out in the late 1940s by P. C. G. Adams, the Superintendent Tutor at the colony's government-run medical training college in Lusaka. To ascertain the extent to which

training in modern medicine influenced African conceptions of disease and medicine, Dr Adams interviewed twenty-nine senior medical students two years into their course in Lusaka. To Dr Adam's dismay, twenty-one (70 per cent) of these students listed witchcraft, witches and magic in descending order of importance as the major causes of disease; sixteen (55 per cent) attributed disease to charms alone; and twenty-seven (92 per cent) of the interviewees admitted to having sought local medicine after the commencement of their training in Lusaka. One of the students, who insisted that it was not germs but witchcraft that caused death, confessed to having consulted a witchdoctor to ascertain the death of his uncle. What is most revealing about Adams's research is that nearly all his respondents either had prior medical training or had worked at government or mission hospitals, including the one at Kalene Hill.[63] Clearly, training in medical science hardly implied wholesome rejection of indigenous paradigms of disease and treatment among auxiliaries.

As African auxiliaries continued to adhere to indigenous cosmologies of disease and healing, it is no surprise that in translating evangelical medicine with its allied discourse into the Lunda language, they drew more on pre-existing medical knowledge, ritual grammar and vocabulary than on scientific discourse. This meant that auxiliary employees interpreted evangelical medicine largely through existing 'pagan' medical idioms, coining as few new terms as they could.[64] This view finds support in two broad categories of the vernacular translations auxiliary staff at Kalene crafted to express Western medical concepts and technologies,[65] translations which found their way into mission-authored Lunda dictionaries and grammar books in the 1940s and 1950s. The first category consists of vernacular terms auxiliaries appropriated directly from the local medical and ritual vocabulary to gloss key Western concepts like 'disease' (*musongo*, pl. *nyisongo*), 'medicine' (*yitumbu*, pl. *nyitumbu*), 'diagnosis' (*kusolola*) and 'prescription' (*kulumbula kwa yitumbu*), etc. A comparative analysis of the meanings missionaries read into the first three concepts, viz. 'medicine', 'disease', 'diagnosis' with those that issued from their respective Lunda interpretations offers a clue to how auxiliaries' cultural translation of Christian medicine served as a double-edged chisel by which auxiliary workers at Kalene Hill unwittingly helped the CMML in establishing its foundation of medical hegemony in the district but simultaneously whittled away at the fabric of the very foundation.

To the CMML, 'medicine', which auxiliaries glossed as *yitumbu*, connoted the science of preventing or treating affliction through the use of drugs, diet or surgery. But *yitumbu* lacked the finer scientific connotations or meanings missionaries invested into 'medicine'. *Yitumbu* consisted of substances, incantations and rituals that the Lunda believed possessed sufficient power (*ngovu*) to drive away disease (*musongo*), which was itself broadly defined to embrace physical disorders and ill-luck in life believed to be caused by disruptions in the patient's lineage or offended ancestral spirits (*akishi*).[66] As Victor Turner who carried out extensive anthropological research in Mwinilunga observed in the 1950s, *yitumbu* was therefore as much employed to combat physiological disorders as it was used to reorder broken social relations within the patient's lineage, to restore harmony between the living and the living dead, and to ward off misfortune and guarantee success in various pursuits of life. Its practitioners thus operated on a much wider range of frontiers than missionary doctors. Apart from confronting human affliction, they shielded their clients from failure in such diverse pursuits as hunting, marriage and politics, etc. In Paul Landau's memorable phrase, those who practised

yitumbu 'sought wellness for others in a domain extending far beyond the body'.[67] *Yitumbu,* from this perspective, was at best a gross mistranslation that eluded the meanings the CMML invested in its medicine.

This argument may similarly be extended to *musongo* and *kusolola* that auxiliaries appropriated from local ritual discourse to define the Western terms 'disease' and 'diagnosis' respectively.[68] 'Disease' to medical evangelists was essentially a physiological disorder within the human body. By contrast, *musongo,* its vernacular translation, represented more than just the dysfunction of the body. *Musongo* was by and large a metaphor for disordered social relationships between kinsfolk held to be induced by envious witches or matrilineal spirits offended by their living relations' quarrels, hidden grudges (*yitela*), and failure to offer sacrifices to the living dead (*akishi*). In this context, the Lunda comprehended disease as a reminder of the presence of hidden grudges or witches within the patient's social group and/or of the displeasure of ancestors (*akishi*).[69]

Turner's works show that *musongo*'s victims were held to experience misfortune (*malwa*) or, in Lunda ritual phraseology, to be in a 'state of darkness' (*mwidima*), 'lacking whiteness or purity' (*kubula kutooka*), 'whiteness' denoting strength (*wukola*), health (*kuhanda*) and life (*wumi*).[70] Even as late as the 1950s, Turner noted, a large measure of the treatment of *musongo* among the Lunda therefore occurred in a ritual context.[71] Besides seeking to remove the afflicted from the state of 'darkness' to a 'white' state and hence good health, the treatment was intended to normalise broken social relationships, neutralise the evil spell of witchcraft and to appease the malevolent *akishi.* Comparatively, then, *musongo* was not merely pregnant with 'pagan' etiological and symbolic meanings; it also eluded the meanings missionaries read in their concept of 'disease'.

The gulf in meanings between Western and Lunda conceptions of disease and medicine further extended to 'diagnosis', defined by auxiliaries as *kusolola.* Diagnosis to missionaries was/is no more than an art by which bio-medically trained personnel could by using scientific techniques or experiments track down pathogens localised in the human body. This process entailed objectifying the afflicted, changing them mentally from suffering victims 'into an integrated set of physiological processes', identifying which of those processes were dysfunctional and treating them irrespective of the social status of the patient, or his/her personality.[72] This complicated process was the province of medical experts in which the patient and the patient's kin and kith played only a trivial role, or were entirely excluded.

In both semantic and practical sense, *kusolola* widely diverged from scientific diagnosis. Because the Lunda conceptualised hidden animosities and invisible etiological forces as the root of human affliction and conceived of disease as a state of 'darkness', *kusolola* (derived from the root *solola,* or 'reveal' or 'make visible what is hidden or private') was an act of bringing into the public domain such invisible forces so that they could be identified and contained. *Kusolola,* unlike mission diagnosis, thus took on a social and public character, inexorably involving the patient, his/her kinsfolk and ritual experts. Initiated by the patients' relations, *kusolola* should be thought of as an etiological discourse intended to ascertain what problematic relationships in their lineage may have induced a witch (*muloji*) or the *akishi* to inflict sickness upon the patient (*muyeji*). This discourse was either confirmed or rejected by a ritual expert or diviner (*mukwakuhong'a*). As Turner observed, the *mukwakuhong'a* accomplished this task through an etiological debate involving the diviner, the patient and the patient's relations. Through the debate and by symbolically manipulating divinatory apparatuses (*ngombu*), the diviner

untangled the web of conflicting relationships at the origin of the disease, re-contextualised the relationships in a wider cosmological sphere, identified the offending the witch or spirits and prescribed remedial action.[73] *Kusolola,* in sharp contrast to scientific diagnosis, was thus a form of social analysis in which all concerned parties actively participated to arrive at what caused affliction so as to contain it.[74]

The second group of vernacular translations that merits brief attention comprises terms and phrases African auxiliaries crafted from English speech, as well as from popular discourse to express scientific technologies that lacked equivalents in Lunda medicine. Included in this category were such diagnostic technologies as the microscope, the stethoscope and X-ray, which auxiliaries interpreted, respectively, as *ikina da kusolola tububu* (literally 'machine for revealing small insects'), *ikina da kutiyilila muchima* ('machine for listening to the heart') and *ikina da kusolola musongo* ('machine for revealing disease'). In a move that lends support to the argument that auxiliaries were constructively engaged in what some scholars have described as 'lexical borrowing', auxiliary employees at Kalene Hill borrowed the term *ikina* (after the English, 'machine') from the technological speech of their employers.[75] Yet to familiarise each *ikina* and to convey a notion of its use to patients, the employees added to the term phrases appropriated from existing secular vocabulary (e.g. *tububu*, i.e. 'small insects' and *da kutiyilila,* i.e. 'for listening'), or, more ironically, from Lunda ritual vocabulary (e.g. *musongo* and *kusolola*). In so doing, the auxiliary employees embedded in scientific technologies diagnostic meanings drawn from local medical discourse, rendering the technologies vulnerable to reinterpretation in ways that were peculiarly African and hence fundamentally at odds with CMML expectations, as demonstrated below.[76]

It will be apparent from the brief analysis above that auxiliary interpreters of Christian medicine at Kalene sought to render the new medicine locally comprehensible by interpreting it through familiar or familiarised terms appropriated from Lunda medical discourse and by limiting the terms they borrowed from the colonial and technological speech of their masters. In this way, auxiliaries unwittingly filtered evangelical medicine through local orders of meaning, unintentionally investing in Christian therapeutics 'pagan' notions embedded in the vernacular translations. Mission archives and memoirs strongly suggest that it is these 'pagan' connotations and meanings that in fact came to guide how Africans understood and debated mission-based medicine. In numerous letters to his main benefactor in Europe between 1922 and 1935, Dr Walter Fisher himself frequently wrote of African patients who endlessly asked him to cure them of witchcraft/ancestral affliction, who persistently implored him to use the microscope to reveal (*kusolola*) whether their afflictions issued from the *akishi* or witches, and who unfailingly insisted on taking an active part in diagnosing their diseases and sometimes rejected his diagnosis.[77] To these patients, Fisher was no different from 'traditional' healers, whose medicine the missionary contemptuously dismissed as 'fetish' remedies.

But perhaps a more convincing illustration that Lunda-speaking patients at Kalene Hill hospital comprehended Christian medicine in the same way as they understood their own medicine emanates from the memoir written by Elsie Burr, the missionary nurse to whom learning Lunda was an uphill task. According to the nurse, 'old grannies' who escorted patients to the mission hospital not only often insisted on taking part in diagnosing patients' diseases, as was the tradition in Lunda village, but they also sometimes refused to follow European medics' prescriptions (in the same way that they would reject diviners' interpretations of disease). To Burr's utter surprise, patients, too,

frequently argued with missionaries over treatment and used mission medicine as if it was *yitumbu* administered by 'traditional' healers in local villages. Elsie Burr wrote of one of such encounters in detail:

> One day when I was surrounded with patients, I handed two tablets (one of quinine and one of aspirin to a man who had malaria with bad headache'. I explained to him to swallow the tablets with some water, and passed on to the next patient. Later I saw the first man with the tablets tied to his forehead with a piece of backrope! I explained again to him that the medicine would not help him at all unless he swallowed it, but he did not again. 'Ndona' [madam], he explained patiently, 'the pain is in my head, not in my tummy; if I swallow these tablets, when will they reach my head?'[78]

Burr and other missionaries at Kalene mocked such responses to Christian medicine as a reflection of African mystification of scientific medicine. However, seen from the perspective of medical auxiliaries' creative labour of translation, mission-authored accounts that mystify African responses to evangelical medicine may be read as indicative of the fact that Lunda-speaking patients seeking treatment at Kalene Hill hospital embraced Christian medicine not as a superior form of confronting human affliction, but as yet another form of 'pagan' healing.[79] This reaction was not peculiar to the Lunda-speaking people. Khama, the Tswana chief who constructed the kingdom of GammaNg-wato out of the ecclesiastical pronouncements and practices of European missionaries in nineteenth-century Botswana, similarly approached missionary medicine together with its underlining belief system 'as if it were a variation on the practice' of local medicine.[80] These reactions, as Larson argues most powerfully in his theoretical study of African reception of Christianity in nineteenth-century Malagasy, attest to the global phenomenon in which colonially dominated societies appropriated and yet altered European discourses and made them their own.[81]

In Mwinilunga, therefore, missionary medicine, much like the Christian belief system it underpinned, came to be characterised by a paradox. Although its CMML dispensers drew a strict boundary between Christian and local medicine, the former was locally expressed and apprehended through 'pagan' terms and grammar derived from Lunda medical culture, which CMML medics vilified as the citadel of heathenism.[82] Stated differently, African medical culture, logic and vocabulary provided the framework through which both local patients made sense of evangelical medicine. This acculturated the missionary medicine in local medical or cultural meanings and values, at least in the eyes of African patients to whom auxiliary employees always interpreted missionary medicine through existing medical and ritual vocabulary. Thus, patients seeking treatment at Kalene Hill saw little difference, if any, between the so-called Christian medicine and their own therapeutic systems.

The significance of the contribution medical auxiliaries made to shaping the outcome of missionary–African encounter cannot be over emphasised. Auxiliaries' vernacular translations provided the raw materials of the communicative process through which European clerics could plant their medical hegemony, declare their intentions, and articulate their universalising claims in their daily encounters with Africans. Yet the foundation of this communicative process was a fragile one, for, as already noted, auxiliaries fashioned the foundation from 'pagan' concepts auxiliaries appropriated from

pre-existing medical culture and ritual vocabulary. In expressing the Christian version of Western medicine through such idioms, auxiliary workers drained the alien medicine of its scientific connotations. They thus created a space behind which they lodged into Christian medicine 'pagan' meanings, a situation that white CMML medics could not prevent or control even though they enjoyed greater social, political and medical power over their black employees. Through their vernacular translations, then, medical auxiliaries knowingly or unknowingly subverted their employers' two-prong imperial agenda aimed at demonstrating to Africans that mission medicine was superior to 'traditional' therapeutics and deploying missionary medicine with its African dispensers as a lethal weapon against indigenous medical knowledge and repertoire.

By the 1940s and 1950s, Christian evangelists in the district were not unaware that vernacular interpretations of mission medical concepts and technologies crafted by Lunda-speaking auxiliaries hardly conveyed the message the CMML wanted to impart to Africans. By the Second War World, some missionaries at Kalene were indeed blaming this situation on what they saw as childlike African incapacity to grasp complicated English concepts and to translate them into the local language. Others not only pointed an accusing finger at the elementary nature of the training auxiliaries received at the hospital but successfully lobbied for its replacement by a more advanced training programme in 1951.[83] Few of these evangelists, however, ever seriously questioned whether the Lunda language with its terms and concepts was an appropriate medium for interpreting Western medicine. Like most other Christian evangelists elsewhere in Africa, CMML medics all took it for granted that Lunda words or concepts (significants) could be emptied of their 'heathen' contents (signifiers), loaded with Western values and thus used to transmit scientific knowledge across the cultural gulf between CMML clerics and Africans.

But words, as a perceptive scholar recently remarked, have an uncanny power to hold on to their old meanings, even when spoken across linguistic and cultural boundaries.[84] Such words as *musongo*, *kusolola*, and *yitumbu*, through which 'traditional' healers also plied their trade, did not therefore drop their ritual or 'pagan' signifiers but retained them long after they were appropriated to define the English 'disease', 'divination', and 'medicine' respectively.[85] When medical auxiliaries and missionaries alike used these words to express evangelical medicine, they unknowingly infused it with the old signifiers associated with those concepts. In Mwinilunga, it was these meanings over which the CMML had no control that, at the risk of repetition, guided how Christian medicine and its technologies were locally grasped, debated and sometimes used. This casts a long shadow on the notion that European missionaries in Africa so successfully colonised indigenous languages that they transformed them into an effective instrument of cultural subordination and suppression.[86]

Kwikala Chiwayi or 'Living Well'

It may be clear from the foregoing analysis that African interpreters of missionary medicine did not share their European masters' cultural agenda and not transform their mission employment into a mechanism of cultural annihilation. If one is willing to accept this argument, it is still necessary, however, to explain why Africans in Mwinilunga so enthusiastically answered the calling of mission healing. Interviews with former auxiliaries who worked at Kalene suggest that the reasons why people joined mission

medical employment in fact varied from person to person but seldom conformed with the expectations of the CMML.[87] Reminiscent of the popular practice in which the first step to the office of healing among the Lunda was successful treatment in a cult of affliction,[88] a few people in early colonial Mwinilunga became auxiliaries only after their recuperation at the Christian hospital.

The majority of the earliest medical trainees, however, mostly came from socially marginalised backgrounds. They were either orphans who lost their parents in the incessant slave wars of the nineteenth century and grew up at the mission orphanage at Kalene or the offspring of slaves who sought sanctuary at the station in the first decade of the twentieth century and formed the nucleus of the first CMML congregations in the district in the 1920s.[89] To these marginalised people, mission employment offered the surest way to escape the constraints of their 'lowly birth', and to realise what the Lunda popularly describe as *kwikala chiwaya*, roughly translated as 'living well'.[90] An omnibus of meanings, *kwikala chiwayi* transcended the acquisition of material comfort made possible by mission income. More importantly, 'living well' among the Lunda encompassed the fulfilment of traditionally recognised goals.

In his elegant study, *Schism and Continuity in an African Society*, Victor Turner convincingly demonstrates that one of the most cherished cultural goals of among Lunda adults before and after the 1950s was to establish one's following, and Turner shows the great lengths people in Mwinilunga could go to attract such followers. Attracting followers, as the anthropologists observes, was the indispensable step to establishing one's own village, becoming a headman and, thus creating ones' social immortality through leaving behind followers who would carry out invocations, rituals and prayers of remembrance after one had journeyed to the land of the living dead (*akishi*).[91] Ample evidence indicates that auxiliary workers in Mwinilunga used their income, social contacts, the influence and the power they accrued from mission employment to fulfil this much desired cultural goal.[92] Most of them thus ended their life not merely as storekeepers or commodity producers but as successful headmen, whose political power sometimes even overshadowed that of hereditary authorities, as if auxiliaries' fathers and mothers had not been slaves devoid of social, economic and political power.

Auxiliaries' ambition to attain culturally valued goals through mission work won no approval from long-standing ruling lineages in the district nor meshed with the CMML plan to turn its African employees into agents of modernity. By the 1950s, missionaries at Kalene were complaining that their mission elite were too steeped in local politics and more keen on material things than on spiritual salvation.[93] Medical auxiliaries were not slow to defend their newly found status from such disapproval by drawing on mission-inspired discourses. To this end, they often projected themselves as politically more enlightened than older ruling lineages and, as frequently, dismissed 'traditional' healers as their primitive subalterns 'who practised the medicine of the devil'.[94] Clearly, auxiliaries echoed the hegemonic medical discourse of the Christian Missions in Many Lands. Yet to translate the movement's medicine into local comprehension, the auxiliary workers invariably appropriated the idioms of the very people they dismissed as their 'lowly' subalterns.[95]

Conclusion

Taking vernacular translation of missionary medicine as its point of departure, this study questions academic discourse that indicts medical auxiliaries employed in colonial

mission hospitals in Africa as accomplices who assisted their employers to subdue African ideologies of disease and treatment. The paper suggests that since auxiliaries largely drew on African languages and 'heathen' concepts to interpret Western medical terms and technologies, they, at least in the eyes of the local people, drained Christian medicine of its scientific connotations and simultaneously invested in it 'pagan' meanings embedded in vernacular terms and concepts, which missionaries neither fathomed nor expected. Evangelical medicine in Mwinilunga thus came to be comprehended as if it was a variation of African medicine and not a superior system of healing. Lunda-speaking employees did not stop at influencing the way mission-based medicine was locally received. They also transformed it into a mechanism for realising traditionally recognised goals, countering the disapproval of such goals from their employers and other quarters by ironically drawing on mission-inspired debates. When *how* medical auxiliaries interpreted Christian medicine and *why* they embraced mission employment are both taken into account, it becomes obvious that academic discourse that presents African medical workers as mere cogs in the wheels of the 'civilising mission' of their European employers requires urgent reinterpretation.

Notes

[1] I wish to thank Professor Megan Vaughan, Dr Giacomo Macola and participants at the African seminar held at Cambridge University on 21 November 2006 for commenting on earlier versions of this paper.

[2] See Lyons, 'The Power to Heal', 202–23; Vaughan, 'Health and Hegemony', 173–201; Arnold, 'Public Health and Public Power', 131–51; and Forbes, 'Managing Midwifery in India', 152–72. For exceptions see Hunt, *A Colonial Lexicon*; Hunt, 'Letter-Writing, Nursing Men and Bicycles'; and Bell, 'Midwifery Training', 293–312.

[3] Forbes, 'Managing Midwifery', 152–53.

[4] Vaughan, *Curing their Ills*, 65.

[5] Lyons, 'Power to Heal', 202.

[6] My insight here derives from Comaroff, 'Images of Empire', 163–97.

[7] See for example, Foucault, *The History of Sexuality*, Vol. I.

[8] There is extensive literature on issues raised here. For examples, see Lyons, 'From "Death Camps"', 69–91; Curtin, 'Medical Knowledge and Urban Planning', 594–613; Arnold, 'Introduction: Disease, Medicine and Empire'; Farley, *Bilharzia*. For a study questioning Western medicine as an effective tool of empire, see Harrison, *Public Health in British India*.

[9] Waller and Homewood, 'Elders and Experts', 71.

[10] Hunt, *Colonial Lexicon*, 159; Vaughan, 'Health and Hegemony', 173.

[11] My insight here derives from Ollumwullah, *Dis-ease in the Colonial State*, 8. See also Hunt, *Colonial Lexicon*, 8–9.

[12] Larson, 'Capacities', 969–70.

[13] The latter point is made in a book on missionary medicine published as late as 2004: Good and Charles, *The Rise and Fall of Missionary Medicine*.

[14] Kalusa, 'Disease and the Remaking of Missionary Medicine', 4; Bell, 'Midwifery Training', 293; Vaughan, *Curing their Ills*, 203.

[15] Hunt, *Colonial Lexicon*.

[16] My insight here emanates from Rafael, *Contracting Colonialism*, 21.

[17] Ibid.

[18] Nandy, *The Intimate Enemy*, xiv.

[19] Beer, 'Development of Medical Missions'.

[20] Ibid.

[21] Kalusa, 'Disease and Remaking of Missionary Medicine', 92–93. See also Tatford, *That the World May Know*, Appendix 1.

[22] Fisher and Hoyte, *Ndotolu*.

[23] National Archives of Zambia [NAZ] HM8 F1/2/2/1, Extract from Anna and Walter Fisher's Diaries, No. 17 (undated); Fisher and Hoyte, *Ndotolu*. This biography was initially published as *Africa Looks Ahead: The Stories of Walter and Anna Fisher of Central Africa*.

[24] NAZ HM8 F1/2/2/1, Extract from Anna and Walter Fisher's Diaries.

[25] Kalusa, 'Disease and Remaking Missionary Medicine', 96.

[26] NAZ KSE 4/1, Mwinilunga District Notebook.

[27] The number of outpatient attendances at Kalene peaked at 10,000 in 1926 alone. See NAZ KSE 6/1/5, Annual Report for the Year ending 31 March 1926.

[28] In 1928 when the number of in-patient and out-patient attendances at Kalene hospital respectively stood at 359 and 15,103, the population of baptised Lunda converts throughout the district was only 57.

[29] NAZ KSE 6/1/4, Annual Report for the Year ending 31 March 1921. See also NAZ KSE 6/1/4, Annual Report for the Year 1928, Annexure XV; NAZ KSE 6/2/2, quarterly Report for the Quarter ended 30 June 1929.

[30] CMML, Echoes of Service, January 1922, p. 166. See also CMML, Echoes of Service, July 1922.

[31] NAZ KSE 6/1/6, annual Report for the Year ending 31 March 1928.

[32] NAZ KSE 4/1, Mwinilunga District Notebook, 1906–64.

[33] Interview with Barry Haigh, CMML Missionary, 4 February 2001. All the interviews cited in this paper were conducted in Mwinilunga in 2001 and 2005.

[34] NAZ KWT 1/1, Balovale District Notebook, 1907–64.

[35] Fisher and Fisher, *Lunda Handbook*; Fisher, *Lunda–Ndembu Dictionary*.

[36] Fisher and Fisher, *Lunda Handbook*, 6.

[37] Ibid.

[38] Ibid., Preface.

[39] Burr, *Kalene Memories*, 16 and 57.

[40] Ibid., 17.

[41] Fisher, *Lampposts*.

[42] Ibid., 159–60. Missionaries in many other parts of Africa had similar experiences. See Spear, 'Toward the History of African Christianity', 6; James, *The Listening Ebony*, 223–25.

[43] Interview with Hilda Wadsworth, former Nurse Matron, Kalene Hill, 7 January 2001.

[44] NAZ KSE 6/1/4, Annual report for Mwinilunga Sub-District for the year ending 31 March 1922; Hilda Wadsworth, Interview cited; Arnold, 'Public Health and Public Power', 148, advances a similar argument for British India. However, Illife, *East African Doctors*, 34–38, maintains that European medical practitioners in colonial East Africa began to train African medical auxiliaries in order to stem the rising tide of disease caused by the First World War.

[45] See Bell, *Frontiers of Medicine*; Bell, 'Midwifery Training and Female Circumcision'; Summers, 'Intimate Colonialism', 787–807; Lyon, 'The Power to Heal'; Forbes, 'Managing Midwifery'; Arnold, 'Public Health and Public Power', and Kalusa, 'Disease and Remaking Missionary Medicine'.

[46] NAZ KSE 6/1/4, Annual Report, Mwinilunga Sub-district, Kasempa, for the Year ending 31 March 1922.

[47] NAZ KSE 4/1, Mwinilunga District Notebook.

[48] Interviews with Basoni Samulozela, former medical orderly, 14 March 2004.

[49] Fisher and Hoyte, *Ndotolu*, 182.

[50] Interview with Brinton Sameta, former medical orderly, 7 January 2001.

[51] These aspirations were shared by several other Europeans involved in training indigenous medical auxiliaries and other mission elite in Africa and beyond. See Vail and White, 'Tribalism', 154; Bell, *Frontiers of Medicine*, 200; Illife, *East African Doctors*; Summers, 'Intimate Colonialism'; Arnold, 'Public Health and Public Power'.

[52] See Fisher and Hoyte, *Ndotulu*. For similar biblical imagery, see Maxwell, 'The Spirit and the Scapular', 292.

[53] Illife, *East African Doctors*, 28.

[54] Ibid., 27.

[55] Meyer, *Translating the Devil*, 57.

[56] Ibid.

[57] This view was shared by many other European missionaries evangelising overseas. Rafael, *Contracting Colonialism*.

[58] NAZ KSE 6/1/5, Annual report for Mwinilunga Sub-district for the year ending 31 December 1926; Hilda Wadsworth, Interviews cited.

[59] Group interview with retired medical auxiliaries, 12 November 2005.

[60] See de Boer, *Northern Rhodesia, Medical Report*, 1–2.

[61] NAZ ZA7/6/7; de Boer, *Northern Rhodesia, Medical Report*; see also de Boer, *Medical Report following Tour*; Kalusa, 'Disease and Remaking Missionary Medicine'.
[62] Interviews with Bernard Sambundu and Joseph Chipisha, former medical orderlies, 13 February 2004.
[63] Adam, 'Disease Concepts among Africans'.
[64] James, *Listening Ebony*, 223, makes a similar point for Sudanese Christians who translated the Bible from English into the Uduk language.
[65] My approach here is informed by Meyer, *Translating the Devil*.
[66] For more details on Lunda conceptions of medicine and disease, see Turner, 'Lunda Medicine', 652–719.
[67] Landau, *Realm of the Word*, 126.
[68] For an excellent analysis of the symbolisms embedded in Lunda religious and medical rituals, see Turner, *The Forest of Symbols*.
[69] Turner, 'Lunda Medicine'.
[70] Ibid.
[71] Ibid.
[72] Cunningham and Andrews, *Western Medicine*, 5.
[73] See Turner, *Drums of Affliction*, and his 'Ndembu Divination'.
[74] Turner, *Drums of Affliction*.
[75] Cited in Hunt, *Colonial Lexicon*, 40.
[76] A similar point has been made by recent scholars interested in unveiling how vernacular translation of Christian concepts into African languages obscured the distinctiveness of the Christian message European evangelists want(ed) to convey to African Christians. See Sanneh, *Encountering the West* and his *Translating the Message*.
[77] NAZ HM8 F1 2/1/1, Walter Fisher to Singleton Darling, 13 November 1928; see also Fisher and Hoyte, *Ndotulu*.
[78] Burr, *Kalene Memories*, 67.
[79] This point is informed by Larson, 'Capacities'.
[80] Landau, *Realm of the Word*, Chapter 1 and 113; see also his 'Preacher, Chief and Prophetess', 1–22.
[81] Larson, 'Capacities'. See also Landau, *Realm of the World* and Meyer, *Translating the Devil*.
[82] That European Christianity in Africa came to be characterised by this paradox is convincingly analysed by Meyer, *Translating the Devil*.
[83] Hilda Wadsworth, Interview cited.
[84] Meyer, *Translating the Devil*.
[85] Rafael, *Contracting Colonialism* and Meyer, *Translating the Devil*.
[86] Fabian, 'Mission and the Colonization of African Languages', 165–87.
[87] Group Interview with ex-medical auxiliaries, 13 November 2005; Kalusa, 'Disease and Missionary Medicine'.
[88] Turner, 'Lunda Medicine'.
[89] NAZ KSE 4/1, Mwinilunga District Notebook.
[90] Group Interview cited.
[91] Turner, *Schism and Continuity in an African Society*.
[92] Group Interview cited.
[93] Burr, *Kalene Memories*.
[94] Group Interview cited.
[95] For a stimulating discussion on this topic, see Hunt, *Colonial Lexicon*.

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