CHAPTER 2

Trouble with "Status": Competing Models of British and North American Public Health Nursing Education and Practice in British Malaya

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Two distinct nursing styles fought for dominance within the nursing world in the interwar period and British Malaya provides a historical laboratory with which to study the varied goals of British and North American nursing. Where the British approach in the field relied upon the notion of "character," the North American model favored a more techno-scientific approach emphasizing the importance of leadership. The "organic" British approach appears to contrast with that of American colonial policy and that of the American Rockefeller Foundation (RF) in the Philippines, where there was a concerted attempt to lay down a legacy and create "lighthouses" of leadership.[1] Yet, British and North American attitudes were initially similar in two respects: training of local nurses and the feminization of the local nursing workforce. However, the focus of this chapter is the collaboration and conflict between American and British nursing styles in British Malaya in the 1920s and 1930s. The title of this chapter refers to the experience of a nurse, Elizabeth Darville, who was trained in Britain, recruited by the Overseas Nursing Association (ONA), and was inspired by further training in North America before working in Malaya where she experienced a clash

of attitudes. The challenges which Darville faced reveal that "Western" nursing and medical leadership styles were not homogenous in colonial contexts.[2] The chapter concludes by considering how lethargic British nursing was in laying down a clear legacy of leadership throughout the period of British rule.

In this chapter, Darville's experience of working with the American Rockefeller Foundation's Straits Settlement Rural Sanitation Campaign (SSRSC) is situated within an analysis of the history of colonial nursing policy in British Malaya from the 1890s to the 1950s. Independence of Malaya and Singapore from 1957 and 1959 resulted in dependence upon the World Health Organization (WHO) for assistance with training. We explore the twists and turns that shaped nursing in Malaya before independence from the United Kingdom. The themes of integration and inhibition are used to explore the processes at work that drove the supply and demand factors for female British and Asian nurses in British Malaya in the early to mid-twentieth century.

Between 1896 and 1966 the Colonial Nursing Association (CNA) recruited and sent 8,450 nurses to areas overseas. The Association was run by volunteers, but quickly came to serve the Colonial Office, with this relationship finally formalized in 1940.[3] The CNA changed its name to the ONA in 1918, in recognition of the fact that it not only served the colonies but other areas with British populations.[4] From the 1920s on, Malaya hosted the most British colonial nurses, only overtaken by the East African colonies in the late 1950s, after Malaya gained independence in 1957.[5] Figure 1 illustrates the concentration of these nurses in Malaya during the years that this chapter largely focuses upon: 1925–35. The graph illustrates the number of nurses in the six most common destinations during that period. Malaya was able to employ so many nurses because the colonies of East and Southeast Asia were amongst the richest in the British Empire.[6] Before World War II, services within colonies were funded internally.[7] Therefore the Eastern colonies of Malaya, Hong Kong, and Ceylon, and the international concession in Shanghai were in an economic position to employ British nurses. India does not feature in this graph as a separate organization supplied most of its British nurses, Lady Minto's Indian Nursing Association. Despite this concentration of nurses in the area, British Malaya has been largely neglected by historians of nursing. The most extensive works on nursing in Southeast Asia have focused on the US experience in the Philippines.[8]

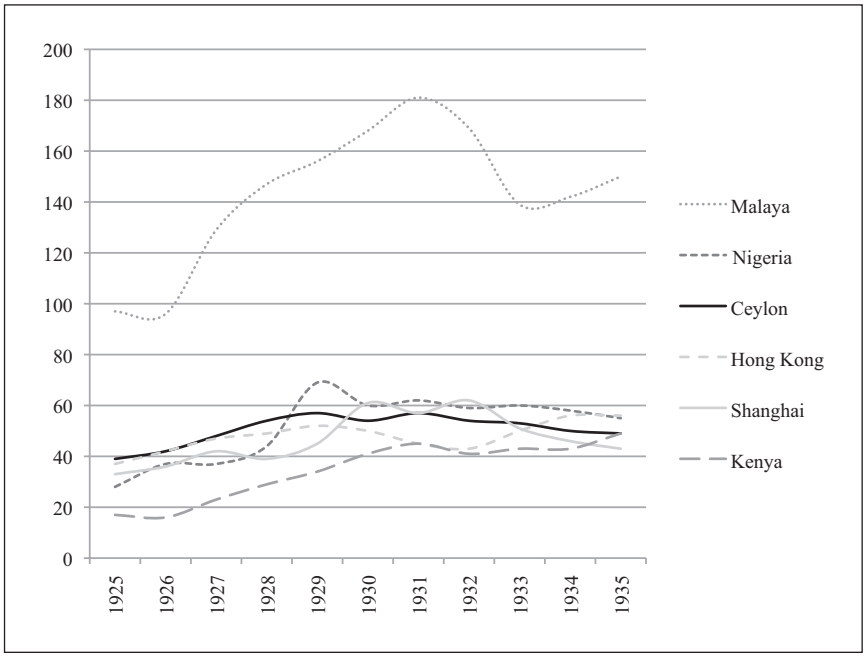

Figure 1. Number of nurses in territories with the highest number of Overseas Nursing Association nurses, 1925–35 (Source: Colonial/Overseas Nursing Association, *Annual Reports*, 1925–35, box 131, MSS Brit Emp s400, Overseas Nursing Association Collection, Commonwealth and African Studies, Bodleian Library, University of Oxford).

Early Colonial Nursing in British Malaya

The term British Malaya is used to denote the three administrative areas —the Federated Malay States (FMS), Unfederated Malay States (UFMS), and the Straits Settlements—which were further divided into "twelve geopolitical units."[9] European health care began with trade and military medical care in the Straits Settlements in the eighteenth century, organized centrally from the nineteenth century. The FMS were formed in 1895, with little co-ordination of medical provision between the states and no uniformity in provision until 1911.[10] The RF interventions, on which this chapter is centered, took place within the Straits Settlements in the 1920s. In 1932, during the economic depression, the medical and health departments of the Straits Settlements and the FMS were joined in order to cut costs and became the Malayan Medical Services.[11] Following World War II, the Malayan Union was created by the British,

with the FMS, UFMS, and Penang and Malacca (formerly in the Straits Settlements), administrated separately from Singapore.[12] Not only was British Malaya a complex administrative construct but its population was a complicated ethnic mix as a result of the colonial economy. Muslim Malays, together with the immigrant populations from China and the Indian subcontinent, presented ethnic and gender hierarchies and political policies that needed to be navigated in nurses' work and social lives.[13]

Prior to the arrival of colonial nurses, the FMS medical department was staffed by European surgeons and Chinese or Indian apothecaries, the majority being Chinese or Indian dressers and apprentices; the entire staff was male.[14] Male dressers performed a role similar to that of nurses, but their responsibilities included additional tasks such as microscopy.[15] Therefore, the role of a "dresser" was not equivalent to the role with this title in Britain at that time, which described medical students on surgical placements. This system of using dressers for the care of patients became unpopular with the British doctors and Residents (the term used for the representatives of the British government in each of the states comprising the FMS). In the 1893 Perak report, the Resident commented that patients in hospitals were only being looked after in the daytime and were left without nursing at night, when "many of their lives depend on being fed and attended to every hour."[16] In Negri Sembilan, dressers were learning and being slowly promoted on the job, but the Resident bemoaned the fact that they were "plunged straight away into the mysteries of surgery and medicine and the prescribing of drugs of whose action they know nothing."[17] In Pahang, the Resident was concerned that the Malay community did not generally attend hospitals, as they viewed the Chinese and Indian dressers with suspicion. In 1896, he suggested training Malay dressers to encourage the Malays to attend. However, he noted that the situation was still complicated as Malays wanted to be treated by female family members, and Malay families would not allow women to be treated in hospital.[18]

At this stage, the training of local women as nurses was not considered appropriate. It was not the custom for Malay women to work within the colonial economy.[19] Training of other Asian women was problematic as the British treated the Chinese and Indian populations as transient migrant labor, adopting a laissez-faire attitude towards them until the 1920s, after which Chinese and Indian women were encouraged to migrate, marry, and reproduce. A paternalist attitude, including education, was reserved for the Malays.[20] Treatment by male medical staff,

in particular physical exposure of the female patient to the male doctor, was anathema to Muslim Malays. This led to increased provision of Lady Medical Officers in the 1920s. However, female doctors could not devote all of their time to Malays as there was demand in the towns from Chinese and Tamils, and it was a strain to spend day after day visiting rural kampongs.[21] A Malay-only hospital opened in Perak at the beginning of the twentieth century, which had improved attendance, but this experiment was not repeated in the state.[22] Concerns about provision of maternity care resulted in an emphasis on training local women in antiseptic procedures for childbirth, leading to many more locally trained midwives than nurses in the rural areas.[23]

Despite these challenges, as soon as female British nurses arrived, an attempt was made to train a female nursing workforce. Although some colonies, such as Hong Kong, had already begun recruiting British nurses in the 1890s, the Colonial Office's suggestion of employing British nurses made a radical change to nursing in Malaya.[24] In 1898, European nurses were obtained from Britain.[25] Although there are records of a British nurse being sought for Selangor in 1889, and of a nurse being sent from the London Hospital to Perak in 1897, there are no records in the FMS reports that these nurses arrived.[26]

An alternative pattern of nursing care emerged in the Straits Settlements. Although care was initially primarily carried out by male attendants, suggestions of employing British- or Madras-trained nurses were made by the Principal Civil Medical Officer and the Surgeon-in-Charge of the General Hospital in Singapore in the 1880s. However, it was deemed uneconomical to bring nurses from Britain, and nurses from Madras did not want to come to Singapore.[27] The male attendants were replaced with partially trained female nurses of mixed nationalities from Roman Catholic convents in Singapore, Penang, and Malacca.[28] Even though there were benefits to employing the nuns as they were multilingual, cheap to employ, and the convents sent replacements when the nurses were unwell, there were protests as the nuns came from foreign-run convents and could not look at naked bodies. A total of 144 European residents petitioned for recruiting English nurses instead.[29]

In 1896, J. Irvine Rowell, head of the medical services in the Straits Settlements, and William Hoad, who was in charge of medical services in Singapore, wanted to pilot British nursing in the Straits Settlements by starting with "one fully trained nurse, from some good home hospital" who would be paid by the government to start organizing the scheme. This nurse would have to have "marked intelligence,

energy, and tact, physically strong, not less than 35 years old, and with, if possible, few home ties." Rowell's and Hoad's initial intention was to employ nurses to teach women in the pauper hospital in order for women of different nationalities to nurse their own "race." They thought that "in the Eurasian community there will be found many members who will gladly lend themselves to a service of this nature, and who would probably be found, in the end, to make excellent nurses for general purposes."[30] However, as Felicia Yap has discussed, Eurasians had a marginal status, with difficulties integrating into colonial and Asian society, with many Europeans perceiving them as the "embodiment of degeneration," a product of a moral lapse as many were illegitimate.[31] Therefore, they may not have been able to fulfil the role which locally trained health care workers could have as "cultural brokers," disseminating Western ideas of health education.[32] Nevertheless, only two British nurses would be brought over as they wished to use the "ample material available in the Colony itself."[33] By November 1900 their ideas had clearly changed as eight British nursing sisters were employed in Singapore.[34]

The introduction of female British nurses who would train women locally was part of a plan to feminize the nursing workforce. Feminization was equated with modernization, whether in the case of British military nursing in the mid-nineteenth century or replacing male dressers in the colonies.[35] This pattern was also followed in the Philippines, where American nurses actively aimed to delineate the male and female spheres, a process which was seen as part of civilizing a race.[36] Yet in contrast to Malaya, where the feminization program persisted, from 1913 on Filipino men were reintegrated into nurse training and some were promoted to senior hospital positions; they were also recognized as valuable for remote public health nursing work.[37] Catherine Choy suggests this reintegration of men may have been accepted as there was a minority of male nurses working in the US.[38]

The process of feminization was complicated as recruitment of local female Asian nurses could be difficult with nursing not always seen as a desirable vocation. This also explains the recruitment of Eurasians. In an oral testimony recorded in the 1980s, one woman recalled that in the 1930s, her parents would not allow her to be a nurse as it was thought that boys and men visited the nurses in their hostels.[39] Even by the early 1960s, an interviewee's mother asked her why she was training to be a nurse, worried that her friends thought that nursing was menial and not respectable.[40] A danger was perceived that the nurses might

consider certain duties beneath them. In the early 1940s, a British nurse wrote about an Asian nurse who had only been training for 18 months, yet complained that she was "too senior to be a 'temperature nurse'." Another, who had been told to give an enema, was "found holding the funnel, but she had called the *ayah* to insert the catheter!"[41] Despite these limitations on recruitment, census statistics reveal that the numbers of Malay and other nurses were increasing. In 1921, there were 43 Malay nurses, 48 Eurasian nurses, 34 Chinese nurses, and 22 Indian nurses in British Malaya.[42] As Figure 1 illustrates, by 1930 the number of British nurses in Malaya had increased dramatically to 168. These nurses were training an increasing number of Asian women from Malay, Eurasian, Chinese, and Indian ethnic origins to work in nursing. By 1947, there were 301 Malay women working as midwives, nurses, or mental attendants, though this must have been minuscule compared to the demand.[43] However, much of the emphasis was on midwifery rather than general nursing, with efforts to enhance maternity care by training the existing *bidan* (traditional midwives) and other Asian women beginning in the Straits Settlements in 1905, leading to at least 1,518 trained midwives working in the Straits Settlements by 1936, but far fewer in the FMS and UFMS, where training programs began in 1914 and 1929 respectively.[44] Also, as the following section reveals, Asian nurses were subordinated within the British colonial health care system.

Critique and Americanization of British Colonial Nursing in Malaya

The health care system that had been established by the British became the subject of critique by the RF from 1915 on. In that year, the International Health Commission (IHC) of the RF surveyed and attempted to influence British policy and practice in Malaya. Although nursing was not a priority for the RF, over 34 years the Foundation assisted with nursing education in 44 countries.[45] When the IHC was established in 1913 the main foci were eradicating hookworm, malaria, and yellow fever, as well as training public health physicians and public health nurses. Malaya was one of the IHC's first areas for attention in 1913–15, along with British Guiana, the British West Indies, Egypt, and Ceylon, illustrating that the IHC was not afraid to intervene in British territories.[46]

Subordination of Asian nurses through limited training and lack of promotion was highlighted in 1915, when a survey of medical education

in Malaya was undertaken by Victor Heiser, the IHC's Director for the East. Heiser worried much more about hospital assistants, nurses, pharmacists, and dentists than about doctors. He found nursing more racially divided than medicine, with medical courses primarily attracting Malays, whilst nursing was limited to European and Eurasian applicants. The course attracted only a few students. Heiser also observed that the British nurses in Penang did not wash the patients or apply dressings, leaving this to the locally trained staff. Heiser wanted to provide scholarships for Malayan nurses to train at the American-run nursing school in Manila in the Philippines, as he believed the Malayan patients were not receiving the care they would if they were cared for by nurses trained to American standards.[47] However, Heiser had arrived in Malaya after ten years as Director of Health for the Philippines (1905–15) and was therefore praising his own nursing program.[48]

Heiser noted that training and prospects for Asian nurses were very different in Malaya than in the American Philippines. The American rule of the Philippines was, according to Sunil Amrith, "self-consciously 'progressive'" with more focus on the health of indigenous populations.[49] American colonial rule had a "light bureaucratic presence" administered through a "public-private" nexus, in comparison to European tropical colonies in the early twentieth century.[50] The Philippines were acquired abruptly in 1898 as a result of the Spanish-American War, and the American colonizers initially intended to reform the style of Spanish centralized colonial rule. Yet the Philippines were inherited as nationalism was brewing, which resulted in four years of American pacification, surveillance, and control.[51] Whereas Malaya and Singapore were highly significant for the British in terms of raw materials and trade—hence the protracted struggle to maintain the area as a colony after World War II—the Philippines were valuable to the US as the archipelago was well located for trade and as a military base close to China.[52] Nevertheless the stages of "retention and self-rule" transitioned much more swiftly in the American than the British Empire.[53] Although the American colonizers initially infantilized the Filipinos, as Warwick Anderson has argued with the example of public health policy, in contrast to other colonial powers, the Americans soon moved towards "civilizing" as a "precursor" to the "development" projects organized by other colonial powers from the 1940s.[54]

The legacy of Spanish colonization led to religious differences between the populations in some areas of the Philippines, in comparison

to largely Muslim Malaya, which must have made a key difference in the recruitment of nurses for training. The Philippines had been exposed to 300 years of Spanish "clerical colonialism" by the Catholic orders, with hospitals for the poor and universities for the elite, and, from 1806, a vaccination program.[55] Religion and politics also played an important role in terms of greater empowerment in nursing, as from 1905 Christian provinces were granted "partial, local self-government," in contrast to nearly half the territory which was populated by animists (who believe that natural objects have souls and are invested with spirits) and Muslims and which remained under American control. However, American colonists used comparisons between the administrations to justify why this bifurcated system should continue, arguing that this revealed that Christian Filipinos did not have the capacity for full self-government.[56]

William H. Taft, the first civil governor, thought that the Christian Filipinos could be trained for self-government over many generations.[57] His perception of Filipinos as infantilized led him to believe that they could be trained. He developed a "policy of attraction," aiming to show benevolence following the suppression of the people in the Philippine-American War.[58] Adam D. Burns relates this "hearts and minds" strategy to recent US foreign policy.[59] However, in terms of empowerment of nurses, Tafts' policy can be related to the actions of the British colonial government as a reaction to the Malayan Emergency in the 1940s and 1950s, which we have written about in detail elsewhere.[60] American training in the Philippines would have accelerated following anti-imperialist lobbying in the US, which argued that a "subservient empire" was contrary to the nation's ideals; as early as 1907, President Theodore Roosevelt was concerned that the islands should be independent, with legislation passed in 1916 promising future independence.[61] From 1911, Filipino nurses were funded to travel to the US by the RF and other organizations.[62] However, American nurses still led most of the hospital training schools and from the 1920s, more American nurses worked in the Philippines, funded by the RF in an attempt to improve public health.[63] Although Americans had been keen to promote Asian nurses, they exerted cultural dominance in their conviction of the supremacy of American nursing, and as Choy has shown, used racist and patronizing language in discussing Filipino nurses.[64]

In 1925, the RF returned to British Malaya, and continued to question the quality of the training of British public health nurses. The RF established the SSRSC, largely concentrating on hookworm and on

implementing American-style public health nursing, a strategy that had been used within RF Health Units in the US.[65] When the Straits Settlements government agreed to cooperate with the RF, Milford Barnes, an RF doctor, doubted that English nurses would initiate activities of the kind American County Health nurses undertook. He worried about convincing the British to accept North American training for the public health nurses who were to be sent to work on the campaign. According to A.L. Hoops, the Principal Civil Medical Officer for Singapore, the British felt a "loss of prestige" in accepting help from Americans.[66]

Politically, this was a difficult period for American intervention. After World War I, Britain remained the country with the largest foreign trade, foreign income, share of international services, and merchant fleet in the world. However, British finances had been weakened by the loss of dollar securities to the US in order to finance the war.[67] Frederick Gates, who helped to establish the RF as the philanthropic arm of John D. Rockefeller's Standard Oil, saw American influence in non-industrialized colonies as an opportunity to increase markets, whereas Dr Howard, who also worked for the RF, directly linked improved health with productivity, happiness, and prosperity.[68] Revealing the perception of British attitudes towards American internationalism in Malaya in 1928, Heiser wrote in his diary, "America is reviled and slandered almost continuously in the press. This seems a strange thing to do to your best customer."[69]

Despite these political tensions, Barnes succeeded in convincing the colonial government that the British nurses required extra American training.[70] The RF provided them with experience in public health nursing in America for three months, with the British government paying the salaries, whilst the RF paid the extra expenses—their board and travel in North America, and the extra expenditure on travel incurred by traveling to Singapore via North America.[71] RF funding for rural health was perhaps welcome at a time of increased Malayan nationalism in the 1920s.[72] This rural campaign may have been seen as valuable for reaching more of the population through Western medicine, seen by historians as accelerating "cultural colonialism" and justification of empire.[73]

In 1926, Elizabeth Darville and Annabella McNeill were recruited by the ONA to lead public health nursing in the Straits Settlements.[74] Darville had worked as a health visitor in England, with four years' school nurse experience, a health visitors' diploma, and work in a sanatorium. McNeill had some specialist training—a Sanitary Science Health Visitors certificate from the University of Liverpool—plus maternity and

children's nursing experience.[75] Although they had some experience of training and working in public health, the RF did not view British public health nursing and training highly, as shown in Barnes' letter and a disparaging RF survey of public health nursing in Britain. The RF's criticism targeted a "jumble" of qualifications and the need to build leadership capacity in the field.[76] These findings were a disappointment to the RF as they had hoped to establish demonstration projects in England that could be used across the British Empire.[77] In 1923 an RF survey stated that trained nurses should be carrying out the role of health education. American RF nurse, Elizabeth Crowell, reported back from the UK that fellowships should be awarded for nurses to study in the US, Canada, and France, where superior training facilities for public health nurses were to be found.[78] These concerns were not unfounded. A survey carried out in 1926 showed that 1,974 health visitors had between them 22 different kinds of certificates or varieties of experience, held in 88 combinations, with some holding as many as 5 separate certificates. Health visiting lacked direction and the College of Nursing (now the Royal College of Nursing) was concerned about standards. In 1925 the College was successful in gaining the necessary government approval for a full-time course in health-visiting for nurses.[79]

The RF continued to be exercised about the quality of British public health nurse training in the 1930s.[80] Americans believed that nurses needed a college-based education, in contrast to the apprenticeship-style training within British hospitals.[81] In another example of Anglo-American collaboration in the 1920s, the RF believed that the international courses in public health nursing at King's College for Women and Bedford College, London, in the 1920s, influenced by American vision, and financed and organized through the League of Red Cross Societies, were led by "unimpressive individuals."[82] The North American leaders of nursing education, Annie Goodrich, Dean of the Yale University School of Nursing, and Kathleen Russell, Director of the School of Nursing at the University of Toronto, believed standards at the colleges were low. Hence, the leader of those courses, Olive Baggallay, was provided with an RF fellowship in public health nursing undertaken in the US and a second in Europe accompanied by Goodrich.[83] Additionally, nurses were trained in public health alongside "engineers… statisticians, bacteriologists, chemists, administrators, sociologists and economists" in the US.[84] Although American training in public health was established 50 years later than in the UK, it provided nurses with esteem and was located in centers of prestige in American universities,

as exemplified by the training which Darville and McNeill received in North America.

Darville and McNeill's training in the US began with three-and-a-half weeks at the East Harlem Nursing and Health Demonstration in New York. Next, they spent three-and-a-half weeks in rural Alabama, including visits to the Public Health Nurses Annual Conference in Birmingham and the Tuskegee Institute. Then they visited Yale University and Providence, Rhode Island. They attended public health lectures at the Massachusetts Institute of Technology (MIT), where a School for Health Officers had been established in 1913 to train postgraduate sanitary engineers, biologists, and physicians.[85] In Toronto, Canada, they learnt about the chlorination of water and pasteurization of milk, visited schools and clinics, and met with the head of the nursing school at the University of Toronto.[86] This school of nursing had attracted RF attention as it was the only program where nurses were trained in public health as well as hospital nursing. The RF officers also considered the school's director, Russell, to be the best nurse educator in the world.[87] Therefore, Darville and McNeill were treated with corresponding respect, meeting with the leaders in North American nursing education, Goodrich and Russell.[88] Perhaps the experience of this higher status of nursing in North American higher education affected their attitude when they reached Malaya. In contrast, it was not until the 1950s that serious associations between public health nursing and universities occurred in Britain.[89]

Once in the Straits Settlements, the health sisters undertook an enormous amount of work for the RF campaign, which was led by Dr Paul Russell, and they were based in new District Health Centers.[90] These were introduced to provide more rural health care for Malays, adding to the provision of traveling dispensaries which were established in the late nineteenth century, and the Infant Welfare Centers which were introduced as another part of this increased rural service in the 1920s.[91] McNeill was stationed in Singapore and Darville in Penang. In 1927, there were a total of 13,024 home visits by health sisters or nurses in the six district health centers involved in the project. Additionally, there were 5,539 visits to the Health Centers. Darville and McNeill were by now joined by another British public health nurse, an unofficial health visitor, plus their Asian nurse assistants.[92] The functions of the Health Centers went beyond hookworm eradication.[93] The more scientific role of the nurses in the District Health Centers, compared to British nursing, is indicated by the training which Darville and

Figure 2. Elizabeth Darville in Penang, second from right, with staff of the Government Health Center at Tanjong Tokong, Penang rural area, including a Chinese health nurse, third from right (Source: Straits Settlements Rural Sanitation Campaign, Report for the Third Quarter of 1927, 13, folder 2594, box 210, series 473H, RG 5.3, Rockefeller Foundation records, Rockefeller Archive Center, © Courtesy of Rockefeller Archive Center).

McNeill received at MIT and in Toronto, as well as the laboratory work in these health centers. Significantly, Darville's uniform resembles a laboratory coat rather than a nurse's dress (see Figure 2).

Darville was invited to discuss her work in maternity and child welfare in a lecture to the students of tropical hygiene at the London School of Hygiene and Tropical Medicine (LSHTM). Her early work involved visiting local areas, including visiting girls' schools with Russell where they treated children for hookworm. After establishing the six district centers, Darville attended a different one each day, meeting with the local staff, which consisted of a Chinese, Indian, or Eurasian nurse; a Chinese attendant acting as cleaner and interpreter; and a Chinese or Malay midwife. As requested, the lecture emphasized her role with mothers and infants, but she also listed the other work which took place within the centers: prevention of diseases involving worms, skin, and eyes; breaking down "old traditions, prejudices and superstitions;" and improvement of "domestic sanitation and hygienic living" and Malay attendance at government hospitals. Part of Darville's role was also

to provide locally educated health visitors with training in "curative and preventive work," including advice for mothers, but also regarding malaria transmission, insanitary conditions, as well as the importance of "tact and patience and courtesy in dealing with the mixed races."[94]

Heiser was full of praise for McNeill and Darville. In 1927, Heiser wrote to Russell, considering that the two British nurses had benefited greatly from their trip to the US and hoping that they would be an added stimulus for developing public health nursing in Malaya.[95] Heiser went on to commend the importance of Darville in Butterworth, Penang, demonstrated by the reduction in attendance whilst she was on holiday.[96] He gave special mention to Darville and McNeill in his summary of his 1931 trip around the Straits Settlements:

> Another Rockefeller Foundation investment that has produced profitable returns was in having Miss Darville and Miss O'Neill [sic] come to the United States for a brief study tour. Their example has interested others in health center work, and the apprentice system has already produced a considerable number of women, both native and foreign, who are doing acceptable public health nurse work.[97]

The British nurses received great praise in confidential British colonial documentation too.[98] Contrary to Lenore Manderson's argument that RF influence was short-lived in Malaya, with public health nursing the RF fulfilled one of their crucial intentions of creating a sustainable scheme through short-term funding.[99] The British hired another specific public health nurse in 1927 and Darville and McNeill remained working in Singapore into the 1940s.[100] As Heiser noted in 1931, the three public health nurses had already trained a significant number of Asian women.

Integration or Inhibition?

Although Darville appears to have integrated with the locals in Malaya, demonstrated by the decreased attendance at clinics whilst she was on leave, integration into hierarchical colonial society could be more difficult. Darville confided in Heiser that it was hard to convince local British doctors of her ideas and that she was having "troubles with status."[101] This was exemplified by how she could speak to Heiser about her problems, yet was unable to "call" in this way in England or in "British circles" in Penang.[102] Her life was also unpleasant as another nurse was jealous of her role as a public health nurse because she worked fewer days. She told Heiser she would have resigned but for the

"sympathy" of Paul Russell.[103] Stark differences in the hierarchy in the colonial Philippines can be seen by RF nurse Alice Fitzgerald's ability to meet with the Director of the Health Service, and persuade the Governor General to send out a telegram encouraging provincial governors to hire new graduates of public health nursing.[104] Filipino nurses were invited to meet government officials and attend government functions, though Choy suggests this could have been to showcase how Americans had nurtured Filipinos. However, a Filipino nurse interpreted these opportunities as the prestige which Americans bestowed on nursing.[105]

Darville was not the only person to find working amongst the British difficult. American doctors appear to have been marginalized in British colonial society. Heiser described their encounters with the British as a "veritable hell" as they had not been introduced to the Colonial Club or social amenities.[106] They were classed socially among the lowest assistant surgeons, and Barnes even had problems gaining permission to practice medicine.[107] Heiser's diaries cannot be taken at face value. Rather they are judgmental, bloated accounts designed to bolster the reputation of the RF's approach to public health. For example, in the Dutch East Indies, Heiser was also dismissive of the Dutch, dubbing them "stupid or discourteous."[108]

It is unlikely that Darville would have presented difficulties with her British colleagues when she discussed her work at LSHTM, which trained Colonial Medical Officers. Indeed, in 1935 she told students that the Senior Health Officer in Penang "took endless trouble to make things as easy as possible for me…. He has always been most sympathetic and I always feel that I can rely on him to give me any advice or assistance that I may need," and that the other European and Asian staff were very helpful. She also acknowledged the help she received from Paul Russell.[109] Contrary to Heiser's account, she claimed that she was "allowed to organize the work in my own way, which I did as far as possible on the same lines as it was done in Surrey [England]," thus not referring to the American model.[110] Given that Heiser's diary was a report of his trip, submitted to the RF, and that Darville was presenting to potential Colonial Medical Officers, each were probably propagandizing their own national interests. Perhaps the reality of Darville's situation is somewhere in between—she did boldly tell the students that she had difficulties with her salary.[111] With their new colleague, I. Simmons, McNeill complained from 1927 as they were concerned that they were unable to receive promotion like their hospital sister colleagues, arguing for the creation of a public health matron post.[112]

In September 1929, A.L. Hoops, the Medical Officer for Singapore, argued that these nurses needed to know the habits and customs of the various races and that "their work is more responsible and more independent, and they have to be specially trained and selected if they are to succeed."[113] From January 1930 they were provided with an extra $10 per month and the promise of an extra $30 per month if they passed their Malay examination.[114]

Despite the difficulties which British nurses could face in Malaya, Asian nurses were subjected to far more hierarchical subordination, as highlighted by Heiser's survey in 1915. Although there was an early attempt to integrate a black nurse into the ONA in 1903, patients objected and her contract in Sierra Leone was not continued after her six-month probationary period ended.[115] Until the late 1940s, the ONA placed a great deal of importance on the nurses it sent out to the colonies being not only white, but almost always British.[116] There was an impetus for change in the early 1940s, when Asian nurses and doctors ran the health care systems in East and Southeast Asia, as British nurses either left, were interned, or died when the Japanese seized British Malaya.[117] Locally-recruited Malayan Medical Service staff could continue their work, but their job was harder as the Japanese took from the hospitals what they needed to treat their forces, and largely took over from the Malayans in 1943.[118] British control of health care in Malaya was regained in the summer and autumn of 1945. Heiser's concerns about the subordination of Asian nurses were echoed in reports by a Colonial Office doctor after World War II; in 1946, A.G.H. Smart, Medical Adviser to the Secretary of State for the Colonies, visited Malaya. His purview was to recommend actions following the Japanese occupation, but he also critiqued Malayan medical planning prior to World War II.[119] Like Heiser's report of 1915, Smart recommended in his summary that training of local nurses had to be increased, as recommended by the British Rushcliffe Committee on the Training of Nurses in the Colonies (1943–45), which encouraged training equivalent to that in Britain. Smart found that the subordination of local nurses' training and prospects was highlighted by Asians' work during the occupation, and he discussed several nurses and dressers who could be selected for more training and promotion.[120] World War II changed the relationship between Asian health care staff and the British. For example, Chee Kong Tet, a hospital administrator and later a doctor in Singapore, remembered that local people could not tolerate the British sisters who

returned, as the locals were put back in their old positions whilst the British took charge again.[121] Indeed, Smart noted that the local staff were "tired out after a period of great stress and exhaustion…[and] are asking for a clear statement as to their future prospects."[122] The push for the feminization of nursing endured with Smart's belief that he could see the difference between hospitals with female nurses compared to those with male nurses.[123] Smart also documented the neglect of rural health relative to urban health in Malaya, and the need for more public health nurses.[124]

There had been some efforts to train local nurses in Singapore since 1913. In 1934 a plan was made for a nursing school with a full-time Tutor Sister for 1935. With a larger settler population in Singapore than elsewhere in Malaya, there were more European and Eurasian children from which to recruit nurses: in the 1920s, 72 per cent of the 12,645 Eurasians in Malaya lived in the Straits Settlements.[125] By 1949, training in Singapore was recognized as equivalent to that of the UK and nurses were given reciprocity with the UK's General Nursing Council.[126]

At the nursing school in Penang, 66 nurses completed their general training in 1949.[127] Gradually, efforts were made to train Asian nurses for more prestigious posts. In 1949, two fully qualified local nurses were given the opportunity to undertake a tutor's course and were subsequently sent to the Royal College of Nursing in London to study for the Sister Tutor's diploma. Two more received training in teaching.[128] In the same year, 28 Asian women worked as health or nursing sisters, positions previously limited to Europeans; this increased to 67 in 1952.[129] In 1952, the training in Penang was deemed to be equivalent to that in Britain with the School gaining reciprocity.[130] By 1953, the School was offering a three-month public health nursing course and was planning an expanded course complying with the Royal Sanitary Institute.[131]

Presumably inspired by the British model of State Enrolled Nurses, established in 1943, an Assistant Nurses scheme began in 1951, with a two-year training course that aimed to improve the "haphazard" work which was carried out by attendants, and to relieve trained nurses from tasks requiring less responsibility.[132] WHO doctor Donald Huggins noted the utility of these assistant nurses in his yaws report, noting that they were drawn from the kampongs and were young and able to approach shy Malay women.[133]

Remedying the under-provision of nurse training, particularly in rural areas, became a goal of international health organizations visiting

Malaya in the 1950s. This came at a particularly difficult time for Malaya. The Malayan Emergency (1948–60) affected nursing recruitment, with staffing still badly affected by World War II.[134] There were 176 British colonial nurses in Malaya in 1942, 48 of whom died during the war. By 1948, 137 colonial nurses were working in Malaya, slowly increasing to 166 by 1955.[135] During the Emergency, large nursing teams from the Red Cross, the Order of St. John, and the Soldier, Sailors, Airmen and Families Association provided care in rural areas of Malaya.[136]

The Cold War led to increased funding for public health, which was seen as a "depoliticized field" of goodwill, particularly as Asian states were not willing to spend large amounts on it themselves.[137] In the 1940s and 1950s, poor health was believed to result in a "breeding ground for communism."[138] With policy and funding being driven by experts in Western biomedicine in the US and Europe, the Cold War climate demanded quick remedies rather than slow economic and social change to improve health and win "hearts and minds."[139] Alongside developments in techno-centric biomedicine, including DDT, antibiotics, and vaccination, the WHO included interventions in public health nursing under the banner of "technical assistance."[140] From 1950, various WHO nurses were appointed in Malaya, mainly in teaching roles.[141] In 1953, the WHO agreed to funding of $47,000 for a Rural Health Center, attaching "unusual importance" to this project of "very considerable potential value," even though there were financial challenges at this time. Between 1950 and 1953 the United Nations Children's Emergency Fund (UNICEF) provided an additional $100,000 for equipment.[142]

Prior to independence, Malayanization of public services resulted in an official policy of the cessation of recruitment of British nurses from the mid-1950s.[143] The Malayanization program and independence from Britain in Malaya (1957) and Singapore (1959) had a drastic effect on the number of British colonial nurses. Between 1955 and 1960 they declined from 90 to 25 in the Federation of Malaya and from 62 to 22 in Singapore.[144] Staff shortages resulted in the WHO being asked to assist again in 1957.[145] Australia also provided assistance through the Colombo Aid Plan for Southeast Asia, providing Australian nurses and training for at least 48 Malay nurses in Australia in the mid-1950s.[146] A consequence of the Malayanization program was the acceptance of male Malayan nursing after half a century of attempting to feminize nursing. In 1954, an unpopular proposal aimed to recruit male nurses

and pay both male and female nurses the same rate.[147] In 1955, male practitioners who had formerly been called hospital assistants were able to register as nurses. Men would no longer be recruited as hospital assistants.[148]

Conclusion

This chapter has explored the role of training and education as a lightning rod for rival models and interpretations of public health nursing. Nurses faced the constraints of conventional British social norms of class and gender in Malaya, contrasted with respect, status, and opportunities from North Americans. Hostility was displayed towards Americans within the Malayan medical services, affecting the way in which the RF-trained British nurses perceived colonial society, following their interaction with their friendlier and more egalitarian cross-Atlantic colleagues. The chapter also reveals how British, American, and international organizations' efforts and funding to improve public health nursing in rural areas coincided with periods of increased nationalism in the 1920s and communism in the late 1940s and early 1950s. In the 1920s, in particular, the RF, rather than the British, drove public health nursing in Malaya, enhancing health care in politically fragile rural areas.

The difficulties of imposing Western structures on a largely Muslim, Asian country have been demonstrated by the failed attempt to feminize Malayan nursing. The misplaced expectation of recruiting enough girls educated to School Certificate standard led to the eventual return to training men as well as women, although men continued to be trained as dressers and hospital assistants.[149] Yet the goal of feminization persisted far longer than in the American Philippines, where men had been reintegrated into nursing 30 years earlier.

Comparisons with American colonial nursing also reveal that the long-term subordination of and lack of career opportunities for Asian nurses in Malaya led to continual nursing shortages in comparison to the Philippines, where locally trained nurses had better career prospects and believed their profession to be prestigious.[150] But the approach adopted by the RF by investing in "lighthouses of leadership" belies deeper tensions within American nurse leadership regarding what an appropriate model for training development should be.[151] This tension reflected differences in philosophy derived from contextual conditions with which American and British nurse leaders had to contend to build

capacity.[152] Assistance from the RF, the WHO, and Australia highlights the declining prestige of British nursing and the legacy of under-investment in higher education that would constrain its global competitive edge for decades to come.

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