Medical Training, African Auxiliaries, and Social Healing in Mwinilunga, Zambia

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Introduction

After the Second World War, medical missionaries of the Christian Missions in Many Lands (CMML) at Kalene hospital in Northern Rhodesia's Mwinilunga district supplanted their training scheme for African auxiliaries with a more scientifically-oriented programme.[1] This came in the wake of the missionaries and the colonial authorities' growing dissatisfaction over the older training scheme under which Lunda-speaking medical auxiliaries had been trained at Kalene hospital since the early 1920s.[2] CMML missionaries were particularly apprehensive that this scheme had failed to wholly erode pre-existing "pagan" cosmologies of disease and healing among auxiliary graduates. To the missionaries, the tenacity of such cosmologies among the local employees issued not least from the deep-rootedness in the African society of "heathen" medical belief systems and associated practices. It also arose from the elementary nature of training they had hitherto offered to African trainees at the mission hospital.[3]

Underlying these apprehensions, which outlived colonial rule, was the widespread assumption in missionary circles that the medical training programme of the inter-war period had proved utterly incapable of churning out scientifically-minded auxiliaries. Medical authorities and missionaries therefore worried that auxiliary workers trained

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[1] Interview with Hilda Wadsworth, retired Nurse Matron, Kalene Hill, 7 January 2001. See also Evelyn Nightingale, "Medical Missionary Work in Northern Rhodesia," *Echoes of Quarterly Review* 1, 2 (1959), pp. 16-21. Some data in this chapter derives from Walima T. Kalusa, "Disease and the Remaking of Missionary Medicine in Colonial North-Western Zambia: A Case of Mwinilunga District, 1902-1964," PhD Dissertation: Johns Hopkins University, 2003.

[2] See National Archives of Zambia (hereinafter NAZ)/KSE 6/1/4, Annual Report for the Year ending March 1922.

[3] Nightingale, "Missionary Work".

during that period hardly appreciated the 'objectivity', 'rationality' and 'superiority' of mission-based medicine over African "fetish remedies".[4] As such, auxiliaries could not constitute an effective vanguard of the Christian ideological battle against indigenous cosmologies of disease and praxis. To CMML medics, overcoming this obstacle was essential to emasculating local "pagan" belief systems and associated healing rituals that missionaries regarded as a huge barrier against reclaiming black souls for Christ. The need to replace the existing training programme with a much more effective scheme capable of imbuing African auxiliaries with greater appreciation of biomedical knowledge consequently became an urgent affair in the 1950s and 1960s. The medics expected auxiliaries trained under the envisaged scheme to effectively internalise the scientific trappings of mission-based medicine and thus appreciate biomedical power. From this standpoint, newly-trained auxiliaries would more convincingly persuade their patients to embrace the new medicine than their ill-trained predecessors employed in the antebellum. This generation of auxiliaries was thus to be in the frontline of the Christian crusade to annihilate local religious and medical beliefs, persuading their fellow Africans to jettison pre-existing therapeutic systems in favour of mission-based medicine with, of course, its underlying Christian ideology.[5]

CMML evangelists at Kalene hospital hoped to enlist scientifically-minded auxiliaries as their junior allies particularly in the combat against local healing systems that located human affliction within prevailing social relations.[6] They were optimistic that auxiliary employees well steeped in scientific medical knowledge would help them to relocate African healing from its social domain in which disease was locally comprehended to the confines of mission-controlled hospitals, clinics and dispensaries. Moreover, CMML medics envisaged that auxiliaries would come to see disease more as a function of microbial invasion of the human body than the consequence of dysfunctional social relationships.[7] Armed with such theories, auxiliary workers would convince patients that human disease was best treated in isolation from kinship relationships within which the local people managed affliction. Thus, the auxiliary was to be the handmaiden in missionary crusade to

[4] William S. Fisher and Julian Hoyte, *Ndotolo: The Life Histories of Walter and Anna Fisher of Central Africa* (Ikelenge: Lunda-Ndembu Publications, 1992, first published in 1948).
[5] Hilda Wadsworth, interview cited.
[6] Fisher and Hoyte, *Ndotolo*.
[7] Ibid.

de-contextualise illness from its social space, ultimately conferring upon the African society new medical, cultural and social identities.[8]

Like CMML missionaries, European doctors in the medical service in colonial and post-colonial Zambia shared the concern that auxiliary graduates in mission hospitals were too poorly trained to appreciate the "superiority" of biomedicine.[9] But whereas the former blamed this situation partly on the tenacity of "pagan" culture and beliefs, as earlier intimated, medical authorities attributed the persistence of such beliefs among local medical workers to the low level of Western education with which most auxiliary trainees were admitted to training programmes in the territory and to their lack of proficiency in the English language.[10] Medical authorities who periodically inspected Kalene hospital routinely castigated the CMML's subordination of medical work to evangelisation as yet another cause of the problem.[11] Convinced that ill-trained auxiliaries compromised the state's efforts to build a satisfactory medical practice in the territory, the authorities turned after the war into ardent advocates of far-reaching improvements in the training of their subjects at both state- and mission-controlled health centres.[12]

Their efforts soon paid off. Barely two years after the conclusion of hostilities in Europe, the authorities devised an ambitious ten-year development plan partly designed to boost African health in order to increase the production of raw materials in the territory. The plan, bank-rolled by the British government eager to re-build its own war-torn metropolitan economy through increased production of raw materials in its colonies and to

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[8] This point is informed by Megan Vaughan, "Healing and Curing: Issues in the Social and Anthropology of Medicine in Africa," *Social History of Medicine* 7, 2 (1994), pp. 283-295; Stuart Paul Landau, "Explaining Surgical Evangelism in Colonial Southern Africa," *Journal of African History* 37, 2 (1996), pp. 261-281; The *Realm of the Word: Language, Gender and Christianity in a Southern African Kingdom* (Portsmouth, NH.: Heinemann, 1995; "When Rain Falls: Rainmaking and Community in a Tswana Village, c. 1870 to Recent Times," *Journal of Southern African Studies* 26, 1 (1993), pp. 1-30.

[9] National Archives of Zambia (hereinafter NAZ)/ ZA7/6/7, H.S de Boer, Report on [medical] Conditions in Northern Rhodesia, 1933; H.S. De Boer, *Medical Report following Tour through North-Eastern and North-Western Rhodesia* (Lusaka: Government Printer, 1934), p. 11; Northern Rhodesia, *Medical Report on Health and Sanitary Conditions for the Year 1931* (London: Crown Agent, 1931), p.61; Northern Rhodesia, *Medical Report on Health and Sanitary Conditions for the Year 1936* (London: Government, 1937), pp. 1-2; Northern Rhodesia, Medical *Report on Health and Sanitary Conditions for the Year 1939* (Lusaka: Government Printer, 1940), p.8; Adams, "Concepts of Disease," p. 15.

[10] NAZ/ZA7/6/7, H.S. de Boer, Report on Conditions in Northern Rhodesia (medical), 1933.

[11] Ibid.

[12] See P.C.G. Adams, "Disease Concepts among Africans in the Protectorate of Northern Rhodesia," *Rhodes-Livingstone Journal* 10 (London: Oxford University Press, 1950).

abate the rising tide of international anti-colonial agitation, directed substantial fiscal support toward qualitative and quantitative improvement of African health countrywide.[13] Consequently, state grants-in-aid for the training auxiliaries at mission hospitals, including the one at Kalene Hill, rose considerably after the war.[14]

The concern of successive states and of the CMML missionaries to train auxiliaries in scientific medicine was driven by mutually shared, if at times tension-ridden, projects. As earlier noted, medical missionaries were convinced that auxiliaries trained in scientific medicine would not merely more readily internalise its scientific trappings. They would also deploy their newly-acquired scientific knowledge to reinforce the Christian crusade against indigenous paradigms of disease and healing. Of singular significance to this paper, Kalene-based evangelists believed that the new generation of auxiliaries would play a pivotal role in suppressing social healing, which they perceived as one of the strongest fortresses they had to raze down in order to win black souls for Christ.[15] On the other hand, state medical authorities hoped that better-trained auxiliaries could bolster their efforts to create a more effective medical practice. To the authorities, African employees steeped in scientific medicine were indispensable to the expansion of health services, to undermining the influence of local medical beliefs, and to the legitimation of political power. In sum, then, the new auxiliary was to be a lynchpin in evangelical warfare to remake the African society and in the rulers' efforts to bolster and legitimate their power.

Some social and medical historians inspired by Michel Foucault's writings have stressed the centrality of biomedical power in the construction of culture and social control. They have further uncritically endorsed the perception that non-Western medical personnel in extra-European settings accepted the role assigned to them by their employers.[16] Such workers allegedly appreciated the efficacy of modern medicine, embracing the Euro-Christian bourgeois values that their employers attached to Western medical interventions in (post)colonial societies. According to this school of thought, auxiliaries, therefore,

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[13] Northern Rhodesia, *Ten-Year Development Plan for Northern Rhodesia as approved by the Legislative Council on 11th February 1947* (Lusaka: Government Printer, 1947), p. 9.

[14] Hilda Wadsworth, interview cited. See also Nightingale, "Medical Missionary Work".

[15] Fisher and Hoyte, *Ndotolo.*

[16] This and the next paragraph are based on Walima T. Kalusa, "Language, Medical Auxiliaries, and the Re-interpretation of Missionary Medicine in Colonial Mwinilunga, Zambia, 1922-51," *Journal of Eastern African Studies* 1, 1 (2007), pp. 57-78.

regarded themselves as the legitimate spokesmen of scientific medicine in extra-European settings. In so doing, they signalled their willing involvement in the imperial crusade to subjugate local medical beliefs and practices, and, by extension, social healing itself. It is further asserted that auxiliary workers aspired to the European lifestyles, beliefs and habits of their white employers, and thus warmly supported the missionary campaign to annihilate "pagan" medical cultures.[17] From this standpoint, non-European practitioners of modern medicine in societies outside Europe were little more than agents of "medical imperialism".[18] Relegated to performing menial duties in European-dominated hospital regimes so as not to encroach upon the authority of white doctors and nurses,[19] they are depicted as voiceless aides, who would play a major part in undermining African culture and in the creation of Western power in (neo)colonial societies.

Undeniably, neo-Foucauldian scholarship has aptly illuminated the subordinate positions auxiliary employees occupied in colonial/mission medical regimes.[20] But, as shown at length elsewhere, this scholarship has all-too-often been written from the perspective of white doctors themselves, and not that of the local medical workers.[21] Thus, while neo-Foucauldian scholars have unmasked the intentions of Western doctors in colonial and neo-colonial contexts, they have scarcely illuminated how local auxiliaries

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[17] For a recent study that challenges these assumptions, see Walima T. Kalusa, "Advertising, Consuming Manufactured Goods and Contesting Colonial Hegemony on the Zambian Copperbelt, 1945-1964," paper presented at Frigilla Lodge, Chisamba, Zambia on 27-29 August 2010.

[18] See Maryinez Lyons, "The Power to Heal: African Medical Auxiliaries in Colonial Congo and Uganda," in Dagmar Engels and Shula Marks (eds.), *Contesting Colonial Hegemony in Africa and Asia* (London and New York: British Academic Press, 1994), p. 202. In the same volume, see Megan Vaughan, "Health and Hegemony Representation of Disease and the Creation of the Colonial Subject in Nyasaland"; David Arnold, "Public Health and Public Power: Medicine and Hegemony in Colonial India," pp. 131-151; Geraldine Forbes, "Managing Midwifery in India". See also Andrew Cunningham and Bridie Andrews, "Introduction: western medicine as Contested knowledge," in Andrew Cunningham and Bridie Andrews (eds.), *Western medicine as contested knowledge* (Manchester and New York: Manchester University Press, 1997), pp. 1-23. For works that distance themselves from this view, see Kalusa, "Language"; Harriet Bell, "Midwifery Training and Female Circumcision in Inter-war Anglo-Egyptian Sudan," *Journal of African History* 39 (1998), pp. 296-312; Nancy Rose Hunt, *A Colonial Lexicon of Birth Ritual, Medicalization and Mobility in the Congo* (Durham and London: Duke University Press, 1999).

[19] For studies that question this view, see John Illife, *East African Doctors: The History of the Modern Profession* (Cambridge: Cambridge University Press, 1998); Shula Marks, *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession* (London: St Martin's Press, 1994); Kalusa, "Language"; Hunt, *Colonial Lexicon*.

[20] For a study that questions this scholarship, see Kalusa, "Language".

[21] Ibid.

actually practised modern medicine. Consequently, these academics have grossly underestimated the auxiliaries' capacity to circumvent the hegemonising agenda that European practitioners of medicine harnessed to their medical interventions in Africa.[22]

Academic discourse that draws its inspiration from the works of Foucault suffers from other limitations, too. For example, it seldom takes into consideration the social context in which auxiliaries practised Western medicine. But Africans employed in modern hospital did not operate in a social vacuum. Indeed, as this paper seeks to show, there is ample evidence to show that auxiliary workers sometimes practised modern medicine in ways that reinforced local medical beliefs and customs, even when the workers themselves did not support such beliefs.[23] If local customs conditioned how medical auxiliaries practiced medicine, so did the shifting disease environments within which they plied their trade.[24] Yet neo-Foucaldian studies seldom explore how changes in disease environments shaped the work of African employees. This creates the erroneous impression that non-European practitioners of biomedicine uncritically perceived it as effective against disease and thus shared their employers' faith in its alleged superior affectivity over disease. From this standpoint, auxiliaries consequently practiced allopathic medicine in ways that resonated with the expectations of their employers.

This paper takes issue with academic discourse that stresses the imperialising power of Western medicine and that models indigenous employees in modern hospitals as no more than cultural conquistadors who assisted their employers to suppress African medical beliefs and practices. Acknowledging that auxiliaries at Kalene were after 1945 better trained than their predecessors, the study firstly questions the popular assumption in European medical circles that the medical training Africans received at the mission hospital after the war was a purely scientific undertaking. Contrary to this opinion, the paper shows that missionaries at Kalene itself reconfigured their medical training by accommodating some aspects of Lunda medical culture in order to popularise the medical training and to secure recognition for the work of its graduates in local villages.

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[22] Osaak a. Ollumwullah, *Dis-ease in the Colonial State: Medicine, Society and Social Change among the Abanyole of Western Kenya* (Westport and London: Greenwood Press, 2000), p. 8.
[23] Kalusa, "Disease and Remaking Missionary Medicine".
[24] Ibid.

Secondly, and more importantly, this study casts doubt over the view that African auxiliaries became biomedical agents whose work in mission-owned hospitals and clinics was anathema to social healing. It insists that despite their scientific training and their evident admiration of modern medicine, auxiliaries in Mwinilunga perceived missionary medicine as more than just a site for reversing physical affliction. Working in a society with rapidly escalating social inequalities and tensions engendered by post-war policies, they transformed the new therapeutic system into a discursive space for confronting and redressing such tensions. Thus, auxiliaries wittingly or unwittingly became healers of a fragmenting social body. In this way, they reinforced, rather than emasculated, pre-existing social relationships locally held to be the locus of human disease and suffering. Medical auxiliaries therefore reinvented missionary medicine, successfully turning it into an instrument for consolidating interpersonal comprehension of disease. Their reinvention of the Christian version of modern medicine not merely confounded their employers' efforts to undermine pre-existing healing practices. Local auxiliaries also refused to confine mission healing to mission hospitals and clinics. All this demonstrates the cultural hegemony that African auxiliary workers enjoyed over their imperial masters- notwithstanding that the former enjoyed far less medical authority and power than the latter.

Expansion of Missionary Medicine

The preoccupation of medical authorities and missionaries in Mwinilunga to reinvigorate the training of medical auxiliaries after the Second World War may best be appreciated within the context of the unprecedented expansion of medical services in the territory between 1945 and 1967. This phenomenal expansion was largely the result of the socio-economic policies pursued by authorities by Britain in Africa in the aftermath of the war and by the post-colonial state after 1964. As Teleza Tiyambe and several other writers have observed, Britain emerged from the war with a severely battered economy and a diminishing international standing. In response, Britain elaborated a developmentalist agenda to rebuild its domestic economy and waning diplomatic status through mobilizing the productive potential of and exploiting raw materials in its overseas empire.[25] Tapping

[25] Much ink has been spilt over this topic. See, for example, Tiyambe Teresa, "The Political Economy of British Colonial Development and Welfare British Africa," *TransAfrican Journal of History* 15 (1985),

such resources was dependent upon health labourers in British colonies. It is for this reason that British authorities in London increasingly committed funds toward the expansion of health infrastructure and services on the colonial periphery in the post-1945 era.

The metropolitan authorities' concern to improve African health in colonial Zambia particularly was epitomised by their enthusiastic support for the colony's first ten-year development plan in 1947. The plan provided for an expenditure of no less than £1,000,000 on health, the bulk of the funds coming from the much-studied Colonial Development and Welfare Fund set up in the UK after the war.[26] State expenditure on medical services in the territory continued to increase in the 1950s, jumping from £537,436 in 1950 to £995,199 in 1953 and to over £1,000,000 in 1954.[27] State expenditure on health increased even more in the 1960s, when Zambia became independent.[28]

The rise in health expenditure was paralleled by a proportionate increase in grants-in-aid to medical missions across the country. Consequently, most missionary societies, including the CMML expanded medical provision, both qualitatively and quantitatively. At Kalene, missionaries replaced in the early 1950s the sun-dried brick hospital built in the 1920s with a modern, burnt-brick hospital (still in use today) complete with 230 beds, numerous wards and an X-ray plant donated by the colonial state.[29] They also opened additional health centres in many parts of Mwinilunga, including a small hospital at Kamapanda and large clinics at the capital villages of Chiefs Kanongesha, Chibwika, Ntambu. By 1953, CMML missionaries were also running dispensaries at Salujinga and

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pp.139-161; Frederick Cooper, *Decolonization and African Society: The Labor Question in French and British Africa* (Cambridge: Cambridge University Press, 1996), Chapter 5.

[26] Northern Rhodesia, *Ten-Year Development Plan for Northern Rhodesia as approved by the Legislative Council on 11th February 1947* (Lusaka: Government Printer, 1947), p. 9.

[27] The figures derive from Colonial Office, *Annual Report on Northern Rhodesia for the Year 1950* (Lusaka: Government Printer, 1951), p.43; Northern Rhodesia, *Health Department Annual Report for the Year 1952* (Lusaka: Government Printer, 1953); Northern Rhodesia, *Health Department Annual Report for the Year 1953* (Lusaka: Government Printer, 1955), p. 3; Colonial Office, *Annual Report on Northern Rhodesia for the Year 1954* (Lusaka: Government Printer, 1955), p. 14.

[28] For details on this topic, see Walima T. Kalusa, "From and Agency of Cultural Destruction to an Agency Public Health: Transformations in Catholic Missionary Medicine in Post-Colonial Zambia, 1964-1982," paper presented at Joint Conference held in Freigburg, Germany and Basel, Switzerland, 14-17 May 2008.

[29] See National Archives of Zambia (hereinafter NAZ), SEC2/960, Tour Report No. 1/1952; NAZ/MH 1/2/95, Evelyn Nightingale to Director Medical Services, 12 November 1953; Evelyn Nightingale, "Medical Missionary Work in Northern Rhodesia," *Echoes Quarterly Review* 1, 2 (1959), pp. 16-21.

Mwilombi and clinics at Ikelenge twenty mile south of Kalene and at Kanyama ninety miles east of the mission hospital.[30] In addition, they were overseeing the operations of newly-established or enlarged state dispensaries at Lumwana, Tom Ilunga and Chief Sailunga's capital village.[31]

The proliferation of village health centres coupled with the scarcity of European medics in the district necessitated the training of medical auxiliaries capable of running the centres without the daily supervision of white doctors or nurses.[32] The fact that village dispensaries and clinics were to be under the control of auxiliary employees added greater urgency to raising the tone of their training. This was intended to no less uphold modern medical standards at CMML-owned dispensaries and clinics than to equip auxiliary workers with biomedical knowledge deemed by missionaries as essential to effectively waging the evangelical battle against local healing beliefs and practices.

It is in this light that the CMML invited in 1951 Sister Hilda Wadsworth, a Nurse Matron and Tutor from England to reorganise the auxiliary training scheme at Kalene Hill. Under an arrangement in which the colonial state met her emoluments, her major task was to institute a more effective training programme at Kalene Hill hospital to produce suitable auxiliary workers to staff the increasing number of state- and mission-controlled health centres in the district.[33] Sister Wadsworth, who worked at Kalene until 1967 when she retired, shared other missionaries and state officials' enthusiasm for placing the medical training of Africans on "a sound scientific footing".[34] Averse to "traditional" medical beliefs and well-versed in midwifery, anatomy, obstetrics, and physiology and gynaecology, she radically transformed the training of auxiliaries within three years of her arrival in the district. With fiscal support from successive states, the Nurse Matron soon built a new training school (still standing today) adjacent to the hospital. Determined to produce auxiliary graduates with a keen sense of microbial theories of disease, she stocked the school with state-of-the-art laboratory complete with microscopes, skeleton models and other scientific paraphernalia. As Sister Wadsworth herself recalled about fifty years later, this

[30] Nightingale, "Missionary Work"
[31] Ibid.
[32] Ibid.
[33] Interview with Hilda Wadsworth
[34] Ibid.

was intended to inculcate in her trainees with biomedical knowledge and to equip them with techniques essential to identifying and classifying disease-causing organisms.[35]

Hilda Wadsworth did more than just equip her school with latest scientific technologies. She also overhauled the ad hoc medical curriculum hitherto taught at the mission hospital, replacing it with a two-year curriculum heavily biased in favour of anatomy, biology, midwifery, pathology and physiology.[36] Moreover, the Nurse Matron initially excluded illiterate candidates from her medical training, admitting to it only young men and women with Standard IV education, or preferably higher. For, like the medical functionaries who routinely inspected her school, she firmly held that young well-educated Africans conversant with English were more likely to assimilate difficult scientific concepts than illiterate trainees of the inter-war period. The former could thus be more easily moulded into medical professionals, imbued with a deep appreciation scientific knowledge.[37] Indeed, her students had to pass both written theoretical and practical examination that the educator designed to gauge their biomedical comprehension of disease causation and treatment. Only upon passing the examinations did Wadsworth deem her trainees qualified enough to work at Kalene Hill hospital or at any of its satellite dispensaries or clinics in villages.[38]

At face value, Sister Hilda Wadsworth's training program appears to have been no less than a scientific endeavour, and the medical tutor herself routinely to cast it in this light. Her programme indeed soon earned her endless accolades from visiting medical inspectors, who increasingly praised the programme as a model medical project. For example, a medical inspector who visited Kalene hospital in 1954 predicted that once trained in sufficient numbers, newly-trained auxiliaries from Kalene would quickly undermine the influence of "traditional" healers in the district. He concluded that Wadsworth's training

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[35] Ibid.

[36] Hilda Wadsworth, interview cited.

[37] See NAZ/MH1/2/119, L.H. Holroyd, Provincial Medical Officer to Director of Medical Services, 9 July 1959; Hilda Wadsworth, Interview cited.

[38] Interviews with Maggie Thomas Sameta and Dorothy Chipisha, retired nurses, Kalene Hill, 7 January 2001; Chkeza Idah, retired nursing assistant, Kalene Hill, 18 February 2001 and Yuda Kapepala, retired nurse, Kapepala Village, 23 February 2001.

scheme at Kalene was therefore worth emulating by other Christian missionary healers across the territory.[39]

In hindsight, these perceptions were influenced by the authorities and Wadsworth's own perception of the role of auxiliary workers in the wider imperial and evangelical schemes as antithetical to existing medical belief systems and praxis. Such perceptions in fact masked the accommodations Hilda Wadsworth herself made with indigenous healing culture in order to satisfy local expectations and to win popular recognition and legitimacy for her training project. More ominously, these perceptions cast African auxiliaries as voiceless workers who passively endorsed the role that European missionaries crafted for them. In reality, things were more complex than suggested by these views. In the Lunda society where the respectability of "traditional" healer was inexorably tied to old age, experience and trust, Hilda Wadsworth soon discovered that young and unmarried graduates sent to run village health centres met stiff opposition, if not outright rejection from their patients.[40] Expectant mothers particularly objected to being attended to by unmarried auxiliaries in fear that their presence at childbirth violated female sexuality. Such opposition seems to have been greatest against auxiliary employees whose parents or guardians had not worked as medical auxiliaries at Kalene Hill.[41]

To abate this opposition, Wadsworth made a number of modifications to her "scientific" training scheme. Although she initially placed a premium upon training very young, relatively well educated men and women, she in the early 1950s raised the average admission age of auxiliary trainees from sixteen to twenty-five. By the late 1950s, Wadsworth trained even older midwives some of whom had little or no Western education at all. In the same vein, the Nurse Matron increasingly recruited auxiliary trainees whose guardians or parents were working or had worked as medical auxiliaries at Kalene. More than fifty percent of the twenty-four African auxiliary trainees at the mission hospital towards in the early 1960s, for example, came from families with a history of medical work in the district.[42]

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[39] NAZ/SEC2/962, Tour Report No. 8 of 1954.

[40] Hilda Wadsworth, interview cited.

[41] Ibid.

[42] Interviews with Shem Sanikosa, former Medical Orderly, 23 February 2001; Gibbison Chipisha, former Medical Orderly, 7 January 2001; Chilongo Chinyama, former Medical Orderly; Dorothy Chipisha, Auxiliary Nurse, 7 January 2001; Yuda Kapepela, former Male Nurse, 23 February 2001

Wadsworth justified the bias in favour of these students on the premise that they came from Christian families and were thus either Christians themselves or were more likely to convert to the new faith. As such, her auxiliaries would transform their dispensaries and clinics into the nuclei of evangelisation in Mwinilunga. To be sure, Hilda Wadsworth observations were not incorrect, for nearly all her students trained in the period in question were or became Christians. Most of them also played a key role in establishing "native" CMML assemblies close to their clinics.[43] But by increasingly enrolling in the training programme older students and by insisting on training the offspring of former auxiliaries, the missionary unknowingly subscribed to local constructions of the ideal medical practitioner. She also buttressed the local custom of passing the office of healing within specific families, a point that has also been poignantly made by academics working on other African societies removed in time and space.[44]

For all its scientific trappings, the training of African auxiliaries in post-war Mwinilunga resonated with deep religious and moral overtones. Although Hilda Wadsworth wanted her auxiliary trainees to imbibe biomedical comprehension of disease and healing, she also sought to instil in them the belief that God was "the author of life" and, therefore, the only true source of "good health." Her main goal was to persuade auxiliaries that God was the ultimate healer, in spite of their appreciation of microbial paradigms of disease and biomedical power. Accordingly, her lectures always began and ended with prayer. Through these lectures and prayers, Wadsworth exhorted the Christian God as the Greatest Healer, in an attempt to inculcate into her students such Christian values as kindness, honesty and empathy for the sick. Perhaps unknown to her, these virtues were in fact also regarded as the hallmarks of traditional medicine in Mwinilunga. In Mwinilunga, it was these virtues for which her graduates indeed became renown in villages, rather than their scientific knowledge of medicine, a point that eventually was not lost on Sister Wadsworth herself.[45]

It is clear, then, that the training that Sister Wadsworth crafted at Kalene Hill after the Second World War was not a purely scientific affair foisted upon passive Africans. Like

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[43] Ibid.

[44] See for Example, Heather Bell, "Midwifery Training and Female Circumcision in the Inter-War Anglo-Egyptian Sudan," *Journal of African History* 39 (1998), p. 206.

[45] Hilda Wadsworth, interview cited.

most other colonial and neo-colonial projects in Africa and beyond, her training scheme was not immune from localising forces to which other aspects Western interventions were subjected. Local medical expectations, coupled with how auxiliaries were received in villages ultimately influenced the age, the marital status and the familial backgrounds of the auxiliaries trained at Kalene hospital from the 1950s on. In responding to such expectations by raising the entry age, recruiting married midwives and increasingly training (former) auxiliaries' sons and daughters Hilda Wadsworth legitimated their training in local terms.

This conclusion is neither new nor unique to Mwinilunga. In a fascinating article Heather Bell has convincingly shown how British medical educators in the Anglo-Egyptian Sudan appropriated pre-existing ideas of midwifery and used them in training local midwives. As Bell argues, the educators' accommodation of Sudanese culture- which issued from negotiations between them and their African interlocutors- was central to local recognition and appropriation of Western midwifery practices and medicine.[46] In her theoretical study of imperial rule in Sub-Saharan Africa, historian Karen Fields advances a similar argument. Fields rightly insists that colonial rulers in the region could not win legitimacy for their alien rule without deferring to pre-existing indigenous institutions, practices or ideas through which their subjects exercised political power and authority. They, therefore, Fields continues, at least tacitly participated in local institutions, appropriating beliefs and practices linked to such institutions. Among the ideas colonial authorities pressed into their service, the historian concludes, were those surrounding witchcraft, which the authorities paradoxically dismissed as inimical to their imperial crusade and hence routinely inveighed against.[47]

Auxiliaries as Social Healers

If the new medical training at Kalene hospital was not an exclusively scientific endeavour, there are indications, too, that its graduates scarcely turned into simple agents of cultural suppression, a role that their employers imagined for them. That auxiliaries subverted their employers' intention to transform them into pliant allies against African

[46] Bell, "Midwifery Training".

[47] Karen E. Fields, "Political Contingencies of Witchcraft in Colonial Central Africa: Culture and the State in Marxist Theory," *Canadian Journal of African Studies* 16, 3 (1982), p. 568; see also Sean Redding, "Government Witchcraft: Taxation, the Supernatural, and the Mpondo Revolt in the Transkei, South Africa, 1955-1963," *African Affairs* 95 (1996), pp. 555-597.

healing beliefs and practices may perhaps best be appreciated against the backdrop of post-war socio-economic policies. These policies contributed to the deterioration of the district's disease landscape and widened existing social inequalities and tensions in Mwinilunga and beyond.

Chief among the policies that led to the deterioration of the district's disease ecology and that deepened social inequalities in post-war period were those linked to Britain's efforts to rebuild its metropolitan economy after the war. From the perspective of the British post-war economic policy, Zambia's contribution toward resuscitating the metropolitan economy lay in expanding copper production on the Copperbelt. To this end, the British government enticed mining companies to increase their production of the metal in the colony. The response of both British and other companies was overwhelming, leading to the opening of additional mine in the territory. This was especially so in the 1950s when soaring copper prices induced by the Korean war resulted into a boom in the copper industry in colonial Zambia. Ultimately, the colony emerged as one of the world's copper major copper producers, African workforce on the Copperbelt rising from 200,000 in 1946 to 270,000 in 1953.[48]

Scholars operating within underdevelopment models have correctly remarked that the expansion of the African mine workforce on the Copperbelt after the war increased the demand for beef and maize in the mining area so highly that European farmers who had hitherto monopolised the foodstuffs market in the country could no longer meet the demand.[49] For most of the post-war period, therefore, successive states actively encouraged market production in rural areas in order to feed the growing number of miners. Besides urging people in Mwinilunga and other areas to abandon large villages in favour of small-scale settlement ideal for peasant commodity production,[50] they constructed roads in the

[48] James Anthony Pritchett, "Change and Continuity in an African Society: The Kanongesha Lunda of Mwinilunga," PhD Dissertation, Harvard University Press, 1989.

[49] See Kenneth P. Vickery, "Saving Settlers: Maize Control in Northern Rhodesia," *Journal of Southern African Studies* 11, 2 (1985), pp. 212-234; *Black and White in Southern Zambia: The Tonga Plateau Economy and British Imperialism, 1890-1939* (New York: Greenwood Press, 1986); Samuel N. Chipungu, *The State, Technology and Peasant Differentiation in Zambia: The Case of Southern Province* (Lusaka: Historical Association of Zambia, 1988) and Maud S. Muntemba, "Thwarted Development: A Case Study of Economic Change in the Kabwe Rural District, 1920-1970," in Robin Palmer and Neil Parsons (eds.), *The Roots of Rural Poverty in Central and Southern Africa* (London: Heinemann, 1977).

[50] NAZ/KSE 4/1, Mwinilunga District Notebook, 1964; NAZ/SEC/962, Comments by the Provincial Commissioner on Tour Report No 5 of 1952.

district, provided free instruction in cash cropping, organised annual agricultural shows, and advanced loans in form of cattle to the local people. They further established buying centres from which African and white traders purchased locally-grown grain and cassava flour for the export to the Copperbelt.[51] Lastly, in the mid-1950s, state officials made marketing arrangements with mining companies in the nearby Belgian Congo to facilitate the export surplus crops from Mwinilunga.[52]

By most archival and oral accounts, people in Mwinilunga responded to these initiatives enthusiastically. From the late 1940s on, district administrators consistently reported that the Lunda were rapidly scrambling for land for commodity production, igniting endless and, often violent, land wrangles within and between chiefdoms.[53] In the place of consolidated villages of the inter-war era now emerged small villages, especially along motor-roads or near trade centres. There, nuclear families established what locally came to be popularly known as *amafamu* (the Lunda corruption of the English "farms"), where they engaged actively in market commodity production, usually with either family or hired labour. Mwinilunga thus became a chief exporter of foodstuffs. In 1954 alone, the district exported more than 670 tons of cassava meal and, a year later, the District Commissioner proudly informed his superiors in Lusaka that "The Year has seen a record increase in the production of surplus foodstuffs". This, the DC continued, enabled the district to export foodstuff worth £15,145, indicating a rise of more than £3,000 over the previous year's earnings.[54] Such earnings excluded income earned from exporting beeswax and rubber to Europe and rice, beans, and millet to other parts of the colony.

It is clear, then, that by the mid-1950s Mwinilunga had emerged as a major food growing area. With its deepening involvement in commodity production, the district not only replaced its barter economy with a money-based economy. It also escaped the economic depression into which the area had sunk after its incorporation into the colonial order at the beginning of the twentieth century. As a corollary, the pedicle chiefdoms in north-western section of district saw the rise of wealthy men (*mukwakuheta*), particularly in

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[51] NAZ/SEC2/155, Annual Report on Native Affairs for the 1948; NAZ/SEC2/960, Tour Report No. 3/1952; NAZ/SEC2/958, O.S. Wallace to the Director of Trade, Transport and Industry, 31 May 1951; NAZ/SEC2/962, Tour Report No. 9 of 1954.

[52] NAZ/SEC2/962, Tour Report No 8 of 1954

[53] See NAZ/SEC2/962, Tour Report No 4 of 1954; NAZ/KSE 4/1, Mwinilunnga District Notebook.

[54] NAZ/SEC2/137, Northwestern Province Annual Report for the Year 1955.

the chiefdoms of Nyakaseya, Ikelenge and Mwinimilamba. There, such rich producers men as Thomas Kapita and Joseph Kanema accumulated sufficient wealth to enjoy a standard of living that state authorities regasrded, perhaps exaggeratedly, to be "on the same plane as [that of] the middle class salaried man in England."[55]

But rising prosperity came at high epidemiological and social costs. The agricultural prosperity mostly took place in the pedicle area, which boasted of fertile soils, good roads, markets and several African and European traders.[56] While agricultural prosperity in this area apparently insulated the *nouvelle riche* from diseases of impoverishment, it did not extend to less successful producers within and outside the pedicle. Most adversely affected were the "remote parts of the district" devoid of fertile soils, roads and markets and from which the prosperous chiefdoms in the district increasingly recruited labour. It is no surprise, then, that although authorities in Mwinilunga after 1945 routinely recorded that "The health of the people in [the pedicle region] is excellent,"[57] they also noted that the lack of agricultural development and deepening poverty in remote parts of the district rendered people there vulnerable to devastating diseases and epidemics.[58] In 1948, DC R.C. Dening, for instance, reported a very high incidence of tuberculosis, hookworm and malaria in villages under Chiefs Kanyama and Kakoma, the poorest areas in the district.[59] His observations were a few years later echoed by successive administrative personnel who reported seeing "extremely thin and undernourished children" in many villages. They attributed this situation to the high incidence of tuberculosis, influenza, hookworm and dysentery, with resultant rising mortality rates in affected villages.[60]

Besides altering the pattern of distribution of disease in the district, the expanding involvement of the Lunda people in market production aggravated prevailing social inequalities and tensions. The world-renown anthropologist Victor Turner and his wife who carried out fieldwork in Mwinilunga in the 1950s found that since the nascent *la classe opulante* relied more on nuclear family or hired labour, they were less inclined to assist their

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[55] NAZ/SEC2/962, Tour Report No. 8 of 1954; NAZ/SEC2/963, Tour Report No6/1955.

[56] Ibid. See also E.L.B. Turner and V.W. Turner, "The Money Economy among the Mwinilunga Ndembu: A Study of Individual Budget," *Rhodes-Livingstone Journal* XVIII (Manchester: Manchester University Press, 1955.

[57] NAZ/SEC2/960, Tour Report No. 3/1952.

[58] NAZ/SEC2/963, Tour Report No. 10 of 1955.

[59] NAZE/SEC2/956, Tour Reports No. 1, 2 and 7 of 1948.

[60] NAZ/SEC2/961, Tour Report No. 1 of 1953,

kinsfolk in keeping local matrilineal obligations. To the contrary, successful Lunda traders and peasants, the Turners observed, sought to disencumber themselves from such obligations by establishing their *amafamu* or businesses far away from their relations, by hiding surplus income in boxes secretly buried in the ground, or by investing it in such capital goods as sewing machines and luxuries.[61] Exacerbating the deteriorating social relationships was the ruthless exploitation of hired labourers, who sometimes included the *mukwakuheta*'s matrilineal kin.[62]

In recent studies of shifting perceptions of witchcraft beliefs in modern Africa, several academics have remarked that socio-economic forces that act upon kin dynamics tend to magnify social conflicts, thereby deepening existing societal tensions.[63] This observation applies to post-war Mwinilunga where the accumulative spirit of successful peasant and traders was fundamentally at odds with the Lunda matrilineal ideology with its emphasis on kinship ties and related obligations. The accumulative spirit- epitomized by rising land disputes within and between families, the setting up of *amafamu* away from the plying eyes of kinsmen evidently spawned tensions that fractured the social body.[64] Such social tensions manifested themselves in increasing witchcraft accusations in the decades following the Second World War. These accusations were apparently levelled against young successful entrepreneurs regarded by their less successful kinsfolk as witches who prospered not through thrift or diligence but supernatural means, especially witchcraft.

As Martin Chanock has eloquently argued, these accusations may have served as a strategy by which lineage elders sought to gain access to younger entrepreneurs' goods and income essential to bolstering the elders' own social, economic and political power severely eroded by colonial rule.[65] To safeguard their wealth, the new economic elites themselves

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[61] Turner and Turner, Money Economy," p. 28. See also V.W. Turner, *Schism and Continuity in an African Society: A Study of Ndembu Village Life* (Manchester: Manchester University Press, p. 135.

[62] NAZ/SEC2/960, Tour Report No. 3/1952; Wilson Ilunga, peasant farmer, 7 January 2001.

[63] The literature on this topic is legion. See for example, Elizabeth Colson, "The Father and Witch," *Africa* 70, 3 (2000), p. 333; Mary Douglas, "Sorcery Accusation Unleashed: The Lele Revisited, 1987," *Africa* 69, 2 (1999), pp. 177-193; Peter Geschiere, "Sorcery and the State: Popular Modes of Action among the Maka of southeast Cameroon," *Critique of Anthropology* 8, 1 (1988), pp. 35-63.

[64] Turner and Turner, "Money Economy," p.36. See also Boris Wastiau, "Mahamba: The Transforming Arts of Spirit Possession among the Luvale-Speaking People of the Upper Zambezi," PhD Dissertation: University of East Anglia, 1997, pp. 252-260.

[65] Martin Chanock, *Law, Custom and Social Order: The Colonial Experience in Malawi and Zambia* (Cambridge: Cambridge University Press, 1985).

were, however, not slow to counter-accuse their elders of witchcraft. Thus, in 1955, an administrator in the district lamented that witchcraft disputes now "painted every aspect of the lives of the people."[66] This situation engendered growing anxiety among authorities and CMML missionaries who, respectively, saw increasing witchcraft disputes as antithetical to the spirit of rural capitalist accumulation and inimical to Christianity.[67]

In a society with deteriorating health and where the majority of the people perceived broken social relationships as the root cause of disease, it is little wonder that most patients brought not only their physical afflictions to medical auxiliaries. The patients also brought to the attention of auxiliary personnel their life's social challenges.[68] It is against this background that one may best comprehend how the role of auxiliaries diverged from the expectations of CMML evangelists. Shem Sanikosa, an auxiliary who ran the mission dispensary at Salujinga between 1955 and 1968, recalled that he spent less time on treating patients than on discharging pastoral duties that included settling land and family disputes in the villages close to his dispensary. When kinsmen fought over land, a situation that often sparked witchcraft accusations, or when they "had other personal problems," Saniko later recalled, "they [came] to me for arbitration." According to the former medical orderly, the concerned parties were assured of an impartial hearing because he was a Christian.[69] But it is more likely that people who took their social problems to him did so largely because they saw the medicine he practised as a variation of Lunda medicine -- whose practitioners operated beyond the medical frontier, resolving social conflicts as often as they confronted physical afflictions.[70] That Shem Saniko did not confine his work to treating diseases alone but also willingly attended to his patients' social challenges certainly reinforced this perception.[71]

Auxiliaries' duties went beyond settling disputes. Samuel Majaji, who opened the CMML dispensary at Mwilombi and the only Standard VI graduate trained by Hilda

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66 NAZ/SEC2/963, Tour Report No. 7 of 1955.
67 Ibid.
68 Interview with Shem Sanikosa, former Medical Orderly, 22 February 2001.
69 Ibid.
70 See Kalusa, "Remaking Missionary Medicine".
71 Shem Sanikosa, interview cited.

Wadsworth in the late 1950s,[72] reminisced that he and other auxiliaries often engaged in healing activities that were anything but scientific.[73] According to Malaji, auxiliaries routinely administered mission therapies to the gravely sick in the patients' homes through rituals that the auxiliaries crafted. In ways reminiscent of local healing ordeals, they engaged the sick together with their therapy management groups in healing prayers, invoking the Holy Spirit. Apparently, these healing rituals attracted huge crowds, including the sick and their relations, the rich and the poor. At overnight prayers, medical auxiliaries kept vigil for the dying, dealt with diseases suspected to be induced by witchcraft and enjoined relatives of sick to bury their differences. These practices invariably drew the wrath of their European employers who dismissed them as little more than "rank heathenism".[74]

In the hands of African medical auxiliaries, therefore, mission medicine became more than an instrument for restoring good health to the afflicted. It was also, more significantly, served as a vehicle through which auxiliary employees, like "traditional" healers, helped their patients rework breaking social relationships, contain expanding inequalities and come to terms with other conflicts spawned by the Lunda's growing involvement in commercialized market economy after the Second World War. Through their healing ordeals, auxiliaries practised Christian medicine as if it was a variation on Lunda medicine, which focused upon resolving social conflicts, perceived by the local people as the locus of human disease. Despite their rigorous training in scientific medicine, then, African auxiliaries in post-war Mwinilunga may have seldom "thought in terms of biomedical paradigms," a point that Paul Landau makes most poignantly for Christian converts in colonial Botswana.[75]

The last observation is not intended to imply that Hilda Wadsworth's students did not appreciate microbial explanations of disease and healing. Numerous interviews with many former medical auxiliaries plainly show that they did. But this did not stop them from

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[72] See NAZ/MH1 2/119, Dr. Evelyn A. Nightingale and Dr. J.A. Lees, Kalene Mission Hospital African [Medical] Assistants, 1959.

[73] Interviews with Samuel Majaji, former Medical Orderly, 23 February 2001; Crushwell Buluwaya, Church Elder, 23 Feberuary 2001; Costa Kapula, Pastor, 25 February 2001 and Shem Sanikosa.

[74] CMML, *Echoes of Service* April 1952.

[75] Landau, *Realm of the Word*, especially Chapter 5.

reading disease in terms of existing social relationships.[76] Far from being concerned with treating disease *per se*, medical auxiliaries sought to harmonise wider social relationships that gave form and meaning to disease, its comprehension and, indeed, its treatment. Through healing prayers and other rituals, which missionaries dismissed as "pagan" practices, auxiliaries placed "a [social] network of concern beneath," the sick and the dying, inexorably tying the missionary therapeutics to confronting socio-economic and epidemiological concerns in a rapidly transforming society. In Landau's erudite terms, auxiliaries reinvented evangelical medicine "by working on the boundaries and connections between the patient and [the patient's] changeful milieu" and by treating disease a matter of the patient's situation in a wider social environment and not as a mere "interplay of conflicting elements within her [or his] body."[77]

Seen from this perceptive, it is not surprising that auxiliary workers in Mwinilunga rejected the particularising tendencies of mission medicine, whose white practitioners focused on the human body as the only possible site of healing.[78] Their healing rituals, in which all and sundry participated, de-compartmentalised Christian medicine from its narrow confines in mission enclaves. Consequently, auxiliary workers bolstered interpersonal comprehension of disease. In this manner, they confounded their employers' efforts to undermine social healing through relocating the treatment of disease from its social space to mission-controlled health centres. Through their agency, African auxiliaries refashioned CMML medicine into a means to confront new social conflicts in order to heal the fragmenting social body.

Conclusion

When Hilda Wadsworth at Kalene Hill reorganised the training of African auxiliaries with the support of successive states in the 1950s, she, and the successive states that financially supported her, hoped to produce a new breed of auxiliaries who would be in the frontline of the combat against social healing. But the auxiliaries she trained in the 1950s and 1960s were no simple inventions of the missionary, or of (post)colonial states.

[76] This point is informed by John L and Jean Comaroff, *Of Revelation and Revolution: The Dialects of Modernity on the South African Frontier* Vol. Two (Chicago and London: The University of Chicago Press,), p. 343.

[77] Landau, *Realm of the Word*, p. 124.

[78] Kalusa, "Disease and Remaking Missionary Medicine".

Confronted with rising social inequalities and tensions spawned by post-war economic policies, local auxiliaries refused to restrict their medical practice to mission enclaves, or to just healing bodies. To the contrary, they invented their own healing rituals and practised Christian medicine in ways that enhanced social relationships in which their patients understood as well as managed disease. Ultimately, auxiliary employees bolstered interpersonal comprehension of disease, and hence played an important role in managing social conflicts and tensions. Notwithstanding that they enjoyed less medical power and authority than missionary doctors, auxiliaries therefore confounded their employers' agenda to turn them into pliant agents of cultural suppression.