‘Healing of Bodies, Salvation of Souls’: Missionary Medicine in Colonial Tanganyika, 1870s-1939

Michael Jennings
School of Oriental and African Studies, University of London,
Thornhaugh Street, Russell Square, London WC1H 0XG
mj10@soas.ac.uk

Abstract
This paper re-examines missionary medicine in Tanganyika, considering its relationship with the colonial state, the impulses that led it to evolve in the way that it did, and the nature of the medical services it offered. The paper suggests that, contrary to traditional depictions, missionary medicine was not entirely curative in focus, small in scale, nor inappropriate to the health needs of the communities in which it was based. Rather, missionary medicine should be considered as a vital aspect of early colonial health services, serving those excluded by the colonial state. Missionary medicine before 1945 was fragmented, small-scale, lacking in resources and overstretched. Its services could not necessarily compete in quality with the best of the state hospitals. But it succeeded, within the local context, in providing a network of health services that stretched into the rural society, and ensured that, where there was a mission hospital, there was an option for the local people to make western biomedicine a choice for healing.

Keywords
missionaries, missionary medicine, Tanganyika, colonial medicine, theology of mission medical service

Introduction
In his book, Jungle Doctor, the former Church Missionary Society (CMS) doctor, Paul White, tells a story of a young boy who is brought to his hut, unconscious and severely ill with cerebral malaria, the local witchdoctor having failed to cure the disease. Dr White tells the family that only God’s assistance will cure the child.2 The boy is saved: the malarial parasite, that potent symbol of Africa’s curse, is conquered. The family turn to Dr White and declare: ‘Bwana, we see in his recovery the hand of God. We know now that these new ways are much better than our Gogo customs. We want to learn more about Jesus.’3

A man whose cataracts are removed by Dr White declares:
I could not get rid of them, nor could the witchdoctor, nor my relatives, but you did with your little knife, and behold, I understood how Jesus could take away my sin, the cataract of the soul... you preached better with your knife than with your tongue.4

The image of the heroic figure of the missionary doctor or nurse permeates such accounts: struggling alone against the twin evils of disease and superstition (represented by the figure of the ‘witchdoctor’), using his or her healing skills to provide a living example of Christ, to save the body and convert the soul.

For much of the early colonial period throughout sub-Saharan Africa, and especially in the British colonial territories, western biomedical services for the African population were provided overwhelmingly by missions. Until the 1930s, and in some cases even later, secular state medical services were in short supply, confined largely to the urban and administrative centres. For the bulk of the population in many African countries, the state provided little regular medical care. The first hospitals in Tanganyika, the first clinics and doctors, were missionary. Missions were responsible for training African medical personnel, bringing African midwives and maternal and child welfare services to the rural areas, and they dealt with the day-to-day health concerns of the African communities in which they were based. For most Africans up to the 1930s, then, the experience of western biomedicine was largely under the auspices of the church. Missionary medicine was not just an alternative form of western medicine: for most Africans it was western medicine. Even at Independence in 1961, Tanganyikan health services were still dominated by missions, despite fifteen years of colonial state expansion. Missions operated more hospitals and dispensaries, had more beds and treated more mothers and children at Maternal and Child Health Clinics, at a fraction of the cost to the state and with fewer physicians.5

These ‘types’, created in large part by the missionary societies themselves, have been passed down through colonial and Christian rhetoric, through novels and history, and into popular consciousness. The medical missionary has become a cipher through which nineteenth- and twentieth-century evangelisation has been explored, colonial history examined and European domination over the body of the ‘other’ explained. These images are not solely the province of the imagined daily life in White’s Kilimatinde. They hold force because they—or images similar in substance—were held and expressed in the official colonial documents, and have subsequently been reflected in the historiography of missionary medicine.6

Inevitably, analysis based on constructed narratives and idealised types has failed to explain adequately the richness and variety of the medical mission
sector. In particular, the construction of missionary medicine as ‘curative’, rather than ‘preventative’ (with the negative connotations that this implies) is central to both colonial and modern understandings of missionary medicine in this period. Indeed, in some accounts, medical missions are almost completely absent from accounts of medical provision in sub-Saharan Africa.

This paper argues that colonial depictions of missionary medical work underplayed the essential role of such agencies. Moreover, the adoption of this analytical paradigm in the literature has led to a continuation of misconceptions over the roles of missions in both the medical and the wider sphere. Missionary medicine was far from the poor cousin of secular/colonial state medicine: it was innovative at times, extensive in its reach, and a key element of the attempts to establish a national health service in post-war Tanganyika.

The history of the medical mission is intertwined with that of changes in western healing practices. Although the first missionary contact with Africa from the sixteenth century brought with it early modern European healing traditions, ‘missionary medicine’ as we would today understand it began in the eighteenth and nineteenth centuries with the onset of the Protestant evangelical movement. However, missionary physicians in this period held little of the heroic status they would acquire by the twentieth century. As David Hardiman writes, the ‘sickness’ of the African, for Evangelicals, reflected both ‘moral and physical contamination’. Accordingly, ‘any Godly person who understood the rudimentary principles of hygiene and sanitation was in a position to bring health to the “native” by cleansing their bodies with soap and their minds with the Gospel.’ Moreover, before the late nineteenth century, western healing offered little in the way of a competitive advantage over African traditions. By the mid-nineteenth century, mission medical work became increasingly prominent within the evangelical task. The establishment of the Edinburgh Medical Missionary Society (1841), and the example of Dr David Livingstone, were only the most obvious signals of this new emphasis. Within the mission more widely, and especially within British missionary organisations, medical work began to be granted a distinct space within mission activity. As western medicine began, from the late century, to offer more efficacious healing (for some, but by no means all, diseases) than traditional African medicines, and as the professionalisation of medicine in Europe began to take root, so too healing within the mission became ever more confined to those with specialist training. A distinct theology of medical mission emerged to provide a rationale and intellectual foundation for the work, justifying the diversion of resources from specifically evangelical work towards this new form of engaging with non-believers. After 1918, with the increased availability of
funding for medical work, mission doctors and nurses saw their status further enhanced.

In East Africa, early mission medical services coincided with the rise in profile, and professionalism, of mission medical work. From the 1860s, but generally from the 1880s onwards, mission dispensaries, hospitals and clinics began to be established in the interior. The place of healing in these organisations thus reflected the changing environment of the missions themselves. It was firmly rooted in the growing theology of healing within an evangelical setting, the rise of the professional physician, and coincided with the establishment of colonial rule and domination. Analysis of missionary medicine in East Africa, therefore, has often focused on these broader issues: the extent to which it was driven by its theological underpinnings; the link between missionary endeavour and the establishment of colonial hegemony; and differences between secular and religious medicine.

The nature and timing of colonial structures in East Africa (and, in the case of Tanganyika, the transfer of authority from German to British control post-1918) created a different experience from that of South Africa, or British India, where contact between missionary and colonial subject pre-dated the shifts in missionary medicine (and western biomedicine more widely). Nevertheless, the argument—that the growth of services must be understood as reflecting the local context, its constraints and opportunities, as much as its theological grounding and scientific advances—has wider implications.

**Narratives of Missionary Medicine**

Over the past decade, there has been a resurgence of interest in the work of medical missionaries in Africa. Previously, however, their contribution to the evolution of African national health systems was largely neglected. The 1964 Titmuss Report to the Tanganyikan government, for example, whilst acknowledging that the country’s first nurses and doctors were missionaries, noted: ‘…outside a very small circle these early endeavours by voluntary agencies made little impression on the health or health practices of the African population. The history of medical services properly begins in 1888 with the period of German administration.’

Similarly, David Clyde’s comprehensive *History of the Medical Services of Tanganyika* (1962) focuses mainly on the colonial state. This exclusion of the missionary from the historical records of medical services in Tanganyika, reflecting the state-centric analytical framework of the early 1960s, has been replicated by later writings. Barbara Turshen’s 1977 account of the impact of colonialism on health gives little space for a consideration of medical mission
(despite looking at an area where, for much of the period, mission services were far more prominent than their state counterpart). Writing in 1985, Steven Feierman similarly downplays the extent of missionary medicine in his examination of healing and medicine in Africa. He is surely correct that western biomedicine in general never reached more than a minority of Africans, citing as he does a Christian Medical Commission report that estimated just 20 percent of sub-Saharan Africa’s population was reached by a western biomedical facility. But at the local level, especially within British colonies where medical missions played a greater role in supplementing (or even replacing) colonial services up to the late 1930s, the picture that emerges is slightly different. In Shinyanga District in Tanganyika—with a population of around 150,000—one mission hospital alone saw 77,478 patients in 1928. In a small area, well served by mission hospitals, the potential number of Africans that could be dealt with in hospitals and clinics was significantly higher. As Terence Ranger notes in his assessment of the Universities’ Mission to Central Africa: ‘Its clinics and hospitals provided, with those of the Catholics, the sole effective medical facilities in Masasi district.’

However, the relative neglect of the medical mission has been addressed by a growing body of literature that has sought to re-cast the history of the medical mission (and, indeed, the mission itself more widely) in Africa, and to understand more fully its contribution to health care across the continent. The historiography of medical mission in Africa has largely focused on three key aspects: namely, the place of medical mission within a theological understanding of the evangelical endeavour (the struggle for the soul); the function of the missionary in the colonial setting (to what extent, in other words, medical mission operated to support the extension of colonial hegemony over the body of the other); and the nature of missionary medicine (the struggle for the body). These perspectives are important foci of analysis, essential to an understanding of the working of the missionary. But are they entirely satisfactory in their explanations for the rise of missionary medicine (and beyond that the working of the mission in its wider work)? As explored by growing numbers of historians, the depiction of the missionary—medical or otherwise—as a simple agent of empire is to simplify what is a highly complex relationship with secular state authority and the establishment of colonial rule. Similarly, whilst the strong theological underpinning of medical work is of central importance for an intellectual understanding of the place of such work in the mission field, it is not the only analytical lens through which to interpret it. A study of the emergence of medical services in many parts of sub-Saharan Africa in the late nineteenth and early twentieth centuries suggests a fuzzier link between the evolution of medical care and a distinct theology of missionary
medicine. The latter certainly existed, but was it truly the sole and main driving force behind the rise of the mission hospital, dispensary, doctor and nurse? As this paper explores later, surely immediate, practical concerns were as much a factor as theological?

As a result of these trends within the literature, the place of missionary medicine within the overall provision of western biomedicine in colonial Africa has been generally defined in contrast to its secular, colonial-state counterpart. Moreover, such divisions have posited, implicitly if not explicitly, a qualitative (even moral) distinction between the two.

If, as David Hardiman suggests, the medical missionary exerted a ‘powerful hold over the Western imagination’ in the colonial period, ‘heroic figures’ undertaking a dangerous task,\(^{16}\) such depictions did not last long into the postcolonial reassessment of the place of missionary activity in the European empires. Nationalist writers were amongst the first to criticise missionaries as at best connivers, if not active agents, in the imposition and maintenance of colonial rule. Walter Rodney, for example, regarded the nineteenth-century missionaries ‘as much part of the colonising forces as were the explorers, traders, and soldiers’. They were, he continued, ‘agents of colonialism in the practical sense, whether or not they saw themselves in that light’.\(^{17}\) Early postcolonial writers criticised depictions of European missionaries as benign, or ‘well intentioned philanthropists’.\(^{18}\) For the Comaroffs, writing about evangelical Protestant missionaries in southern Africa, missionaries were certainly linked into colonial hegemony:

Not only were Nonconformist evangelists the vanguard of the British presence in this part of South Africa; they were also the most active cultural agents of empire, being driven by the explicit aim of reconstructing the ‘native’ world in the name of God and European civilisation.

In this perspective Christianity was, Thomas Beidelman suggests, ‘an essential element of Western culture. The force of weapons, skill in manufacturing medicines and textiles, and widespread literacy were all implied somehow to be part and parcel of the same cultural package.’\(^{19}\)

If the mission in its broadest conception has been implicated in colonialism, so too have the activities associated with the coming of the missionary, not least in the provision of medical services. Missionaries, it has been argued, supported colonial rule in two key areas: by facilitating the spread of colonial rule, and by acting as cultural brokers (in both a relatively benign, and a more explicitly coercive manner). Missionary teachers could encourage compliance to both the church and the colonial state as a strong Christian moral value.\(^{20}\) Similarly, as Thomas Aidoo suggests, mission clinics in Gold Coast, modern-
day Ghana, were ‘most helpful to the government in their endeavour of opening up tropical Africa’. The Benedictine Mission in Songea District, Southwest Tanganyika, according to Barbara Turshen, designed its Maternal and Child Welfare Services to maintain the reproduction of the labour force for the colonial economy. The establishment of a dispensary offering western biomedicine transmitted to African users cultural discourses far wider than medical paradigms alone: notions of sanitation (and the corresponding, often incorrect, belief in the unsanitary nature of African life); notions as to ‘correct’ behaviour and attitudes, wrapped up within a medico-discourse; concepts of ‘industriousness’, work and obedience; the promotion of routines and systems to ensure cleanliness and health; western conceptions of the body, of sickness and health. In attacking traditional healers, missionaries sought not only to undermine alternative systems of healing and medicine, but to challenge African cultures and identities at their very heart. Lynette Jackson saw in the London Missionary Society (LMS) in Matabeleland ‘agents of European culture and conquest’ who used their struggles against indigenous healing traditions and practices as one weapon in their struggle.

Medical missions could be more explicitly coercive in their actions. Nancy Rose Hunt’s examination of medical mission in the Belgian Congo has suggested missions were entwined with colonial state and commercial interests, conniving in the exploitation of the Congolese. She concludes:

Missionary medicine has often been portrayed as an anomaly within colonial medicine, as a benevolent, persuasive, sentimental form, an interpretation that has served to underscore the coercive aspect of colonial medicine as practiced by company and state doctors… The dichotomy does not work here. Colonial evangelism was not soft, and ‘the’ colonial state was not (always) strong.

Yet, as Beidelman notes, if Catholic missionaries in the Belgian Congo are deeply implicated with the policy of the state, elsewhere the relationship between mission (and medical mission) and state was more complex and problematic. As the nuanced account of mission presented by the Comaroffs suggests:

Recent writings at the juncture of history and anthropology have begun to show how important were the divisions within colonising populations… The Christian missions were from the start caught up in these complexities. Not only did the various denominations have diverse and frequently contradictory designs on Africa—designs that sometimes turned out to have unpredictable consequences; their activities also brought them into ambivalent relations with other Europeans on the colonial stage. Some found common cause, and cooperated openly, with administrators and settlers. Others ended up locked in battle with secular forces for—what they took to be—the destiny of the continent.
Their account of mission medicine in South Africa reveals the popularity of mission doctors that rested upon far more than their ability to command respect.

Medical personnel were rarely explicitly committed to promoting colonial dominance. Even implicit support through action and teaching could not be assumed. In Tanzania, Catholic missionaries were perhaps more ambivalent in their response to British colonial rule (albeit not necessarily colonialism itself). And even if, during the inter-war period, Catholic missionaries were not as unsympathetic to British rule as Beidelman suggests, certainly he is correct in his assertion that elements within the Catholic Church were active in the nationalist struggle in the 1950s. Moreover, differences existed not only between missions of different organisations and denominations, but within individual organisations. Terence Ranger’s study of the Universities’ Mission to Central Africa (UMCA) revealed such sharp internal divisions. The Bishop’s attempts to incorporate male circumcision within a Christianised ‘age’ ceremony (to be performed by the UMCA’s doctors) were resisted by lay medical personnel who championed a modernising agenda that called for such practices to be condemned outright. European missionaries were broadly supportive of colonialism, or at least large elements of the colonial endeavour. However, they were also critical and suspicious of what many regarded as the spread of secular values.

The purpose here is not to argue whether or not missionaries—and medical mission—acted as ‘agents of empire’. They did, but in ways more complex and nuanced than is often presented. But to reduce the narrative of mission in Africa to such a simple construction misrepresents the myriad of impulses driving forward its endeavours. Ultimately, missionaries were agents of their mission first and foremost. Where interests coincided with those of the colonial state, the latter could expect support. Where not, conflict between the two could result. Thus, the position of the mission within the local community—in some cases in East Africa pre-dating colonial contact by several decades—was more subtle than the agent of empire hypothesis allows for. As the Comaroffs note, medical missions were ‘a space of ongoing existential and cultural exchange’ between European missionaries and local African societies.

The complexity of the medical mission rested, in part, on its distinctively different (from the colonial state) world-view. Whilst mission Christianity and the self-proclaimed civilising mission of colonialism had many points of commonality, the interests of the former were not always easily reconcilable with the secular concerns of the state: the concept of ‘civilisation’ formed a Venn diagram, overlapping in many, but by no means all, instances. The importance
of the theology of healing has been well covered by historians. Ranger, for example, identifies four main claims made for mission medical work: it functioned as a living example of Christ’s own work; it offered a means to penetrate communities of non-believers; the (self-proclaimed) efficacy of western biomedicine would undercut traditional beliefs; and embedded within the hospital system were notions of ‘time sense, discipline, sobriety—those invaluable preconditions of rational thought and action’. The Comaroffs, whilst noting a transition in language from Christian well-being to scientific rationale over the long period, point to the firm theological underpinnings of missionary medicine emerging in the mid-nineteenth century. Similarly, Hardiman suggests that from the 1870s, healing was regarded by missions as an increasingly important tool in conversion.

The importance given in the analysis of missionary medicine to its theology has contributed to its being defined as qualitatively different from secular medicine. Missionary medicine, it is suggested, is different from state medicine by virtue of its Christian foundation. Akerele et al., for example, have asserted that mission doctors were preoccupied with winning souls, using medicine as a deliberate tool to further these objectives. They go on to argue that the Christian discourse, within which the missionaries functioned, led them inevitably to focus upon particular medico-social ‘tasks’ such as relief for the leprous, the blind and the handicapped. In other words, biblical manifestations of disease and misery were more attractive to the missionary than, for example, the more mundane task of vaccination. This is in contrast to the more preventative-medicine approach of the colonial state. Similarly, Paul Landau asserts that the primacy of the evangelical objective led to a focus on the African as an individual: ‘surgical missionaries focused on the southern African body as a discrete site, with a view to producing ‘an individual’ and a Christian.’

Missionary medicine, therefore, has a dual purpose, of which one objective—healing of bodies—was subservient to the other—salvation of souls. Many missionary doctors and nurses, indeed, would regard their personal mission in terms such as these. However, the link between healing and Christianisation was never as crude as such implications suggest. Moreover, the criticisms levelled at missionary medicine for incorporating this double element in guiding their health policy rests upon an assumption that the primary function of health care systems is the maintenance, or betterment, of health. However as Lasker argues, improved health is merely one output of a health service, and not necessarily the most important. Medical services tend to reflect the non-medical goals of the socially dominant group. If missionary medicine was attempting to serve two, not necessarily incompatible, purposes,
so too was the colonial model. The question then, if one is to seek to analyse the impact of colonial medicine in relation to the needs of African societies, is which model best met those needs, whether intentionally or not?

As Megan Vaughan argues in her excellent analysis of missionary medicine, direct evangelisation during medical work was rarely put into practice—there simply was not the time. However, it did inform their work, and inevitably shaped to some extent the areas in which they focused, especially maternal and child health work. Nevertheless, Vaughan’s definition of missionary and secular medicine still falls back on traditional forms. For the missionary, she argues, if illness was the result of sin, much of that sin stemmed from the evils of traditional society. Missionary medicine was, therefore, inherently modernising in practice. It sought to replace traditions which were the root cause of sin and suffering. As a consequence, particular diseases stood out as symptomatic of a rotten society. Disease, for the missionary, was essentially a social phenomenon, not merely pathological. It was a personal experience, affecting the individual who had been corrupted by sin. The Christian notion of disease and suffering thus predisposed the mission doctor or nurse to curative medicine. In contrast, secular medicine regarded the collapse of traditional African social structures and culture as the root cause of disease. In other words, its purpose was to protect those traditional structures from decay. Secular medicine ‘tended towards an ethnic model of collective pathology’. The social group rather than the individual was the primary unit of concern. Stemming from this analysis, preventative medicine was of greater value than curative. For the colonial state, the problems of African society came from the outside; for the missionary they originated within.

The problem with such a clear distinction between mission and secular medicine is that it assumes that both worked within the same sector, faced the same problems, and thus posits any differences as primarily ideological. But structural factors also account for many of the differences between mission and colonial state medicine. If missionary medicine was predominantly curative (and this element, as will be explored, has been largely over-stated), there were practical, as well as theological, reasons why it was so. Before 1945, in many areas state services extended little beyond the major towns and administrative centres, and in a few key economic areas. The rural medical service (covering where most Africans resided) was dominated by missions. The colonial state was preoccupied by sanitation and preventative medicine from an early stage in colonial occupation, not just because it regarded it as qualitatively superior, but because the interests of the European were of primary importance. The state did not offer a network of hospitals and dispensaries because it was unwilling to pay for them.
Missionary medicine was, in fact, never solely curative, and introduced many innovative forms of care that were to be adopted by the state. Moreover, the colonial state was not particularly prevention-oriented in practice, despite its own rhetoric. If one can state a definitive difference between the two models prior to 1939, it is that colonial state medicine was confined to urban areas, and areas of strategic economic interest, whereas missionary medicine was the model that catered to the day-to-day needs of the majority of Africans.

Much of the historiography of medical missions finds echoes in colonial discourses on the services and healing traditions of missionary societies. The colonial administration, in Tanganyika as well as in other British colonial territories, relied to a large extent for the provision of western biomedicine in the rural and remote areas on medical services offered by missionary societies. Even at the end of the colonial period, the Provincial Commissioner of West Lake Province noted that he was fortunate to have ‘some up to date Mission Hospitals’ in his Province to ‘supplement the very inadequate Government ones’.

There was little doubt amongst colonial administrators that missionary medicine was not merely useful, but essential. District and Provincial reports throughout the 1920s and 1930s noted the medical work of missions, and their importance in their local areas. A 1937 policy paper written by the Director of Medical Services (DMS) on cooperation with missions recognised as much. He wrote: ‘If Government were to subsidise medical missions at every centre at which assistance is needed, it would virtually mean its handing over eventually most of the higher medical education and most of the native clinical medical work carried on in the Territory.’

The DMS recognised that medical care of Africans in the late 1930s was still overwhelmingly dominated by the missions. The government might have been wary of such organisations, sometimes sceptical about the quality of the service, and reluctant to set precedents for state funding of such services, but it could not ignore its importance.

However, whilst acknowledging the value of this sector, the colonial state simultaneously constructed a narrative, which sought to establish a qualitative gap between secular and medical health care provision. It was a gap the colonial Medical Department was keen to point out:

I think it is desirable at this stage to make very clear to the Missions the somewhat different outlook of the Government [medical practitioners] and the Missions, the former being concerned with the mass of the people and particularly with the prevention of the spread of disease; and the latter more particularly with the individual and with, so far, the curative aspect.
The Medical Department, and Administration in general, thus posited a fundamental division between mission and state medical services. The essential premise guiding colonial definitions of missionary medicine was not just that it pursued different objectives, working within its own particular ideological framework. It also offered a particular type of medical care: curative, and focused on the individual.

Reflecting shifts in western biomedicine and health care in the metropoles, colonial administrations from the start had emphasised preventative medicine as the key objective of medical policy. During the period of German administration, the Colonial Secretary Dernberg suggested the ‘extraordinary high mortality in East Africa is an indication of the absence of adequate preventive medical services’. Throughout the inter-war era, the British administration similarly sought to emphasise the primacy of preventative, over curative, medicine (in rhetoric, if not always in reality).

The distinction was important, reflecting not just a different approach methodologically, but a superior quality of care. Preventative medicine was concerned, according to the official rhetoric, with the community at large, not the individual at the hospital door. It sought to limit illness and disease more widely, not simply provide a remedy once it occurred. State medicine was, in this constructed narrative, socially oriented. In contrast, this narrative continued, missionary medicine was focused upon the ill and suffering in the immediate surroundings, geared towards the individual not society.

To some extent, the colonial narrative did reflect services offered by the medical missionary sector: most were indeed small-scale, operating out of rough and ready buildings, lacking in the latest equipment and hampered by lack of supplies. However, the assertion that state medicine was concerned with the mass of society bore little resemblance to reality. Outside of medical campaigns against diseases that threatened European life or economic interests, vaccination campaigns (which, in fact, utilised missionary experience and personnel, about which more later), state medicine had little impact in the rural areas until the 1930s. It was the missions that provided the network of health care for the rural dwellers.

This being the case, why was the narrative of preventative versus curative medicine so important? Why did the colonial state regularly seek to portray missionary medicine in particular ways, suggesting implicitly that its curative model was inferior in both quality and orientation? The concern of the colonial government was financial. From the late 1920s, the central debate within the British administration over mission medical services was the financial commitment the state ought to be making. It recognised the importance of funding medical missions: ‘such assistance affords the most effective and eco-
nomical means of bringing the advantages of modern medicine within the reach of the indigenous population’.39 However, such support came at a potential cost. Throughout the 1920s and 1930s, even as the Administration gradually began to provide funds to support medical services run by missions, there was significant concern that ‘the grant of assistance directly from [Government] funds to one mission is likely to lead to similar demands from others’.40 It was not until 1946 that legislation was passed allowing for the provision of grants-in-aid to mission medical services.

In other words, the downplaying of medical missions in the inter-war period was partly a deliberate policy in order to avoid accepting financial responsibility. The state was responsible, under the League of Nations Mandate, for the welfare of the African population of Tanganyika. It ought to be providing for the medical needs of the people. Yet it clearly did not have sufficient facilities outside key strategic areas. The Administration knew full well that should it subsidise missions’ medical services wherever they were the sole medical service, the vast bulk of its medical budget and responsibility would be transferred away from the state.41 To characterise mission services as curative, focused upon the individual, led by religious imperatives, allowed the government to argue it had no responsibility for funding these services.42 The narrative of medical missions that emerged in the colonial period reflected, then, state financial concerns, rather than a considered analysis of that sector and its potential benefits and weaknesses.

Towards a New Definition of Missionary Medicine

The definition of ‘missionary medicine’ then, has centred on four key areas: first, it is essentially curative; secondly it is concerned with the individual patient (rather than with wider society); thirdly it encompasses a strong moral and theological tone in its practice; and lastly it is driven by a civilising mission, and works against African traditions, social structures and culture. In these aspects, it is considered as qualitatively different from so-called ‘colonial medicine’.

It is suggested here that ‘colonial medicine’ should refer to western biomedicine practised in the colonies. The services offered by the state and by missions (and indeed by the commercial companies) were part of one system, albeit with different emphases, different structures of authority and funding, but nevertheless two vital parts that only together could justify a claim to provide medical care for the African. Missionary medicine was different in many respects to colonial state medicine prior to 1939, but it was a difference based upon structural factors, as much as ideological discourses.
The Place of Curative Medicine in Medical Missions

The work for which missionary medicine is best known—the curative services based upon hospitals, dispensaries, and medical safaris—formed the bulk of medical services. Medical doctors and nurses performed operations, dispensed drugs and dressed the wounds of those who came to the doors of the dispensary. Soon after his arrival in Tanganyika in 1935, Dr Leader Stirling, a UMCA doctor, described his ‘average’ on-station day. After Mass and breakfast, Dr Stirling saw patients in the dispensary from 8.00 a.m. The first to be seen were those in-patients well enough to come to the dispensary. Next came the out-patients who might number over 150 each morning. After this session, he would tour the hospital to attend to those who were too ill to move. Immediately before lunch Stirling would do microscopic and other laboratory-based work, returning to this after lunch. At 4.00 p.m., he attended the evening dispensary session. This should end at 5.30 or 6.00, but often extended beyond.43

Leader Stirling shared responsibility for the UMCA medical services in Masasi with Dr Frances Taylor. His half of the district encompassed, in 1935, two hospitals, four dispensaries, a leper settlement and four leper dispensaries, for all of which he was the itinerant doctor. The central hospital, Stirling’s headquarters, was at Lulindi, but typically he would spend no more than ten days there each month. For the rest of the time, Dr Stirling would travel between the different dispensaries and hospitals, performing surgical operations, treating patients and supervising the work of nurses and African medical staff. Added to this responsibility for the institutional facilities, as the only doctor in his area, Stirling was frequently called upon to vaccinate the local population, treat those patients too sick to leave their homes, to visit missionaries and colonial officials who fell ill, and even, on one occasion, perform an

Table 1: Medical mission facilities in Tanganyika, 193644

<table>
<thead>
<tr>
<th></th>
<th>Out-Patients</th>
<th>Hospitals</th>
<th>Dispensaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>UMCA, Tanga</td>
<td>160,929</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Augustana Lutheran, Kiomboi</td>
<td>88,770</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Lepizig-Lutheran Mission, Kilimanjaro *</td>
<td>49,956</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Bethel Mission, Bukoba</td>
<td>14,100</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Moravian Mission, Tabora</td>
<td>12,500</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

* figures for 1935 supplied by mission.
autopsy on the body of a suspected murder victim. When either of the two
doctors was on furlough, the other’s responsibilities doubled. For six months
in 1939, for example, Dr Stirling was responsible for an area 250 miles long
by 50 miles wide (12,500 sq. miles).

Hospitals and dispensaries catered to the vast numbers of Africans who might
travel a considerable distance to reach the mission doctor. A snapshot of medical
missionary work in 1936 shows the scale of activity in this sector (table 1). These
figures do not include the work done on safari, which could amount to as
many as 1,000 extra patients in a single trip.45

Medical missions faced several constraints that tended towards narrowing
the focus of activity towards curative services. The evangelical purpose of the
mission was clearly the most important, directing, ultimately, all that the mis-
sion did. However, mission medical services had been established for practical
reasons too, and the shape of missionary medicine continued to reflect these
initial factors. The financial constraints on activity were a further vital element
in influencing the type and scale of healing that missions could undertake.

The theology of medical mission was critical in providing a philosophical
rationale for the work undertaken by the medical staff of mission societies. It
gave them their claim to be participating in the work of evangelisation, and in
the establishment of Christian communities across sub-Saharan Africa. In
1893, the Bishop of Zanzibar described the medical missionary:

What is meant strictly by a medical missionary is, I suppose, neither a medical man
who gives simply his services as a doctor to missionary work, nor a priest who is also a
doctor, but a doctor who uses all his medical knowledge for a missionary end; whose
aim it is to use the great influence which his profession gives him to draw his patients
to the love of God; who longs not only for the healing of their bodies, but for the
salvation of their souls.46

For Bishop Smythies, the main attraction of the medical missionary was not
that curing sickness would bring about an immediate conversion; but that
through this social ministry, barriers and resistance to Christian missionaries
in general might be broken down. The missionary doctor, through his healing
work, might find ‘a way to their hearts and to their families’.47 Conversion was
of course the ultimate aim, but medical work was not regarded as the immedi-
ate catalyst, rather the start of a long process.

One UMCA African Reader nursed a wounded Masai warrior at the mis-
station station at Kologwe in 1892. The local WaZigua people would, it was
asserted, ask why an enemy was being cared for, not killed or sold into slavery:
‘The first answer to such questions will be a thousand vague and grotesque
suspicions; the final answer must be conversion.’48
Example of the caring and healing ministry of Jesus, missionaries believed, would be instrumental in allowing for the soul to be won. The witchdoctor, the incarnation of superstitious evil, would be overcome by the obvious benefits of western medicine, and the case for Christianity would be proven. A manual on medical mission, written by a CMS Medical Missionary in 1920, pursued similar themes:

> The true medical missionary . . . regards his medical work as the Gospel translated into action; it is a testimony to a God of love, and a proclamation of the fact that He cares for man; it is an object lesson in Christianity, and thus not only opens the way for the preaching of the Gospel, but itself delivers the message.49

The purpose of medical mission, for the author, was threefold: to relieve suffering, in the example of the healing ministry of Jesus; to reflect the compassion and love of the church; and to preach that the only effective remedy for sin and suffering was Christianity. It had both an evangelistic purpose, and an indirect social impact through its example.50 When Stirling was appointed as medical doctor to Masasi Diocese, he asked the Bishop how, as a doctor, he could help spread the Gospel. The Bishop replied: ‘A mission carpenter spreads the Gospel by being a good carpenter . . . just be a good doctor.’51

Doctors such as Leader Stirling were moved to become missionaries, to apply their skills in the name and cause of the church, because they believed they had been called by God.52 However, the theology emerged in response to the increasing numbers of men and women undertaking medical work in the mission field; it was elaborated in many cases as a post hoc response to internal debates over the relevance of a social ministry. It was not the sole factor guiding the evolution of missionary medicine in Tanganyika.

The first doctors and clinics in the country were established with one simple aim: to keep as many of a society’s members alive as possible, for as long as possible. The extension of these services, first to those African members of the church, and thereafter to Africans in the wider community, was a secondary consideration. The impact of missionary mortality and morbidity should not be underestimated. Of the UMCA mission members between 1860 and 1918, 17.5 percent died, and a further 18.8 percent were invalided home.53 In other words, over one-third of the mission was lost to death and sickness. In common with the experience of missionaries elsewhere, the first three years were the crucial period: the average length of survival for Catholic missionaries in Lagos from the 1870s to 1902, for example, was under three years.54 In the UMCA 31 percent of the members who joined between 1860 and 1899 left or died within three years.55
Given such numbers, it was imperative that societies take measures to prevent such a dramatic loss of life. Illness was both a human and financial cost that few missions could afford. From the start, then, missionary medicine was geared towards the curative. It was an emergency service designed to react to immediate problems. It was small scale, and frequently lacked continuity in the late nineteenth century. The UMCA had no doctor permanently on the Tanganyikan mainland for nine years following the death of its sole mainland doctor in 1895. Nurses were not posted to all UMCA stations until 1903. Thus the structure that emerged was one of a central institution—clinics and later hospitals—with smaller dispensaries and clinics, often under an African medical assistant, and visited periodically by the resident European practitioner. If necessary, a patient could be transferred to the central institution for medical treatment. It functioned, in many ways, as crisis management.

The medical care established for the European missionary personnel was gradually extended to the local Africans, much as colonial state medicine broadened its services. First, the new Christian communities benefited from the new medical option, indeed were expected to use western biomedicine as a sign of their rejection of pagan superstition. Soon, however, as Africans in increasing numbers came to the dispensaries, clinics, hospitals, itinerant safaris, services began to be expanded.

In 1864, Bishop Tozer of the UMCA outlined his priorities for development of the mission in Zanzibar. After establishing a school, he intended to establish some institution to ‘administer relief to sick out-door patients’. In 1887, the UMCA built a hospital at Magila Mission Station in northern Tanganyika. By 1894, out-patients averaged 57 a month. Fourteen years later, 2,741 new patients attended the hospital, and over 5,300 repeat patients. By 1936, Zanzibar Diocese had seven hospitals and ten dispensaries, and treated over 160,000 patients. The first medical facility in Masasi was a dispensary, established in 1903. From this beginning, some thirty years later a rural network of three hospitals and a considerable number of dispensaries would be inherited by Dr Stirling.

The medical mission was reactive to need: it grew and evolved as demand increased. As the prestige of a local European doctor took hold, African patients travelled from ever further afield. If mission doctors were concentrating on curing the sick as individuals, it was in part because the evolution of these services proceeded largely unplanned, and responded to need.

Unlike the colonial administration, and even the district medical officers posted to the provincial towns throughout the Territory, the medical missionary was confronted daily with the experience of sickness and suffering. Missionary societies did not see themselves as colonial occupiers (even if, from our
perspective, they were). They were integrated (as much as Europeans could claim to be) into the communities and societies in which they found themselves. Many had been present in their areas for over forty years by the 1920s; some had played a political and social role that exceeded the needs of evangelisation alone; all had a stake in the survival and betterment of the people—Christian and non-Christian—amongst whom they resided.

For the UMCA missionary at Masasi station, the attitude of the colonial administration during a smallpox epidemic was incomprehensible:

I am bound to put on record here my opinion that the Government's attitude during this epidemic has been far from satisfactory, they have contented themselves with supplying vaccine... and vaccinates in order to minimise as far as possible the spread of disease, but they take no interest whatever in the care of those infected, and appear to regard any time spent on visiting them as so much time wasted, their argument being that the disease will in any case take its course and not much can be done medically to alleviate it. This is true to a certain extent, but there is always the possibility of its affecting the eyes, with corneal ulcers, and these, if not attended to, may lead to blindness, and a certain amount can be done to relieve the discomfort of the patients. It is in any case hard to understand how any doctor could contemplate the possibility of... having sick people un-visited, nor do I believe that such a course would have been suggested if the patients had been Europeans.56

The function of the doctor was to heal the sick and ensure health. Preventative medicine was not ignored by medical missions, or regarded as something inferior in terms of the evangelical mission to proselytise. If people required help, they should receive it. Being a part of a community entailed certain responsibilities. Just as the mission was expected to assist in times of disaster, such as famine, it was expected to provide care when required.

Perhaps the most significant constraint, more so even than the origins of mission medical services, their place within local communities, and even the emerging theology of missionary medicine, was financial. Missionary societies relied for the most part on voluntary income from the public at home. Official government grants for medical work were not made in any meaningful way until after 1945. In comparison with missionary education, which received sufficient funds from the state to allow for massive expansion and coverage, medical work had to be funded from the limited fees charged to patients and income from donations. Inevitably, this constraint limited the type and range of services that could be offered. A hospital-based service was the most economical use of limited funds and limited personnel.

It was not until the post-1945 period that the colonial state provided regular grants-in-aid for mission medical activity. Throughout the 1920s and
1930s, it remained reluctant to set precedents in providing funds for missions. The Medical Department noted in 1927 that ‘the grant of assistance directly from [Government] funds to one mission is likely to lead to similar demands from others’. The state was unwilling to countenance ‘the more or less unlimited obligation’ that grants-in-aid would entail, a situation that would create ‘a most embarrassing precedent’. Grants were thus made on an ad hoc and strictly non-recurrent basis. Missions could apply each year, but with no guarantee that any funds for medical work would be forthcoming. Gradually over the course of the 1930s, this ad hoc system became increasingly formalised, as the colonial state increasingly recognised the inadequacy of the current procedures.

The unpredictable and small-scale nature of official funding in the 1920s and 1930s shaped the extent to which missions could function. In 1928, the Livingstonia Mission in Mwenzo was granted £25 towards the total £600 costs of building a new hospital. The Mother Superior of the Roman Catholic Mission at Mahenge was granted 100 Shillings for the purchase of a donkey to assist in her care for leprosy patients. In 1935, the UMCA mission in southern Tanganyika was paid 55 cents per mile for her assistance in a local smallpox outbreak. In 1936, just £4,309 was granted to missions: £1,644 for the upkeep of leprosy camps; £1,356 for Lutindi Mental hospital; £971 for maternal and child health services; £319 for drugs (including drugs for leprosy patients); and just £19 for ‘epidemic outbreaks’. This was the sole contribution of the colonial state to mission medical care, care which—the state acknowledged—formed the main part of health services available to Africans.

The effects of such limitations can be clearly seen in the work of the Moravian Mission in Tabora in 1939. Expenditure on medical work was Shs 17,646/- (excluding salaries of three Danish nurses and the doctor). Income (including Shs 816/- from the state) was Shs 6,948/-. This to cover over 115,000 attendances at four dispensaries, 25,500 at outstation first-aid centres, and almost 30,000 attendances at Maternity and Infant Welfare Clinics. With the onset of war and German invasion of Denmark in 1940, no further funds from Danish donations to support the Mission would be forthcoming.

Curative medicine did not, therefore, purely reflect a Christian bias. Mission medical services were ‘front-line’ services. The needs of planning were subservient to epidemic outbreaks, and to the lines of sick and wounded queuing outside the dispensary or hospital. There was no other agency in many of these rural areas willing to share the burden. If the missions had neglected this aspect of health care, it simply would not have been done.
Moving Beyond the Curative

Although missionary medicine was structurally predisposed to the provision of curative medicine, it was not, in fact, entirely curative in its focus and application. Despite the constraints upon the medical missions, both ideological and structural, important services beyond the curative were implemented during this period, as missions contributed to important innovations in the care of African health in the wider sense. From the training of African medical personnel, to health and sanitary education in their schools, missions sought to inculcate European ideas of medicine, health and hygiene amongst the African populations with whom they came into contact.

The colonial state preventative health campaigns against endemic and epidemic disease were one of the key foundations upon which colonial claims to be practising preventative medicine were based. However, missions frequently played a significant role in this regard. The Moravian Mission in Tabora district, for example, worked with the medical administration in efforts to control sleeping sickness. In 1925, a large swathe of land in Tabora Province was designated a Sleeping Sickness Area. Dr Keevill, the doctor in charge of medical services at the adjacent Moravian Mission at Sikonge, provided assistance. Much of the work consisted of treatment for infected cases, but Dr Keevill and his staff also played a role in the management and monitoring process. Statistics were provided of infection rates; native dressers were seconded to the medical department as scouts; and the mission assisted in the resettlement schemes. The Augustana Lutheran Mission in Kiomboi implemented schemes in the 1930s for the control of hookworm, tuberculosis and sleeping sickness. During a government tsetse-fly clearance campaign, the mission supplied six mission dressers to assist.

In 1937, the Director of Medical Services proposed that more structured and formal agreements be made with medical missions:

There are mission practitioners situated in places where essential government work, such as attendance on sick officials, vaccination, etc, has to be done but where it is not practicable to station a medical officer. In such cases, if missions wished to cooperate, formal agreements might be entered into and scales of remuneration laid down.

Missions were vital elements in the efforts to control disease undertaken by the state, and the state recognised the clear benefits of cooperation. Missions could execute schemes with their local knowledge and presence on a far more efficient basis and at shorter notice. In many of the remote rural districts, the state provided the funds, drugs and equipment, and the missions undertook the actual work.
Mission activity in this sphere was not only in response to government requests. The official report into an outbreak of smallpox in southern Tanganyika in 1935 noted only three deaths from 438 cases. Yet a larger mortality rate had been averted by a pro-active response by UMCA medical missionaries. The UMCA doctors discovered the outbreak in early June, 1935, one of whom noted the slow response of the state:

The government officials have taken charge but they seem to be doing very little, so we have been shifting ourselves. There are no cases in Masasi, but in several areas round about, some as much as fifty miles apart. They are all scattered about in the bush . . . we are vaccinating hard and our own team (Dr Taylor and myself and about eight of our boys) has so far done more than 10,000 vaccinations in the past two weeks.

Over the whole period of the epidemic, 30,000 people were vaccinated by the UMCA medical teams. Requests for medical assistance went unanswered, except for supplies of vaccine at ‘irregular intervals’.

The slow response of the colonial state was not an isolated incident. In November 1934 the District Officer sent a suspected case to Masasi mission hospital for diagnosis. Smallpox was confirmed, and assistance requested. The priest in charge at Masasi noted:

...the European Medical Officer did not come and instead the Govt [sic] Medical Orderly began vaccinating. There is reason to believe, however, that the lymph is old and not effective. It is also entirely insufficient in quantity, and some more has been asked for from Dar es Salaam.

The mission felt, once more, obliged to act.

Missionary medicine was not only an additional resource the state could draw upon, but an integral element of the colonial response to infectious disease and preventative medicine in the rural areas. The state may have (mostly) provided the funds and the necessary equipment, but it was the mission medical staff who carried out the actual work. The claims by the administration to be practising preventative medicine could only be realised through the agency of the missions themselves.

A second key area in which medical missions operated beyond the confines of a purely curative practice was in the provision of maternal and child health (MCH) services to rural women and their infants. In this sector, missionary medicine was not providing an alternative to the state, but leading the way for the administration to follow. Until the late 1930s, the state remained reluctant to establish such services. The Chief Secretary commented to the Director of Medical Services (DMS) in 1929:
The expansion of Maternity and Child Welfare is a matter of vital importance... There are other missions also doing Welfare work... This, however, to my mind, is not a disadvantage, for we could curtail our own expansion, except in selected areas, by letting the Missions do the work, under supervision and guidance, as at present, at a very small cost to [Government].71

In the mid-1930s, following the collapse of government MCH services in Kahama, this policy was made more explicit:

I am aware that a start has been made to train native midwives at Kahama, but it is very late in the day now to make a beginning, and I personally would prefer to see maternity work outside the big towns left to the Missions, seeing that religious influence has considerable learning on the success of these operations.72

The provision of medical care to women and children was henceforth to be the sphere of the voluntary agency.

In 1943, the DMS in Tanganyika wrote: “The social conscience of the local population has not yet reached the stage when the needs for improving the conditions for normal childbirth have wide recognition.”73 He called for the development of organised Infant and Maternity Welfare Centres, noting that a ‘start’ had been made in Tabora, Tanga and Dar es Salaam. This view underplayed realities on the ground. By 1943, Tabora was well beyond the initial stages that the DMS suggested existed. For two decades, the Africa Inland Mission (AIM) had run a Maternity Home in collaboration with the local Native Authority.

The mission undertook medical work on all three of its sites in Shinyanga District: Kola Ndoto, Luhumbo and Uduhe. The main centre of medical activity was at Kola Ndoto, under the supervision of Dr Maynard, the wife of the resident priest. Even before dedicated services and buildings had been established, Dr Maynard supervised births and treated infants and children in addition to her general medical work which administered to some 26,000 outpatients. In 1926, a Maternity Home was built to provide adequate ante- and post-natal care. In that first year, 146 births were supervised, and over 3,000 infants and children treated.74 By 1933, 1,937 births took place in the Maternity Home.75

In comparison with the scale of activity undertaken in government clinics, the AIM clinic was extremely active. Across the three government-run clinics for Tanganyika, between 1930 and 1933, 1,287 confinements were attended to. In the single AIM clinic at Kola Ndoto, that figure was 5,830. The success of the AIM Maternity Home became a model for MCH facilities across the territory. Dr Maynard was consulted over the planning of a government clinic
in Nzega in 1928. She advised on the building, the layout, the necessary equipment and the potential costs of providing such a service. The Governor of Tanganyika himself declared that: ‘the best possible little hospital should be built on the lines of that under Dr Maynard’s charge in the Shinyanga District’. Education, sanitary ‘western’ birth procedures, curative medicine for the sick, were all combined in the MCH services, and the AIM Maternity Home at Kola Ndoto led the way in such services.

Dr Maynard’s clinic was pioneering not only in that it was the first MCH service to be established in Tanganyika. It also undertook perhaps the first formal statistical survey of infant morbidity and mortality. From 1 January 1927, the first 1,000 births were recorded, and monitored in the following years in order to establish some kind of bench-mark for the success of the scheme. For the first three years of the survey, infant mortality was recorded to be 10.5 percent.

When in 1943 the DMS noted, ‘I feel it is a mistake to train midwives who are spread abroad outside the controlling influence of supervised centres’, he was already behind actual practice. In 1927, five local Wasukuma ‘girls’ were being trained by Dr Maynard at the Maternity Home. The course lasted three years, and the first person to complete finished in 1929 (at which point eight African nurses were undergoing training). The use to which such training was put was not limited to working under the direct supervision of Dr Maynard. Whereas some 13 years later the British administration regarded unsupervised nurses and midwives with a great deal of suspicion, in 1930, three trained nurses had left the AIM Home to get married. One nurse had already begun to undertake maternity work in her chiefdom, and the other two were expected to follow suit. The local District Officer regarded these staff as the bedrock of district medical services in the future:

Meantime Dr Maynard is taking in more girls for training. The trained nurse will form the nucleus of the District nursing staff in the future. The present Home cannot expand very much more and it will be necessary to find means of decentralising the work and this can be done through the medium of trained native nurses.

The benefits of MCH services were thus spread out from the nucleus of Kola Ndoto from as early as 1930.

Other missionary societies offered similar MCH services, if less successfully and on a smaller scale. The CMS began its MCH service in central Tanganyika in 1927, opening seven clinics by the early 1930s. The White Fathers maintained clinics at Karema, on Lake Tanganyika, and at Kagondo; the Augustana Lutheran Mission undertook MCH services based on its hospitals in
Ndolage and in Singida; at Peramiho in southern Tanganyika the Benedictine sisters superintended confinements; the UMCA Hospital at Magila had a special branch for maternity work, supervised by the Sisters of the Sacred Passion; and the UMCA in Masasi district ran several Maternity clinics, with a larger centre at Masasi Hospital.

Perhaps the most unexpected (according to traditional narratives at least) of medical services offered by a missionary society was the mental asylum run by a German missionary in northern Tanganyika. In 1920, 78 patients were living at Lutindi Lunatic Asylum. The asylum also took in those designated ‘criminal lunatics’ by the state’s judicial system, and by 1941 housed some 22 ‘criminals’.80 It was not, thus, simply a missionary facility catering to a perceived need in the local community. It was an integral part of the judicial system, necessary if the correct incarceration and treatment of the criminally insane was to be applied.

As with much of mission medical services, the state—whilst relying absolutely on the service offered—was reluctant to contribute financially to the costs of providing care for the mentally ill. In 1920, a grant of Rs 8,608.50 was made to cover the basic costs of accommodation and food. But no regular grants were paid until the mid-1930s. The Director of Medical Services ultimately admitted liability for these services, and in 1935, a grant was made at a rate of 68 cents per patient per year.81

Lutindi Lunatic Asylum was a rare institution. Yet the example of Lutindi illustrates the hidden aspects of the mission medical services in Tanganyika. Surprising work was undertaken on various mission stations: whether it be an experimental planting station to provide locally grown anti-leprotic drugs;82 giving hygiene lessons to school children on medical safari;83 or the establishment of a joint mission-government dispensary in the small town of Ujiji for the purpose of eradicating venereal diseases. Mission medical services were not confined to the curative, traditional sectors of health care, but were more wide-ranging. Above all, they were critical to the health services operating in the colonial state, be they secular, commercial or mission-based.

**Conclusion**

After 1945, mission and government services became ever more integrated, and the structural and ideological differences that marked out the pre-war services were gradually eroded. The price for the missions of grants-in-aid was increased supervision, and the imposition of standards by the state. The state gradually brought control and direction over national health care into its own administrative sphere, contracting the missions, as it were, as co-providers in
the rural sector. This process was not, however, an annexation of mission independence. The concentration of rural health service provision during the 1950s rested, to a large extent, on the pioneering work of the medical missions. The policy of establishing Rural Health Centres, for example, reflected the holistic vision of the mission community. The concept of the ‘bare foot doctor’, established in practice in independent Tanzania long before its emergence as a global policy at the 1978 Alma Ata conference, had been utilised by missions in an embryonic form since the early twentieth century. Missions were the pioneers in systems of primary health care, now an orthodoxy of medical service development.

So how can we define both the nature and place of missionary medicine? At its simplest, ‘missionary medicine’ was that medicine provided by missionary societies. However, it was also more than that. Missionary medicine was not separate from colonial medicine, but a branch of it. It did not operate in addition to state-provided services, but in place of them. Mission doctors regarded themselves as providing, not curative services for the sick and wounded, but a health service designed to meet the needs of the local community.

Missionary medicine before 1945 was fragmented, small-scale, lacking in resources and over-stretched. Its services could not necessarily compete in quality with the best of the state hospitals. But it succeeded, within the local context, in providing a network of health services that stretched into the rural society, and ensured that, where there was a mission hospital, there was an option for the local people to make western bio-medicine a choice for healing.

In 1913, a UMCA nurse at a dispensary in Luatala, wrote:

The patients increase daily, and the medicine does the opposite. They are a problem, and I feel completely overwhelmed. We talk of sending to the Makonde Chiefs to tell them to prevent the people coming. But can one open a Dispensary and then tell the people to stay away? They come in droves! On Thursday evening fifteen came in from the Makonde. They can’t go straight back when they have come from so far, and they all brought food for three or four days. There were ninety patients sleeping on the station last night. Everywhere crowded with them. Wherever you go, you meet patients. I feel so helpless.

The editor added a note to this account: these numbers did not include outpatients, of whom over 100 attended daily. Doctors—all doctors, missionary or state—had sworn the same Hippocratic Oath: ‘I will use my power to help the sick to the best of my ability and judgement.’ The priorities of missionary medicine can be criticised. Prevention may be better than cure; but it is difficult to tell that to someone already infected with smallpox.
References


Notes

1. This paper was first delivered at the British Imperial History Seminar, Institute for Historical Research, 19 March 2001, under the auspices of the Currents in World Christianity Project, coordinated by the University of Cambridge and financed by the Pew Charitable Trusts. The opinions expressed in this paper are those of the author and do not necessarily reflect the views of the Pew Charitable Trusts. Thanks to the anonymous readers for valuable comments and suggestions.
4. White, Jungle Doctor on Safari, 10.
5. Titmuss, The Health Services of Tanganyika: A Report to the Government, 34, 37, 68.
7. Preventative medicine has long been accorded a greater status in the maintenance of public health than curative medicine. It is not simply an assertion that ‘prevention is better than the cure’; Barbara Turshen (‘Impact of Colonialism’) has argued, for example, that curative medicine ignores the social roots of disease—in particular poverty. Akerele et al. have also argued that mission medicine was predisposed to curative medicine, Akerele et al., ‘A New Role for Medical Missionaries in Africa’, 175-180.
8. Clyde, for example, tends to downplay the role of missions, and concentrates on state services. In one article, he almost entirely ignores the mission sector, and even in his History of the Medical Services of Tanganyika fails to account adequately for the sector. He asserts, further, that the needs of evangelisation were the driving force behind missionary medicine in the pre-1945 period. Clyde, ‘Health and Medical Services in African Territories: Tanganyika’.
13. Shinyanga District Annual Report, 1928, TNA 712, 34-5. This does not mean the mission was treating over half the local population. But it does provide an indication of the extent to which it was linked into the local community, and suggests a significantly deeper coverage, in this area at least, than the 20 percent suggested by Feierman for sub-Saharan Africa as a whole.
15. See, for example, Hardiman (ed), *Healing Bodies, Saving Souls*; Comaroff, *Of Revelation and Revolution*.
34. Vaughan, *Curing Their Ills*, 57.
35. West Lake Province Annual Report, 55, Tanzania National Archives (TNA) library.
36. Director of Medical Services (DMS), 10 August 1937, 1. TNA 450 692 v.1.
37. Secretariat Minutes, 5 August 1937, TNA 450 692v.1.
38. Clyde, *History of the Medical Services*, 38. Dernberg went on to suggest that preventative medicine could be a main focus of missionary activity in the rural areas.
40. Secretariat Minutes, 27 June 1927, TNA 10721 v.1. Such concerns were increased with the onset of global depression in the 1930s.
41. DMS, *Cooperation with Missions* memo, 1937, 1. TNA 24843.
42. A parallel could usefully be drawn here with official donor responses to the role of Faith-Based Organisations in development. Many donors have proved reluctant to fund the work of FBOs, arguing, along similar lines to colonial authorities, that publicly funded, secular organisations should not support the work of organisations geared towards proselytising. For a more detailed discussion on this, see Clarke and Jennings, ‘Introduction’.
44. Information taken from a survey of mission medical services, 1936, TNA 450 692 v.1.
51. Leader Stirling, personal communication.
52. Stirling makes this ‘calling’ explicit and very real. In his account of how he came to join the UMCA he states that he prayed to God to ask him what he should do on completion of medical school. A postcard arrived the very next day, asking if he was prepared to work in Masasi. Personal communication.
53. Jennings, “‘This Mysterious and Intangible Enemy’”, 65-87.
55. Jennings, “‘This Mysterious and Intangible Enemy’”, 65-87.
57. Secretariat Minutes, 27 June 1927, TNA 10721 v.1.
58. Secretariat Minutes, 17 November 1927, TNA 10721 v.1.
59. Ag DMSS to Chief Secretary (ChfSec), 7 September 1927, TNA 10721 v.1.
60. DMSS to ChfSec, 24 April 1928; District Officer, Mahenge, to Provincial Commissioner, 1 May 1928; Ag DMSS to ChfSec, 5 February 1935. TNA 10721 v.1.
61. DMS to ChfSec, 10 August 1937, TNA 450 692 v.1.
62. Statistics for Hospital Dispensaries and First Aid Boxes, Moravian Mission, 1939; DMS to ChfSec, 9 July 1940. TNA 27442.
64. Kimomboi Mission Hospital, Report on medical work, 12 October 1936. TNA 450 692 v.1.
65. DMS, *Cooperation with Missions* memo, 1937, 2, TNA 24843.
69. UMCA Masasi Logbook, 17 August 1934-19 July 1938, 19 November 1934.
71. Secretariat Minutes, ChfSec, 11 April 1929, TNA 10721 v.1.
72. Secretariat Minutes, 30 March 1936, TNA 10834.
73. Director of Medical Services, *Post-War Development—Medical Department*, 8, TNA AN450 1179.
74. Shinyaga District Annual Report, 1926, 30, 32, TNA 712.
75. Shinyanga District Annual Report, 1931, 38; DMSS to Chief Secretary, 3 March 1934. TNA 712.
76. ChfSec to PC Tabora, 5 October 1928, TNA 10834; PC Tabora to ChfSec, undated, TNA 10834; DO Nzega to PC Tabora, 11 October 1928, TNA 10834.
77. Shinyaga District Annual Report, 1930, 30, TNA 712. The main unit for measurement is generally the first five years of life, so the low figure of 10.5% would probably have risen. Nevertheless it still represents a low infant mortality rate for the period.
78. Director of Medical Services, *Post-War Development—Medical Department*, 8, TNA AN450 1179.
80. Lutindi Mental Hospital, Sixth Monthly Report, 4 July 1941, TNA 29670.
81. Ag ChfSec to DMSS, 15 February 1935, TNA 10721 v.1.
82. This was undertaken by the UMCA at Kiwanda, Tanga Province. Sec BELRA to DMSS, 30 July 1931, Rev. A.B. Hellier to Sec BELRA, 27 July 1931; TNA AN 450 30/2 v.1.
83. Summary of Work of the Bethel Mission, Bukoba, 19 September 1936; TNA AN 450 692 v.1.
84. Few RHCs were actually established before 1961, despite the official policy.
85. UMCA *Central Africa* 21, November 1913, 304.