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Dividends Of Disquiet: Popular Politics And Economic Thought In The History Of Government Medical Services In Nyasaland/malawi, 1914-1983

Luke Michael Messac

University of Pennsylvania, lmessac@sas.upenn.edu

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Abstract

This dissertation is a history of medicine in development planning and popular politics in Malawi between the First World War and 1980. Using archival sources and oral histories, this dissertation seeks to explain when and why access to biomedical care became a central political concern and budgetary priority. During both the colonial and early post-colonial eras, Malawi's governments increased spending on biomedical care to demonstrate beneficence, particularly when they faced popular reactions to widely hated policies. Government officials and international advisers persistently attributed Malawi's inadequate medical provision to the nation's poverty, but changes in health spending have not automatically followed shifts in GDP or government revenues. Instead, the construction of new hospitals and dispensaries, the purchase of new supplies and medicines, and the addition of medical staff have almost always come in the wake of social unrest (in particular, following world wars and internal protests). Only at these moments was the government compelled to devote more resources to health. Yet unrest did not automatically lead to increases in Medical Department spending. Increases in health expenditure often came only after influential officials argued that there was a link between medical spending and regime stability. The first attempts to bring "Western" medicine to Nyasaland's African population came after the great disruptions caused by the First World War. The most rapid increase in public sector health spending came during the Federation era, when popular protests threatened the government. This rise in spending occurred even though influential modernization theorists counseled governments like Nyasaland's to avoid spending on health care. In the months after independence in 1964, President HK Banda abandoned health fees during a moment of political crisis. In the years that followed, he turned his attention away from medicine as his hold on power solidified. Each of these episodes demonstrates that official claims that there was simply not enough money to improve health services have almost always been abandoned during periods of political crisis. Still, these moments have been infrequent; placidity, and not just poverty, helps account for Malawi's dismal medical infrastructure.

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DIVIDENDS OF DISQUIET
POPULAR POLITICS AND ECONOMIC THOUGHT IN THE HISTORY OF
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Luke Messac

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Supervisor of Dissertation

Robert Aronowitz
Professor and Department Chair, HSSC

Graduate Group Chairperson

Beth Linker
Associate Professor, HSSC

Dissertation Committee

Steven Feierman
Professor, HSSC

Ramah McKay
Assistant Professor, HSSC

Megan Vaughan
Professor of African History and Health, University College London

DIVIDENDS OF DISQUIET: POPULAR POLITICS AND ECONOMIC THOUGHT IN
THE HISTORY OF GOVERNMENT MEDICAL SERVICES IN
NYASALAND/MALAWI, 1914-1983

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Luke Messac

To my wife, Jamie

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In researching and writing a dissertation about care, I received so much of it.

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Eastern Workshop on Southern Africa in Burlington, Vermont; the 2016 Greater New York Area African History Workshop in Philadelphia; the 2016 History of Recent Economics Conference at the University of São Paulo; the 2015 European Labour History Network Conference in Turin; the fall 2015 seminar in the Department of History at the University of Botswana; the 2013 meeting of the Southern African Historical Society in Gaborone; and the 2013 National Conference for Physician-Scholars in the Social Sciences and Humanities in San Francisco.

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ABSTRACT

DIVIDENDS OF DISQUIET: POPULAR POLITICS AND ECONOMIC THOUGHT IN THE HISTORY OF GOVERNMENT MEDICAL SERVICES IN NYASALAND/MALAWI, 1914-1983

Luke Messac

Robert Aronowitz

This dissertation is a history of medicine in development planning and popular politics in Malawi between the First World War and 1980. Using archival sources and oral histories, this dissertation seeks to explain when and why access to biomedical care became a central political concern and budgetary priority. During both the colonial and early post-colonial eras, Malawi's governments increased spending on biomedical care to demonstrate beneficence, particularly when they faced popular reactions to widely hated policies. Government officials and international advisers persistently attributed Malawi's inadequate medical provision to the nation's poverty, but changes in health spending have *not* automatically followed shifts in GDP or government revenues. Instead, the construction of new hospitals and dispensaries, the purchase of new supplies and medicines, and the addition of medical staff have almost always come in the wake of social unrest (in particular, following world wars and internal protests). Only at these moments was the government compelled to devote more resources to health. Yet unrest did not automatically lead to increases in Medical Department spending. Increases in health expenditure often came only after influential officials argued that there was a link between medical spending and regime stability. The first attempts to bring "Western" medicine to Nyasaland's African population came after the great disruptions caused by the First World War. The most rapid increase in public sector health spending came during the Federation era, when popular protests threatened the government. This rise in spending occurred even though influential modernization theorists counseled governments like Nyasaland's to avoid spending on health care. In the months after independence in 1964, President HK Banda abandoned health fees during a moment of political crisis. In the years that followed, he turned his attention away from medicine as his hold on power solidified. Each of these episodes demonstrates that official claims that there was simply not enough money to improve health services have almost always been abandoned during periods of political crisis. Still, these moments have been infrequent; placidity, and not just poverty, helps account for Malawi's dismal medical infrastructure.

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ABBREVIATIONS

BL = British Library

BLOU = Bodleian Library, Oxford University

BMJ = *British Medical Journal*

CAJM = *The Central African Journal of Medicine*

LSHTM = London School of Hygiene and Tropical Medicine Archives

MNA = Malawi National Archives

SoMA = Society of Malawi Archives

UoELA = University of Edinburgh Library Archives

UKNA = United Kingdom National Archives

UMMC = University of Malawi Library Malawiana Collection

WBGA = World Bank Group Archives

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Figure 3.2: Trans-Zambesi Railway poster, 1925. Source: Exclusive News Agency, London. The caption reads: "Not only has this railway inaugurated a new epoch of economic prosperity for Nyasaland by providing it with direct access to an ocean port, but it has also opened up a region of great forests, a sportsman's paradise wherein the elephant, the lion, the rhino and the antelope have roamed since the beginning of time."

Figure 7.4: Scene outside Mlanje Hospital, February 1964. Note the bicycle in the bottom right. Source: British Information Services, Central Office of Information, London, UKNA.

Figure 7.7: A campaign pamphlet for Dunduzu Chisiza's candidacy in the 1961 Nyasaland Parliamentary elections. Hastings Kamuzu Banda led the Malawi Congress Party, which had as a mascot the rooster (hence, "Vote Kamuzu and the Cock"). Printed by Malawi Press Ltd, Limbe, Nyasaland. Source: George Shepperson Papers, University of Edinburgh Archives.

Figure 8.1: Queen Mother planting a rose tree on hospital grounds of Queen Elizabeth Hospital, Blantyre, Nyasaland, 1957. Source: *Central African Journal of Medicine*, August 1957.

Figure 8.3: Protest during Nyasaland's State of Emergency at Chileka airport, Blantyre, 26 January 1960. Source: HK Banda Archives, University of Indiana Library.

Figure 8.4: Infant with smallpox, Central Province, Nyasaland. Source: *Nyasaland Times*, December 6, 1960, MNA.

Figure 9.2: Prime Minister Banda at Queen Elizabeth Hospital, September 1964. From *The Nyasaland Times*, September 25, 1964, page 1, MNA.

Figure 9.3: President Hastings Kamuzu Banda, surrounded by his *mbumba*, opening the Gogo Chatinkha Maternity wing at Queen Elizabeth Central Hospital, Blantyre, December 25, 1980. Source: Malawi Ministry of Information.

Introduction

I. The thrall of scarcity and the narrowing of the historical imagination

This dissertation interrogates a notion with an air of common sense. It is an idea that seems, to many scholars, so patently obvious as to merit only a fleeting mention. It is an old idea, and it has had many critics, but it remains a common justification for maintaining the *status quo* in global health. Here it is: public sector health care for poor people in poor countries is fated to be poor in quality and quantity. Inadequate funding, poorly trained medical staff, outdated drugs and equipment, and inefficient management are, in this formulation, a necessary consequence of a low GDP. In his *A History of Global Health*, Randall Packard captures the essence of this idea (which he emphatically does *not* endorse) in the following question: “It’s Africa and India, what did you expect?”¹ A corollary is the contention that increased funding for health and other forms of social protection must await a rise in national income. This idea has had remarkable staying power, and has long foreclosed more careful inquiry into the actual forces that have influenced levels of government health spending in colonial and postcolonial settings.

The idea that economically impoverished regions must have poorly funded health services has been repeated by politicians, and accepted by scholars, for decades. In her 1944 report titled *Welfare in the British Colonies* the social anthropologist Lucy Mair (who had worked extensively in Nyasaland) claimed that government efforts to stem the

¹ Randall Packard, *A History of Global Health: Interventions into the Lives of Other Peoples* (Baltimore, MD: Johns Hopkins University Press, 2016).

spread of transmissible diseases had “been hampered by the lack of funds and personnel sufficient to carry it out.”² She did not interrogate any further the reasons for the “lack of funds” for this work. A decade later, in her report on a year of travels through many of Britain’s African colonies, Labour Party activist Joan Wicken noted that each colony had a per-capita income much lower than the United Kingdom’s. “Given these figures,” she concluded, “it is hardly surprising that Government officials constantly commented that certain things were desirable but not possible.”³ In her analysis, Africa’s “basic poverty” was sufficient explanation for governments’ “difficulty in providing the most elementary public services.”⁴

More recent historical scholarship has, at times, continued to accept at face value colonial officials’ claims that resources were too scarce for robust social services, including health care. In a 1985 paper, the historian John Iliffe recounted the response by the Chief Secretary of Nyasaland to a report submitted by the Colonial Secretary’s Advisor on Social Welfare in 1950: “The conclusions were to spend more money,” reported the Chief Secretary, “and we have no more to spend.”⁵ The reader assumes that Iliffe is demonstrating colonial stinginess here, but in another section of the paper, Iliffe himself seems to lend credence to official pleas of poverty. He recounts the Nyasaland Financial Secretary’s denial of a native council’s 1949 proposal to set aside a portion of each

² Lucy Philip Mair, *Welfare in the British Colonies* (New York: Royal Institute of International Affairs, 1944). Page 81.

³ Joan E. Wicken, “African Contrasts,” Alice Horsman Travelling Fellow, 1956-57 (Submitted to Somerville College, Oxford, January 1958), MSS.Afr.s.1726, BLOU. Page 7.

⁴ Ibid. Page 6.

⁵ John Iliffe, “The Poor in the Modern History of Malawi,” in *Malawi: An Alternative Pattern of Development* (Centre of African Studies, University of Edinburgh, 1985). Page 267

African's hut tax to assist orphans and disabled adults; this refusal, Iliffe asserts, was a product of "governmental poverty joined with official ideology." Thus Iliffe himself gives at least some credence to the government's claim that low revenues are sufficient to explain the paltriness of public services and social protection programs.⁶

The examples of this equation between poverty and poor social services are legion. In his history of Malawi's medical services, John Lwanda contends that Malawi's early postcolonial government "did not have enough resources to run universal medical services."⁷ In an otherwise careful study of taxation in British colonial Africa, Leigh Gardner does not elaborate on her claim that postwar plans for improved social services in Northern Rhodesia and Kenya were stymied by "resource constraints." She does not say whether these resource constraints stemmed from the stinginess of officials or the absolute poverty of colonial treasuries.⁸

Yet some of these same scholars admit, at other points in their writings, that such claims of scarcity are too facile. "It is true that social services can only be secured by an adequate economic base," said Wicken. But, she continued, the people of Britain "indirectly benefit" from the poverty of their colonial territories.⁹ Wicken did not explain in this passage precisely how citizens in Britain benefited from African poverty, but the

⁶ Ibid. Page 267.

⁷ John Lloyd Chipembere Lwanda, *Colour, Class and Culture: A Preliminary Communication into the Creation of Doctors in Malawi*, 1st edition (Glasgow: Dudu Nsomba, 2008). Page 38. This is curious claim, because Malawi's government did, in fact, offer medical services that were free at the point of care after a very brief experiment with fees in late 1964 (see Chapter 8).

⁸ Leigh Gardner, *Taxing Colonial Africa: The Political Economy of British Imperialism*, 1st ed. (Oxford: Oxford University Press, 2012). Page 155-156.

⁹ Wicken, "African Contrasts." Page 70.

rest of her report pointed to the use of low-wage labor on plantations and in mines by British capitalists. She suggested that since such a large share of the wealth drawn from African labor had filled British bank accounts, the UK Treasury's long-standing insistence that colonies had to fund their social services with local revenue was inequitable. The people of Britain, Wicken declared, were obliged to use "some of our economic resources to break the vicious circles which bind the peoples of Africa in the chains of poverty."¹⁰

In her study of colonial taxation, Gardner also complicated her acceptance of official claims of "resource constraints" when she detailed increases in spending on health and education just before independence in both Kenya and Northern Rhodesia (Zambia, after independence). The extension of the franchise to more Africans gave them "greater bargaining power...and allowed them to lobby for fiscal transfers, thus fundamentally altering the politics of taxation and government expenditure."¹¹ Thus, the most important change allowing for increased social services spending was neither an increase in gross domestic product nor the growth of public revenues, but a shifting balance of political power between European settlers and African colonial subjects. These effects of new political pressures during decolonization belied to the oft-repeated claims that there was just not enough money to increase spending on health and education.

It is certainly true that colonial officials administered vast populations with finances that were—to most contemporary British observers—absurdly paltry. Yet this "governmental

¹⁰ Ibid. Page 83.

¹¹ Gardner, *Taxing Colonial Africa*. Page 238.

poverty” must be put into context. First, little of the revenue that administrators collected (or, often, forcibly extracted) in the form of hut taxes, poll taxes, income taxes, sales taxes, and customs duties was spent on health, education and social welfare. Officials hoping to spend more on social services in Nyasaland were continually frustrated by the burden of the colony’s massive debts, accrued in loans of dubious merit through a process described in Chapter 3. In 1937, *44 percent* of Nyasaland’s public expenditure went toward servicing the colony’s debts. An additional six percent of Nyasaland’s public expenditure in that year was devoted to pension allowances for British colonial officials. By comparison, eight percent of government spending went toward health care.¹²

Second, there were obvious sources of additional revenue that could have funded social services that colonial administrators in British Africa did not tap. One such source was extractive industry. Northern Rhodesia’s copper industry provides a particularly stark example of the extent of foregone revenues. In her 1941 *Plan for Africa*, Rita Hinden—who will be a significant figure in Chapter 5—explained:

These few facts illumine the extraordinary distribution of the produce of the Northern Rhodesian copper industry. Three private companies, registered in Great Britain, own the richest copper-fields in the world. The value of their exports reaches £10 million a year. Half of this sum is taken directly out of the country and handed over to shareholders, directors, and others. About half a million is paid to a chartered company which apparently does nothing at all to further the production of copper; another half-million is paid over in taxes to the British Treasury. About one million pounds is paid to a few thousand European employees of the company in Northern Rhodesia. The Rhodesian government is itself given half a million in taxes, and the native workers in the mines, ten times

¹² Ewout Frankema, “Colonial Taxation and Government Spending in British Africa, 1880–1940: Maximizing Revenue or Minimizing Effort?,” *Explorations in Economic History* 48, no. 1 (January 2011): 136–49. Also see Gardner, *Taxing Colonial Africa*. Appendix 1.

as numerous as the Europeans, receive about one-quarter of a million pounds a year—less than the royalties of the Chartered Company!¹³

With so much of the territory's mineral wealth destined for capitalists in Britain or European laborers on the mines, there was little left for the Northern Rhodesian administration to devote to social services for the general population. In fiscal year 1937-1938, the Northern Rhodesian administration collected £1 million in revenue, and government expenditure on the medical department was approximately £70,000.¹⁴ Thus, expatriated profits of the territory's three major copper companies amounted to more than 70 times the Northern Rhodesian government health budget.¹⁵

Even while shareholders in London prospered, the UK Treasury maintained a nearly impregnable stance against using its own funds for colonial projects. Even after the passage of the 1929 Colonial Development Act, the Treasury maintained its policy that grants for capital expenditures (on new hospitals, for example) would not oblige the UK Treasury to cover recurrent expenditures (such as the staffing and equipping of those

¹³ Rita Hinden, *Plan for Africa: A Report Prepared for the Colonial Bureau of the Fabian Society* (London: George Allen & Unwin Ltd, 1941). Pages 53-54. The "chartered company" referred to is the British South Africa Company (BSAC), which had administered Northern Rhodesia until 1924. Even after the UK government took responsibility for the administration of the colony, the BSAC retained sole possession of Northern Rhodesia's mineral rights.

¹⁴ *Ibid.* Page 102.

¹⁵ In 2011, only 2.4 percent of 10 billion in revenues from Zambia's copper mines accrued to the government. By then, the relationship between the state and private companies was similar to that maintained during the colonial era (but different from early postcolonial era of nationalization). See Tom Burgis, *The Looting Machine: Warlords, Oligarchs, Corporations, Smugglers, and the Theft of Africa's Wealth*, First edition (London: Public Affairs, 2015).

hospitals).¹⁶ This policy would only begin to change at the end of the Second World War, following developments that will be explained in Chapter 6.

So those officials and observers who argued that there was simply not enough money to pay for social services for Africans had to: first, ignore the relatively low portions of colonial budgets spent on such services; second, obfuscate about flows of wealth from the colonies to the metropole, and; third, maintain a hard line against releasing funds from the imperial treasury for colonial social services.¹⁷ The claims of scarcity were a simulacrum, a distorted vision of reality carefully maintained to deflect criticism and defend against any welfarist claims on public and private finances.

One more piece of evidence that this claim of scarcity was a convenient construction was evident in patterns of public sector spending. In metropolitan Britain, the share of total government spending devoted to health care and sanitation rose steadily throughout the twentieth century (with the exception of 1914-1933 and 1939-1949, when vast increases in expenditures on armaments depressed the share going toward health). Figure 0.1 demonstrates this relationship. This secular increase in the share of government spending on health (both medical care and public health) supports the oft-repeated claims by colonial officials and mid-century modernization theorists that health spending claims

¹⁶ Stephen Constantine, *The Making of British Colonial Development Policy, 1914-1940* (Totowa, N.J.: F. Cass, 1984). Page 181.

¹⁷ Britain was not the only colonial power that was loath to open the metropolitan treasury for colonial development. Elise Huillery has calculated that between 1907 and 1957 the French metropolis provided only two percent of French West Africa's public revenue, while salaries for colonial executives and district administrators claimed more than 13 percent of local public expenditures. See Elise Huillery, "The Black Man's Burden--The Cost of Colonization of French West Africa," *Journal of Economic History* 74, no. 1 (2013): 1-38. Page 6.

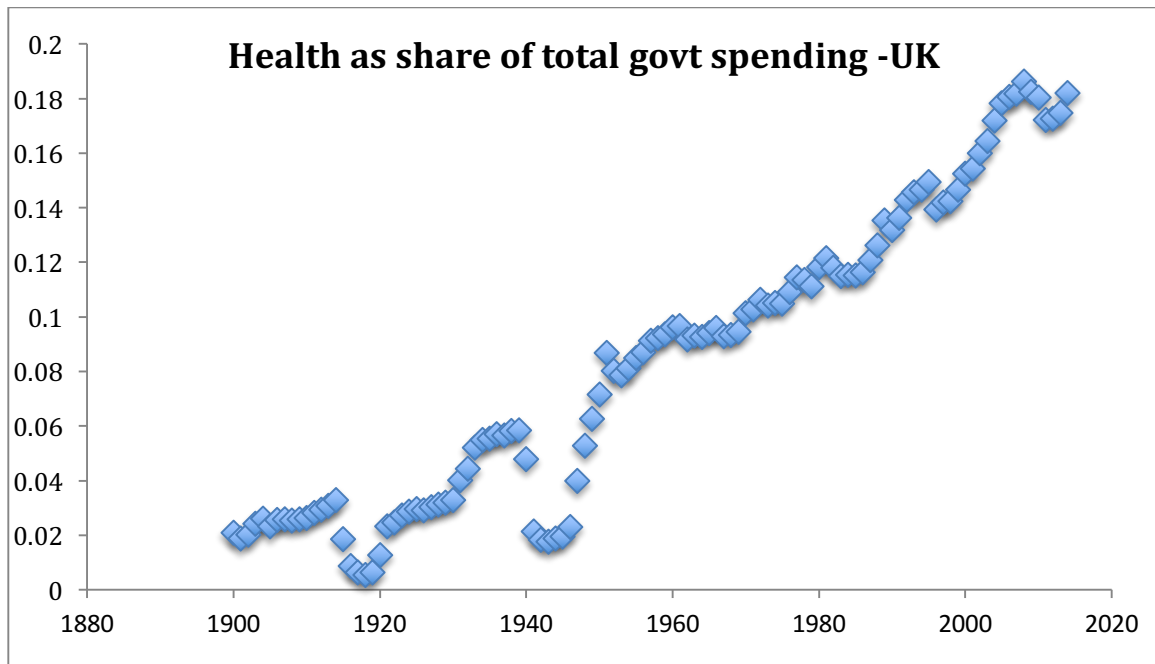


Figure 0.1: Health spending as a share of total (central and local) government spending in the United Kingdom, 1900-2013. Source: http://www.ukpublicspending.co.uk/government_expenditure.html

larger shares of public budgets as nations grow richer. But the same graph looks quite different when we use Malawi's data. As shown in Figure 0.2, recurrent health spending (again, including both medical care and public health) as a share of total expenditure on the Malawi revenue account shows nothing resembling Britain's steady increase. The share fell during the Second World War, but it was already on the decline during the 1930s. It rose during the 1950s, and fell again during the 1960s. I will argue that changes in public expenditure on health services in Nyasaland were driven as much by political events and official perceptions of regime legitimacy as they were by aggregate production or public revenues.

II. Medicine's presence and absence in African history

This dissertation chronicles government medical care in Nyasaland and Malawi between the First World War and the dawn of the AIDS epidemic. This is not a history of health outcomes and mortality rates. Malawi has never had compulsory universal vital registration, so it is extremely difficult to discern how patterns of healthcare and political economy have affected morbidity and mortality rates. Some studies have attempted to determine the impact of health care on health outcomes in Africa using survey data. Because the most extensive survey data is quite recent, these studies tend not to have great historical depth.¹⁸ The most careful historical investigation of health care on health outcomes may be Shane Doyle's painstaking study of three districts in Tanzania and Uganda; among other sources, he mined decades of parish records of births and deaths.¹⁹ But in this dissertation, the focus is on government health spending and health care provision.

Nor is this the history of one disease or individual. Instead it is a political and social history of a government medical system. The main actors are officials (in Nyasaland/Malawi, the United Kingdom, the United States and elsewhere in Africa), healthcare providers (both African and European), and patients (mostly African, though

¹⁸ The most well-known coordinator of developing-country health and demographic survey data, the Demographic and Health Survey Program (funded by USAID, UNICEF, UNFPA, the WHO and UNAIDS), began only in 1984).

¹⁹ Shane (Shane Declan) Doyle, *Before HIV: Sexuality, Fertility and Mortality in East Africa, 1900-1980*, 1st ed. (Oxford: Oxford University Press, 2013). For an overview of the influence of health care on health outcomes, see Paul Farmer, Matthew Basilico, and Luke Messac, "After McKeown: The Changing Roles of Biomedicine, Public Health and Economic Growth in Mortality Declines," in *Therapeutic Revolutions: Pharmaceuticals and Social Change in the Twentieth Century*, Eds. Jeremy Greene, Flurin Condrau, Elizabeth Watkins (Chicago: University of Chicago Press, 2016)."

European settlers and officials sometimes enter the narrative).²⁰ While historians of medicine in Africa have chronicled disease-specific campaigns,²¹ or mission hospitals,²² detailed histories of government medical administration and practice are still few.²³

²⁰ Though this dissertation explores the influence of a number of events happening outside Malawi's borders on its health policy, there are of course some that are emphasized at the expense of others. In particular, this dissertation is focused on events in the United Kingdom, the United States, and the Rhodesias (today, Zambia and Zimbabwe). Particularly during the late colonial and early postcolonial moments (chapters 8-10), there were influences from elsewhere. The Mau Mau rebellion took place at the same time as anti-Federation protests, and Nyerere's long rule (and interest in community health care) in Tanzania was largely coincident with HK Banda's reign. These intra-African influences are only briefly mentioned in this dissertation, as they are slightly less direct than the other influences that are explored in more depth.

²¹ Maryinez Lyons, *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900-1940* (New York: Cambridge University Press, 1992); John Farley, *Bilharzia: A History of Imperial Tropical Medicine* (New York: Cambridge University Press, 1991); *The Making of a Tropical Disease: A Short History of Malaria*, 1 edition (Baltimore, Md.: Johns Hopkins University Press, 2011).

²² Markku Hokkanen, *Medicine and Scottish Missionaries in the Northern Malawi Region 1875-1930: Quests for Health in a Colonial Society* (Lewiston: Edwin Mellen Press, 2007); Michael Jennings, "Healing of Bodies, Salvation of Souls': Missionary Medicine in Colonial Tanganyika, 1870s-1939," *Journal of Religion in Africa* 38, no. 1 (January 1, 2008): 27-56; Terence O. Ranger, "Godly Medicine: The Ambiguities of Medical Mission in Southeastern Tanzania, 1900-1945," *The Social Basis of Health and Healing in Africa*, no. 30 (1992): 256; *The Steamer Parish: The Rise and Fall of Missionary Medicine on an African Frontier*, 1 edition (Chicago: University of Chicago Press, 2004); Nancy Rose Hunt, *A Colonial Lexicon of Birth Ritual, Medicalization, and Mobility in the Congo* (Durham, NC: Duke University Press, 1999).

²³ Ralph Schram, *A History of the Nigerian Health Services* (Ibadan University Press, 1971); Michael Gelfand, *Proud Record: An Account of the Health Services Provided for Africans in the Federation of Rhodesia and Nyasaland* (Printed by the Govt. Printer for the Federal Information Dept, 1960); Michael Gelfand, *A Service to the Sick: A History of the Health Services for Africans in Southern Rhodesia, 1890-1953* (Gwelo, Rhodesia: Mambo Press, 1976); Ann Beck, *A History of the British Medical Administration of East Africa, 1900-1950*. (Cambridge: Harvard University Press, 1970); Ann Beck, *Medicine, Tradition, and Development in Kenya and Tanzania. 1920-1970*, First Edition (Waltham, Mass: African Studies Assn, 1981); RT Mossop, *History of Western Medicine in Zimbabwe* (Lewiston, NY: Edwin Mellen Press, 1997). C Baker, "The Government Medical Service in Malawi: An Administrative History, 1891-1974.," *Medical History* 20, no. 3 (July 1976): 296-311.

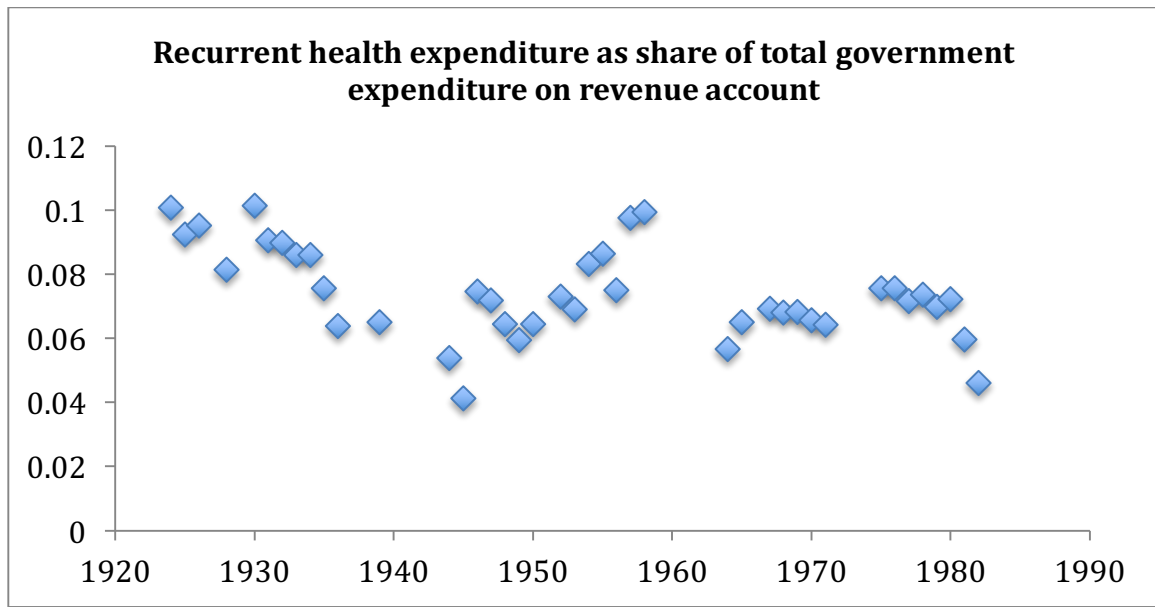


Figure 0.2. Recurrent government health spending as share of total government recurrent expenditure, Nyasaland/Malawi, 1920-1980. Sources: Annual Medical Department Reports (1920-1952), Hazelwood & Henderson (1960) and DT Jack (1959) (1953-63), and Reports of 1974, 1979 and 1983 World Bank Missions to Malawi (1964-1982).

Those that do exist tend to focus on government development plans—while tending to downplay the fact that few were ever brought to fruition²⁴—or to take a teleological perspective in which progress toward a robust system of lifesaving care was stepwise and steady.²⁵ Even those histories that highlight the use of biomedical rationales for segregationist and economically exploitative policies do not generally highlight the extent to which medical care was or was not a part of the daily life of the average African subject.²⁶

²⁴ Ann Beck, *A History of the British Medical Administration of East Africa, 1900-1950*. (Cambridge: Harvard University Press, 1970); Ann Beck, *Medicine, Tradition, and Development in Kenya and Tanzania. 1920-1970*, First edition (Waltham, Mass: African Studies Assn, 1981).

²⁵ Baker, “The Government Medical Service in Malawi.”

²⁶ Maynard W. Swanson, “The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900-1909,” *The Journal of African History* 18, no. 3 (January 1, 1977): 387–410; Curtin, “Medical Knowledge and Urban Planning in Tropical Africa”; Randall M. Packard, “The Invention of the ‘Tropical Worker’: Medical Research and the Quest for Central African

The result is a historiography that either tends to emphasize the *presence* of biomedicine over its absence (for the more celebratory narratives), or biopower and mass experimentation over neglect (in critical histories).²⁷ In both sets of histories, the writings and exploits of a small number of white men (e.g. Albert Cook, David Livingstone) occupy much more of the narrative than African auxiliaries and lay caregivers.²⁸ As Steven Feierman has argued, for the vast majority of people in southern, central and eastern Africa care in times of illness is given not by medical doctors nor by registered nurses, but by kin and neighbors.²⁹ This was even more the case during the first half of the twentieth century, when Nyasaland’s health facilities—both mission and government—were always sparse and poorly-funded, even by the contemporary standards of British Africa.

This dissertation is a biography of government provision of “Western” medicine and public health in Malawi. Though I recognize that this was but one part of a plural medical

Labor on the South African Gold Mines, 1903–36,” *The Journal of African History* 34, no. 02 (1993): 271–92.

²⁷ For a sample of celebratory narratives, see Gelfand, *A Service to the Sick: A History of the Health Services for Africans in Southern Rhodesia, 1890-1953*; Gelfand, *Proud Record*. For a sample of the critical narratives, see Wolfgang U. Eckart, “The Colony as Laboratory: German Sleeping Sickness Campaigns in German East Africa and in Togo, 1900-1914,” *History and Philosophy of the Life Sciences* 24, no. 1 (2002): 69–89; Paul S. Landau, “Explaining Surgical Evangelism in Colonial Southern Africa: Teeth, Pain and Faith,” *The Journal of African History* 37, no. 2 (1996): 261–281.

²⁸ W. P. Livingstone, *Laws of Livingstonia: A Narrative of Missionary Adventure and Achievement* (University of Toronto Libraries, 2011). *The Steamer Parish*; Jennings, ““Healing of Bodies, Salvation of Souls””; Agnes Rennick, “Church and Medicine: The Role of Medical Missionaries in Malawi, 1875-1914” (PhD Dissertation, Department of History, University of Stirling, 2003). There are, of course, exceptions to this generalization. For histories that do focus on African biomedical practitioners, see Hunt, *A Colonial Lexicon of Birth Ritual, Medicalization, and Mobility in the Congo*; Iliffe, *East African Doctors*.

²⁹ Steve Feierman, *The Illusion of Care* (forthcoming).

system in Malawi, and remains so today, I will focus on this one element throughout. Of course other elements (including missionary medicine, millenarian Christianity and popular healers) will enter the narrative, as they had significant effects on the history of government medical care. But by recounting the history of government medical care over the course of the twentieth century, it will become apparent that something is missing from many micro studies and grand narratives of colonial and postcolonial medicine. The missing element is *the key role of social unrest in determining the level of official attention paid to public sector health care*. Malawi's government health facilities often grew during periods of colonial labor agitation and after major global wars, while they languished in during periods of perceived quietus. The disquiet that impelled greater spending on health did not necessarily have to occur within Malawi—particularly during the interwar period, Nyasaland was the beneficiary of funding spurred by striking workers in the United Kingdom, the West Indies and other British African colonies. Colonial officials with a particular interest in social services in Nyasaland made creative use of crises elsewhere to direct resources to the impoverished backwater of the British Empire. The greatest increase (in terms of the share of government spending going toward health) occurred in the 1950s and early 1960s, when Nyasaland's Africans proved unwilling participants in an incipient Federation system of government with Northern and Southern Rhodesia. During these turbulent years, health spending was a response to the unrest within Nyasaland. And shortly after Malawi secured independence in July 1964, a brief and abortive experiment with outpatient user fees in Malawi proved to be a cause of social unrest.

Arguing that unrest has positive social dividends may seem dangerously naïve, particularly in a region long plagued by terrific violence and bloody racial strife. Compared to other countries in southern, central and eastern Africa, Malawi's relatively placid history seems an obvious benefit. Though I will argue in the following chapters that Malawi's political history is often written in sepia tones that obscure bloody events, it is true that Malawians were, for the most part, spared the great brutalities visited upon other peoples in the region. Malawians were not pillaged to the same extent as the Congolese under both Belgium's King Leopold or Mobutu. Malawians were not herded into concentration camps, as the Namibians were under German rule before the First World War, or as Kenyans were by the British during the Mau Mau revolt. They did not experience civil wars like those in Mozambique and Angola. They did not suffer the same degree of systematic and brutal racial segregation as blacks in Southern Rhodesia and South Africa.

By comparison, Malawi's political history seems calm, almost serene. Long described as simple peasants in a remote outpost of the British Empire, Africans in Nyasaland rarely made the front pages of newspapers in Europe or the United States. The famed Scottish missionary physician David Livingstone had railed against slave traders around Lake Malawi in the 1860s—when the territory was a source for thousands of slaves in the Indian Ocean slave trade—but by the twentieth century Nyasaland was, in British eyes, a paragon of primitive placidity.³⁰ And so it would remain, save for an abortive revolt by a

³⁰ David Livingstone, *David Livingstone's Shire Journal 1861-1864*, ed. G. W. Clendennen (Aberdeen: Scottish Cultural Press, 1993); Edward A. Alpers, *The East African Slave Trade*,

fiery African minister in 1915 (Chapter 1) and a brief period in the years leading up to independence when a vibrant movement against the Federation government took hold (Chapter 8). Nyasaland rarely roused great concern in the Colonial Office, or in any other centers of imperial or commercial power. After independence in 1964 outside indifference continued, as Prime Minister Hastings Kamuzu Banda swiftly became Life President Banda and remained firmly in control of the nation's politics and economy until the early 1990s (Chapters 9 and 10). The population and the economy grew, but in terms of per-capita GDP Malawi remained one of the poorest countries on the planet. Bereft of mineral resources and spared headline-grabbing violence, Malawi became the province of aid workers and missionaries, not international journalists or high-level diplomats.

But even though Malawi has lacked easily recognizable drama or destruction in its colonial and postcolonial political history, there was throughout a silent violence being done to its poorest people. In her memoirs, English-born Margaret Fuller compared the experience of her early childhood years in Southern Rhodesia during the civil war in the 1970s with her teenage years in a comparatively peaceful Malawi in the early 1980s:

We feel more dangerously, teeteringly close to disease and death...than we did during the war in Rhodesia...In Malawi we frequently see children bent backward, as easily and rigidly as twisted paper clips, with cerebral malaria, from which, if they emerge alive, they will rarely recover completely.³¹

Malawi's governments—colonial and postcolonial—consistently denied the vast majority of its population access to healthcare services that were the standard of care in much of

Reprint edition (Historical Association Of Tanzania, 1972); Frank Debenham, *Nyasaland: The Land of the Lake*, First Edition (Her Majesty's Stationery Office, 1955).

³¹ Alexandra Fuller, *Don't Let's Go to the Dogs Tonight: An African Childhood* (New York: Random House Trade Paperbacks, 2003).

the rest of the world. Without enough adequately trained medical providers, women perished from treatable complications of labor and delivery. Stringent rationing and frequent stock-outs of antibiotics left thousands to die of treatable infections (see Chapters 4 and 8). The absence of accessible health facilities doomed many to needless suffering and premature death in their homes. And for those patients who did manage to make it to hospitals and health centers, broken X-ray machines and laboratory equipment left medical providers unable to render accurate diagnoses (see Chapters 8, 9 and 10). While Malawians paid taxes and submitted to forced labor under both colonial and postcolonial governments, little of the wealth extracted from their toil came back to them. These, too, were acts of violence. The dearth of funds budgeted to the “staff, stuff, space and systems” necessary to deliver preventive and curative healthcare was, for many, as fatal as a shot from a gun or the slice of a machete.³²

But political inattention to health care was not total. The pervasive neglect was interrupted, at brief and irregular intervals, by additional funding. One question this dissertation seeks to answer is: why did those interruptions occur? The answer, most often, was unrest. Unrest came in many different forms, including non-violent demonstrations and global wars, general strikes and subversive rumors. Colonial subjugation and post-colonial dictatorship proved to be political arrangements most responsive to these kinds of threats to legitimacy. Government spending on medical care was a favored palliative during times of unrest. In contrast to “native” education, which officials feared would stoke rebellion (particularly after the 1915 Chilembwe Rising),

³² Paul Farmer, “Who Lives and Who Dies,” *London Review of Books*, February 5, 2015.

health spending (and, in particular, curative health spending) was seen as a way to quiet restive publics.³³ This contrast in the perceived political consequences of health and education spending helps explain why networks of government-run district hospitals and clinics were constructed throughout Nyasaland during the 1920s and 1930s, while the colony's first government-run secondary school for Africans did not open until after the Second World War.

Unrest did not have to happen within Nyasaland's borders to impact its health budgets. Savvy officials in the UK and Nyasaland with an interest in this oft-forgotten land's health sector drew persuasive—if roundabout—connections between the need to quell unrest elsewhere and the imperative to spend more on health care in Malawi. Such connections by well-placed moral entrepreneurs were key to securing drugs and doctors for a colony (and later, a country) that so woefully lacked them. Popular social unrest, including a number of episodes linked to Malawi only by the most tenuous of connections, was a precursor to every significant increase in public sector health spending. Given the crucial importance of the monopoly on violence to any regime's legitimacy, it is understandable that Malawi's colonial and postcolonial governments would seek to keep potentially violent forms of political agitation from seeping into the

³³ John Chilembwe, who led the 1915 revolt, had been educated at a Church of Scotland Mission, and had been a house servant of the Baptist missionary Joseph Booth. Booth had taken Chilembwe to the United States in 1897, where he continued his studies at the Virginia Theological Seminary. In the years after his return to Nyasaland in 1900, Chilembwe became more and more vocal in his criticism of the treatment of Africans, particularly those who labored on estates. After his rebellion had been put down and Chilembwe executed, a Commission of inquiry questioned Protestant missionaries about the political influence of African education at the missions. See "The Effects of Mission Teaching on the Native Mind," in *Voices from the Chilembwe Rising: witness testimonies made to the Nyasaland Rising Commission of Inquiry, 1915*, ed. John McCracken (London: Oxford University Press, 2015). Pages 359-463.

thinly governed land.³⁴ Yet the fact that official attempts to palliate the populace could so often involve health spending is barely recognized by political scientists, sociologists or historians.³⁵

Perhaps part of the reason why this pattern has gone relatively unnoticed is the fact that not all wars and strikes proved boons to health spending. The relationship between unrest and outlays for health was not an automatic cause-and-effect of the kind readily discernable in regression analyses. Labor unrest and unemployment in the 1920s in *Britain* set in motion events that would lead to the construction of district hospitals across *Nyasaland* during the early 1930s (Chapter 3). Yet *within Nyasaland* the share of government expenditure going toward health care declined markedly during the mid-1930s, a slide that continued after a massive anti-witchcraft movement known as *mchape* swept across the countryside. It persisted even after the return of the infamously

³⁴ I refer here to Max Weber's argument that a state is only a state if its staff can successfully maintain a claim to a "monopoly on the legitimate use of physical force in the enforcement of its order." See Max Weber, "Politics as a Vocation," in *From Max Weber: Essays in Sociology* (New York: Oxford University Press, 1946), 77–128.

³⁵ The political scientists Zeynep Taydas and Dursun Peksen have noted a negative association between social spending and the frequency of outbreaks of political violence. This literature posits that increasing social spending might lead to greater political legitimacy and, therefore, a decrease in coup attempts and civil wars. But in this dissertation the cause and effect are reversed. In my account, official concern that there is a threat to legitimacy (and the threat need not be domestic) spurs an increase in social spending. See Zeynep Taydas and Dursun Peksen, "Can States Buy Peace? Social Welfare Spending and Civil Conflicts," *Journal of Peace Research* 49, no. 2 (2012): 273–87. Political scientist James C. Scott notes this absence of scholarship on the role of seemingly disorganized forms of unrest from below on policy. "And yet," he explains, "the accumulation of thousands or even millions of such petty acts can have massive effects on warfare, land rights, taxes, and property relations. The large-mesh net political scientists and most historians use to troll for political activity utterly misses the fact that most subordinate classes have historically not had the luxury of open political organization." James C. Scott, *Two Cheers for Anarchism: Six Easy Pieces on Autonomy, Dignity, and Meaningful Work and Play* (Princeton: Princeton University Press, 2012), xx.

disruptive millenarian preacher Elliot Kamwana from his forced exile in 1937 (Chapter 4). The connection between unrest and health spending had to be forged deliberately, often using finely tuned arguments delivered by officials with influence in the budget-making process.

Of course, the unrest-driven increases in public spending on health were not sufficient to spare Malawi its dismal health indices, currently some of the world's worst. But that fact does not refute, but rather strengthens, my thesis. Interruptions to the prevailing neglect of the health of Malawi's people were too seldom and brief precisely because of its people's reputation for placidity.

III. The role of economic thought: the eternal health-is-wealth debate

Before a crowded Harvard lecture hall one brisk November afternoon in 2014, Paul Farmer chuckled. He had paused in the midst of discussing an article by the Nobel Prize-winning economist Amartya Sen, with whom he was teaching a graduate seminar. He laughed because he thought Sen had penned a hilariously tongue-in-cheek passage. In the 1998 article, Sen offered a number of reasons economists should concern themselves with indicators of mortality (and not only with measures of income). To Farmer, a number of the arguments were so blatantly obvious as to go without saying. Why, Farmer wondered, would Sen need to remind anyone of “the intrinsic importance we attach—and

have reason to attach—to living,” or—in an even more amusing turn of phrase—of “the fact that many other capabilities that we value are contingent on our being alive”?³⁶

Yet for Sen, who had long encouraged development economists to broaden their scope of inquiry beyond per-capita GDP statistics, these remained necessary arguments. The relevance of human health and even human survival to economics remains a subject of debate in the field’s top-tier peer-reviewed journals. In 2005, the *Quarterly Journal of Economics* published “The gift of the dying,” in which Alwyn Young argued: “The AIDS epidemic enhances the future per capita consumption possibilities of the South African economy, in effect endowing it with additional resources.”³⁷ Resting this argument largely on the (disputed) assumption that high rates of AIDS mortality would lead to decreased fertility rates (thereby leaving more resources for those who survived), Young chided advocates who called AIDS an economic problem. “One cannot endlessly lament the scourge of high population growth in the developing world and then conclude that a reversal of such processes is an equal economic disaster. The AIDS epidemic is a humanitarian disaster of millennial proportions, one that cries for assistance. It is not, however, an economic disaster.”³⁸ Given the prominent place given to such arguments in a major economic journal, Sen did have ample reason to worry about the consequences of understanding poverty only through “the cold and often inarticulate statistics of low

³⁶ Amartya Sen, “Mortality as an Indicator of Economic Success and Failure,” *The Economic Journal* 108, no. 446 (January 1, 1998): 1–25. Page 5.

³⁷ Alwyn Young, “The Gift of the Dying: The Tragedy of AIDS and the Welfare of Future African Generations,” *The Quarterly Journal of Economics* 120, no. 2 (2005): 423–66. Page 425.

³⁸ *Ibid.* Page 460.

incomes,” rather than “the directly relevant and immediately gripping facts of diminished lives, agonized existence, and untimely deaths.”³⁹

These articles added to a storied, and complex, literature in economics. Sen’s arguments about the *intrinsic* value of “being alive” might seem bemusing and obvious at first glance, but they are a deliberate corrective to a long-standing discourse about the *instrumental* uses of health for economic ends. For over a century, a number of economists and policymakers arguing for increased public expenditure on medicine and public health have often framed health as an instrument for aggregate economic growth. Their tracts did not dwell, as Sen’s often do, on the value of health as an end in itself or as a precondition for a meaningful life. Seeking to appeal to the cold calculus of treasuries and taxpayers, advocates for increased health spending have often framed health as a useful “investment” in the pursuit of economic growth. One prominent and fairly recent example is the World Health Organization’s Commission on Macroeconomics and Health, chaired by economist Jeffrey Sachs, which published a report in 2001 claiming that “good population health is a critical input to poverty reduction, economic growth, and long-term economic development at the scale of whole societies.”⁴⁰

³⁹ Sen, “Mortality as an Indicator of Economic Success and Failure.” Page 2

⁴⁰ The report also made the following claim: “The economic costs of avoidable disease, when taken together, are staggeringly high. Disease reduces annual incomes of society, the lifetime incomes of individuals, and prospects for economic growth. The losses are dozens of percent of GNP of the poorest countries each year, which translates into hundreds of billions of US dollars.” Jeffrey Sachs, *Macroeconomics and Health: Investing in Health and Economic Development*, Report of the Commission on Macroeconomics and Health (Geneva: World Health Organization, 2001), 22.

Yet such arguments have often proven ineffective in convincing skeptics. In this dissertation I will demonstrate that presenting human health as an instrument for growth—rather than an end in itself—has sometimes helped to pry open government purses. But I will also argue that the argument has often fallen on deaf ears, or even invited contrary claims, along the line of Alwyn Young’s, that saving the lives of the poor through health spending might *decrease* per-capita incomes.⁴¹ This pattern is clear in the response to a 2001 article co-authored by John Luke Gallup and Jeffrey Sachs. Using data from 1965 to 1990 and controlling for a number of variables, the authors concluded from a cross-country regression that a 10 percent reduction in their “index of malaria” was associated with an annual boost of 0.3 percent to per-capita GDP.⁴² Five years later, economists Daron Acemoglu and James Robinson countered this finding in their own regression analysis. Using a range of data sources on life expectancy starting in 1940, the authors concluded: “There is no evidence that the large exogenous increase in life expectancy [effected, in their account, by chemotherapeutic agents] led to a

⁴¹ The idea that mass death might be beneficial to African peoples is not new. In a 1988 article on population control and conservation, former colonial agricultural advisor Richard Kettlewell, who figures prominently in the history that follows (see Chapters 2 and 8), argued, “The widespread existence and threat of AIDS in Africa may be a blessing in disguise. Of course the disease might itself have some cruel limiting effect on population, but it may influence some counties towards the public advocacy of less promiscuity and the extensive use of contraceptives. This could perhaps help a campaign to reduce the still greater menace of mass starvation in the future—provided the opportunity is grasped before a cure for AIDS is discovered and anxiety on that account abated.” Richard Kettlewell, “Personal Thoughts on the Future of Africa,” LSHTM Nut/05/04, Page 17. This argument is not going out of fashion. In 2014, Young’s paper was taught in graduate economics seminars as an example of the economic benefits of pandemic disease, rather than an object lesson in questionable assumptions and the morally callous extremes of a certain kind of economic logic.

⁴² John Luke Gallup and Jeffrey D. Sachs, “The Economic Burden of Malaria,” *American Journal of Tropical Medicine and Hygiene* 64, no. (1,2)S (2001): 85–96. In this article, each nation’s index of malaria intensity was “the fraction of the population at risk of malaria multiplied by the fraction of cases of malaria that are falciparum malaria.” See page 85.

significant increase in per-capital economic growth.”⁴³ Advocates of the claim that health spending increases economic growth can point to empirical evidence to support their claims, but so can the argument’s detractors. As I will demonstrate, the claim has a less illustrious record in actually increasing public sector health budgets than its advocates might assume.⁴⁴ Multiple chapters (2, 7, 8 and 10) examine the influence—or, more often, the lack thereof—of arguments claiming that public sector health spending is an effective instrument for increasing economic growth (an argument that I will refer to as the “health is wealth” argument) in colonial Nyasaland and post-colonial Malawi.

The inability of changing fashions in development economics to explain actual outlays on health is evident from Malawi’s twentieth-century government budgets. Figure 0.2 (shown above) tracked the share of Malawi’s recurrent expenditure devoted to the Medical Department (or, after independence in 1964, the Ministry of Health) between 1920 and 1980. The graph revealed that health accounted for more than 8 percent of recurrent government expenditure in only two periods: first, in the years between 1920

⁴³ Daron Acemoglu and Simon Johnson, “Disease and Development: The Effect of Life Expectancy on Economic Growth” (National Bureau of Economic Research, Working Paper 12269, Cambridge, MA, May 2006).

⁴⁴ Numerous empirical studies and theoretical models have supported a causal relationship between health spending and economic growth, and many will be cited in the coming chapters. Some of the most prominent and frequently cited include: Mushkin, Selma J, “Health as an investment,” *Journal of Political Economy* 70, no 2, suppl (October 1962): 129-57; Gary Becker, *Human Capital*, New York: Columbia University Press (for NBER), 1964], pp. 33-36; Victor R Fuchs, “The contribution of health services to the American Economy,” *Milbank Memorial Fund Q.44* (1 October 1966): 65-102; Michael Grossman (1972) “On the concept of health capital and the demand for health, *Journal of Political Economy*, Vol. 80, No 2, pp. 223-255; TW Schultz, Prize Lecture, Lecture to the Memory of Alfred Nobel. The Sveriges Riksbank Prize in Economic Sciences in the Memory of Alfred Nobel 1979; Dreze and Sen, *India: Development and Participation*. Oxford: Oxford University Press, 2002. A more recent addition to this literature is Adrienne Lucas, “Essays on Disease, Human Capital, and Economic Growth” (PhD Dissertation, Department of Economics, Brown University, 2006).

and 1930, and; second, between the mid-1950s and the early 1960s. The first such period (the 1920s) will be discussed in Chapter 1. This decade is less pertinent to this argument, as public sector health spending in Nyasaland during this period was still largely focused on the care of European officials. However, in comparing the rest of the graph with the history of thought in development economics, a counterintuitive becomes apparent.

Health secured its highest shares of government spending precisely when the “health is wealth” argument was given the least credence by leading development economists.

In later chapters I will describe in detail the dominant trends in development economics during three major eras. Here, though, I will provide only the most cursory of summaries. In the first era, lasting from the 1930s to the early 1950s, the “health is wealth” argument was an important facet of British thought about how to develop colonial holdings.

Spurred by research nutrition, entomology, and tropical medicine, officials in both the UK Colonial Office and in the colonies spoke ever more forcefully about the futility of efforts to increase output from the colonies without concomitant efforts to improve nutrition and eliminate widespread parasitic infections. Still, the UK Treasury remained doubtful of the impact of health spending on revenues throughout this era, and the need for “economies” in social services such as health limited the reach of health campaigns. With the arrival of the Second World War, even frugal plans for health were shelved in Nyasaland and elsewhere in British Africa.

Though health was mentioned in early postwar economic planning, by the late 1950s the focus had shifted. In this era, university economists from the US and the UK argued for

modernization, a strategy for rapid industrialization that called for focusing public expenditure on the building blocks of capital-intensive industrial production rather than the health of the broader populace. Yet despite the fact that colonial economists and even African nationalists in Nyasaland corresponded with leading theorists of modernization, it was during the 1950s and 1960s that Nyasaland (known after its independence in 1964 as Malawi) experienced its most rapid rise in government health spending. This spending was, in large part, a response to a crisis of political legitimacy that led political authorities to discard some prescriptions of modernization in favor of overt and widely-publicized demonstrations of beneficence made possible by health spending.

Finally, in the 1970s (the third era in economic thought covered in this dissertation) international development discourse rediscovered nutrition and health. A burgeoning literature on “human capital” and a focus within the World Bank on Basic Needs prompted increased attention to and financing for health projects. For the first time since independence, Malawi could obtain more substantial assistance from bilateral and multilateral donors for health projects. But once again, there was discordance during this era between health spending and trends in economic thought. Health spending remained limited, as Britain no longer felt it necessary to spend its resources on an independent Malawi and President Banda no longer perceived internal threats to his own political legitimacy.

Again, aside from the 1920s, the share of public sector recurrent expenditure devoted to health was greatest during the 1950s to the early 1960s. The coincidence of increased

health spending (in both absolute and relative terms) with the era in which modernization theorists dismissed the “health is wealth” argument motivates this historical analysis of the relationship between economic theory and economic policy. Academic economists have long repeated John Maynard Keynes’ observation that “practical men, who believe themselves to be quite exempt from any intellectual influence, are usually the slaves of some defunct economist.”⁴⁵ The argument that economic ideas hold great sway over health budgets is prevalent in accounts of international health since the dawn of the neoliberal era in the 1980s; in these histories of the recent past, International Monetary Fund and World Bank officials compelled the governments of poor nations to enter into structural adjustment programs (SAPs) that gutted health sector budgets in the name of debt repayment.⁴⁶ The policy prescriptions of World Bank and IMF officials were, as these histories demonstrate, inspired by the ideas of “neoliberal” economists such as Milton Friedman and Friedrich von Hayek.⁴⁷

These histories reveal deep and disquieting truths about the relationship between armchair elite theorizing and the “immiseration” of health care systems for poor people in poor countries.⁴⁸ But in this dissertation I am concerned with an earlier era, *before* the

⁴⁵ John Maynard Keynes, *The General Theory Of Employment, Interest, And Money* (Palgrave MacMillan, 1936).

⁴⁶ *Unhealthy Health Policy: A Critical Anthropological Examination*, Edited by Arachu Castro and Merrill Singer (Lanham, Md: Altamira Press, 2004); Salmaan Keshavjee, *Blind Spot: How Neoliberalism Infiltrated Global Health* (Oakland, California: University of California Press, 2014); Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (Berkeley: University of California Press, 2003).

⁴⁷ Keshavjee, *Blind Spot*, pages 88-96; David Harvey, *A Brief History of Neoliberalism* (Oxford; Oxford University Press, 2005).

⁴⁸ James Pfeiffer and Rachel Chapman, “Anthropological Perspectives on Structural Adjustment and Public Health,” *Annual Review of Anthropology* 39 (2010): 149-65.

much-discussed age of structural adjustment.⁴⁹ By chronicling the history of a public sector health system prior to the neoliberal age, I intend to demonstrate the profound influence not of elite theory, but of popular politics. Mine is not a history in which regnant economic theory is the most important determinant of health policy. Instead, the story follows closer to the lament of Peter Ruderman, an economist who had worked in development policy. “Decisions as to public spending on health,” Ruderman explained, “are often taken in response to...political pressures.”⁵⁰ I ultimately conclude that economic thought can provide a hospitable (or inhospitable) international milieu for the officials and politicians holding the purse strings of government spending. Yet the credence (or lack thereof) given to the “health is wealth” argument does not explain the major changes in health spending in Malawi during the colonial and early post-colonial eras. Intellectual histories of Western economic thought are unable to explain patterns of health spending. Claims about the economic value of health spending have a long and contentious history, yet shifts in economic thought have not been the primary influence on levels of government spending on medicine and public health.

For the key influences, the historian must look to popular politics and the ideological commitments of key political officials. Ferguson was correct in noting that the poorer nations of southern Africa were under the thrall of an “anti-politics machine” by the

⁴⁹ For an overview of Malawi’s health sector during the era of structural adjustment (early 1980s to early 2000s), see Ezekiel Kalipeni, “Structural adjustment and the health care crisis in Malawi,” *Proteus* 21 (2004); 1: 23-30. Also see Elias Banda and Gill Walt. “The Private Health Sector in Malawi: Opening Pandora’s Box?” *Journal of International Development* 7 (1995): 403.

⁵⁰ A. Peter Ruderman, “General Economic Considerations,” in *Health Planning: Qualitative Aspects and Quantitative Techniques* (Baltimore, Md.: Johns Hopkins University School of Hygiene and Public Health, Department of International Health, 1972). Page 109

1980s, but it was not always thus.⁵¹ Patterns of growth and retrenchment of the Malawian health sector can only be explained with reference to broader African, European and American political histories. Health spending was long seen as a political weapon, an instrument intended to quell restive publics. It was popular politics, and not the writings of the elite academics, that determined whether or not the rulers of one of the world's poorest peoples cared about matters of health and sickness, life and death.

IV. Outline: political crises and health spending in Malawian history

The chapters ahead chronicle the role of medicine in development planning and popular politics in Malawi between 1914 and 1983. This time span is bookended by two calamities that fundamentally changed the nature of health care in Malawi. The period begins with the First World War, a war in which hundreds of thousands of Nyasaland's Africans encountered both European forced labor and European medical provision for the first time. Before the First World War, government health programs for Africans were so sparse that, aside from mass campaigns to vaccinate against smallpox and monitor for sleeping sickness, they rarely touched the lives of most Africans in Nyasaland (Chapter 1). This dissertation ends (save for a conclusion and ethnographic interludes) with the start of the AIDS epidemic in the 1980s. This was a massive conflagration that would, by 2004, grow to claim the lives of 80,000 Malawians every year (out of a population of 12.5 million) before mortality began to fall with the free provision of antiretroviral

⁵¹ James Ferguson, *The Anti-Politics Machine : "development," depoliticization, and Bureaucratic Power in Lesotho* (New York: Cambridge University Press, 1990).

therapy.⁵² This epidemic was so traumatic that it profoundly colored, and even erased, earlier memories of government health provision (see conclusion). The AIDS crisis also helped usher in a new era of health financing in Malawi (as elsewhere in southern Africa), an era in which significant external resources would change the relationship between crisis politics and health spending.⁵³

In the seventy years between these two disasters, I ask, when and why did access to biomedical care become a central political concern and budgetary priority? During both the colonial and early post-colonial eras, Malawi's governments increased spending on biomedical care to demonstrate beneficence, particularly when they faced threats to legitimacy. These threats could come from within Malawi, but they could also arise from seemingly unrelated and far-flung events. Officials and international advisers persistently attributed Malawi's inadequate medical provision to the nation's poverty, but changes in health spending have *not* automatically followed shifts in GDP or government revenues. Instead, the construction of new hospitals and dispensaries, the purchase of new supplies and medicines, and the addition of medical staff have almost always come in the wake of social unrest, such as world wars, international waves of labor action, and domestic protests. Only at these moments were the government and its international partners compelled to devote more resources to health. Oft-repeated official claims that there was simply not enough money available to improve government health services have almost

⁵² Andreas Jahn, Sian Floyd, and Amelia C Crampin, "Population-Level Effect of HIV on Adult Mortality and Early Evidence of Reversal after Introduction of Antiretroviral Therapy in Malawi," *Lancet* 371 (2008): 1603–11.

⁵³ Luke Messac and Prabhu Prabhu, "Redefining the Possible: The Global AIDS Response," in *Reimagining Global Health: An Introduction* (Berkeley: University of California Press, 2013).

always been abandoned during periods of political crisis. Yet these periods have been infrequent; placidity, and not just poverty, may account for Malawi's dismal medical infrastructure.

Health services in Malawi have been a product of strife, not quietus. War and unrest, often in far-flung locales, brought spending on healthcare provision, while periods of perceived calm have spurred retrenchment. Because the idea that government spending on health has been as much a function of international political instability as national prosperity is so counterintuitive, it will be proven not with one example, but with many, spanning seventy years and involving actors and events many countries. The history is drawn from numerous archives in Malawi, the United States, the United Kingdom, and Botswana. Written sources include official reports, memoirs and correspondence of civil servants in both the colonial and postcolonial administrations. Oral sources include interviews conducted with dozens of Malawians and expatriates between 2011 and 2015. Fieldwork in two Malawian villages (one in Neno District, and another in Mangochi District) provides additional data.

The chapters ahead are organized in roughly chronological fashion, but each relates a different episode to compare the influence of social unrest and economic thought on the attention given to health care in public sector budgets in colonial Nyasaland and post-colonial Malawi. Each chapter is preceded by a “prelude.” Most of these preludes are vignettes from my fieldwork in Mangochi and Neno Districts. The questions and issues raised in each prelude are similar, though not identical, to those explored in the

corresponding (historical) chapters. The preludes, then, are intended to show resonances and dissonances, to trace the lineaments of history in an emergent present. I have changed the names of people (except for public figures) and village names (but not district or hospital names) in the preludes (except for 2, 4, 8 and 9), in order to protect the identities of my interlocutors.

The first five chapters focus on the period spanning the two world wars (1914-1945). Chapter 1 draws a link between the conscription of hundreds of thousands of Nyasaland Africans into the Allied carrier service during the First World War and the first deliberate efforts to provide some measure of health care to rural subjects in Nyasaland during the 1920s. Many conscripted carriers and soldiers had their first contact with hospitals during the Great War, though these facilities were far more impressive in official records than in reality. During the early 1920s—not a particularly hospitable time for health spending in the British Empire—persistent advocacy by the Director of Medical Services and chief’s demands to resuscitate health facilities shut down after the war helped prompt the administration to fund the construction of more than sixty rural dispensaries around the colony.

Chapter 2 turns to the interwar era of investigations into the health of Africans in the British Empire. These investigations were conducted by experts in diverse array of scientific fields, including nutrition, entomology, agriculture and anthropology. During the interwar era, these fields were high on the British imperial research agenda.

Physicians and administrators echoed the academic findings that hardy, productive bodies

could only be sustained with diets containing enough vitamins, minerals and calories and living environments sufficiently free of parasites. Multi-disciplinary investigations, such as the Nyasaland Nutrition Survey (1938-1940) buttressed officials' claims that increased production from colonial subjects depended on increased investment in the health of colonized Africans. Commonly proposed investments included agricultural extension services and vector control campaigns, but also improved health care facilities.

But, as chapters 3 and 4 demonstrate, these visions for colonial social medicine were not the principal determinants of spending on health during the interwar years. Chapter 3 recounts the passage of the UK Colonial Development Act of 1929, and the effect of this law on Nyasaland's health sector. Odd as it may seem, health spending in Nyasaland in the early 1930s was a piece of the government's response to the 1926 General Strike in the United Kingdom. In the years following this strike, British officials with experience in both domestic labor relations and colonial administration argued that colonial development spending could both alleviate a worsening unemployment crisis and calm labor militancy within the UK. Other officials in the Colonial Office in London and the Colonial Medical Service then drew special attention to Nyasaland, a poor colony which held little promise as a market for British goods but which—according to these advocates—languished in such a state of neglect as to threaten to bring “grave public discredit” upon the Crown. As a result of this lobbying, Nyasaland's health sector became a major beneficiary of 1929 Colonial Development Act. Many of the colony's district hospitals were built with funds made available by this legislation. Thus, moral entrepreneurs in the British administration were able to subvert the law's original intent

(to increase employment in the UK through the purchases of manufactured goods for the colonies) in order to improve a health system in Nyasaland they had long lamented.

Chapter 4 demonstrates the other side of the link between unrest and health spending. Once the well-connected moral entrepreneurs with a concern for Nyasaland departed from their posts, the colony's health sector languished. The late 1930s and early 1940s were a period of profound disquiet in the British Empire; waves of riots and strikes roiled the oil fields and ports of the British West Indies, the mines of Northern Rhodesia's Copperbelt, and cocoa farms in West Africa. Secretary of State for the Colonies Malcolm MacDonald used these crises of colonial legitimacy to usher the Colonial Development and Welfare Act of 1940 to passage. But most of the initial funding made possible by this law went to the perceived centers of unrest, such as the West Indies, and not to a seemingly docile Nyasaland. Medical administrators in Nyasaland complained bitterly to their superiors, but to no avail; even as the metropolitan government touted the new Colonial Development and Welfare Act, proposals to improve nutrition and medical training in Nyasaland were shelved.

Yet developments in Britain during and immediately after the Second World War changed political discourse about social services in British Africa. Chapter 5 focuses on changing metropolitan thought about colonial development during and immediately after the Second World War. During the late 1930s and early 1940s, powerful voices in Britain's Labour Party challenged the persistent claim that there just was not any money available to improve health services for Africans in Britain's colonies. At the same time,

a new consensus emerged in British society about the government's responsibility to ensure the health of the *British* people. This consensus was in evidence both in the popular reception to the 1942 Beveridge Report, and in the 1946 enactment of the UK National Health Service. For many, including William Beveridge and prominent members of Britain's Labour Party, the social and economic rights embodied in the Beveridge report seemed applicable not only to Britain, but also to its colonies. In the years following the publication of the report, officials throughout the British Empire and Commonwealth contemplated their own plans for social protection.

But once again, Nyasaland's reputation as a land of quietus helped officials in Whitehall exclude the colony from discussions about more robust social services in Africa. The causes and consequences of this relative neglect in the immediate postwar period are the focus of Chapter 6. Instead of enacting the old-age and disability pensions and health-care provisions that were the backbone of the consolidated British welfare state, officials in London and Zomba argued that rural Africans in Nyasaland were already protected against ruin by traditional village mechanisms of social security. The idealized image of egalitarian social solidarity among rural Africans amounted to a historically dubious and politically interested argument for inaction. So when a postwar wave of labor unrest spread across much of British Africa, Nyasaland was dismissed as a haven of political quietus, and its health sector saw relatively little of the newly available development financing.

Despite the dearth of official attention given to Nyasaland's dismal health centers and hospitals, African subjects in the colony showed increasing interests in health facilities in the decades following the Second World War. In Chapter 7, I chart the rapid rise in attendance at government health facilities in the postwar decades, and argue that the (slow and halting) arrival of new drugs and equipment during the postwar years were key to attracting patients to government facilities. The increased popularity of government health care among the general population had profound effects on the politics of medicine in the postwar era. Health care itself became an even more important response to social unrest, and health care became a major subject of late-colonial and post-colonial political demands.

Even as more patients began to present for care, prominent development economists in the United States and the UK argued ever more forcefully that government spending on healthcare was "consumption" rather than investment, and that such spending was an imprudent use of public resources in poor countries. Yet in Chapter 8, I explain how it was that precisely during the period when modernization theorists seemed most influential in economics, recurrent government health spending in Nyasaland rose dramatically, from £273,000 pounds in 1953 to £1.48 million pounds in 1969. The prevailing development discourse of the moment cannot explain this pattern of spending. Instead, we must look again to political crises. Officials in the government of the controversial and short-lived Federation of Rhodesia and Nyasaland (1953-1963) publicized financial commitments to health in an attempt to quiet growing protests within Nyasaland and critics in the UK. Government health care even became a focal point of

political contests, as pro-Federation commentators accused anti-Federation nationalists had sabotaged a smallpox vaccination campaign, while anti-Federation voices countered that the Federation government had neglected health care for Africans.

Shortly after Malawi gained independence in 1964, another political crisis prompted Malawi's new government to turn its attention to health care. Chapter 9 chronicles a short-lived rebellion by Malawi's cabinet ministers, which prompted the embattled Prime Minister Hastings Kamuzu Banda to abandon the outpatient user fees he had enacted only a few months earlier. His attempts to establish legitimacy in the eyes of Malawi's citizenry included well-publicized visits to government hospitals. Yet throughout the 1960s he could find scarce support for health care from other governments and international agencies. This was the heyday of population control in international health, so aid for health was focused almost entirely on contraception. Yet Banda refused to contradict his regime's own carefully constructed ideology of abundance by promoting contraception at government health facilities.

Chapter 10 documents Banda's turn away from healthcare as a major priority during the 1970s. Not coincidentally, this shift in focus coincided with greater regime stability. Without any mortal threats to his rule, Banda could turn his attention to estate agriculture and a new capital city, even as the rise of human capital arguments in development discourse led to increased interest in health among bilateral and multilateral aid donors. Banda came to rely on external donors, particularly governments that were facing international crises of legitimacy, for health financing, rather than drawing upon

Malawi's own domestic revenues. As in prior decades, Malawi's public sector health expenditures and policies were *the opposite* of what the cosmopolitan advisors and august professors advised. Here, once more, the shifting tides of economic theory are unable to explain patterns of outlays for health.

In the conclusion, I consider how this pattern of crisis-driven health spending has changed during Malawi's crisis-riddled recent past. In the three decades since the mid-1980s, a period marked by AIDS, famine and periodic suspensions of donor aid, Malawi's governments have come to hold little legitimacy in the eyes of the citizenry. Still, public officials continue to try to regain the public's trust through displays of solicitude. But political leaders have devoted relatively little in the way of domestic revenues to health, instead seeking to claim personal credit for international aid coming into Malawi.

Over the last few years I have been asked a question. It recurs in libraries and archives and district hospitals and government offices and cafes, in the United States and Europe and Africa. The question is innocent enough: "What are you researching?" Among the many expatriate aid workers and volunteers that I meet, the most frequent response to my explanation ("I'm studying the history of the government health service in Malawi") is something akin to "Oh, I can't imagine there is much to study there." They are correct that there is not much in the way of government medical care in Malawi, nor has there ever been. But just as action has a history, so, too, does inaction. Just as acts of care and attention can be chronicled and explained, so can records of neglect. The dreadful

disrepair of Malawi's public hospitals and the empty shelves in public dispensaries are just as much a product of history as Britain's well-equipped clinics and socialized health insurance. In fact, they are a part of the *same* history. Who has the government cared for? Who has been left to die? And why? These questions can only be answered with a global, contingent, and often ironic history of crisis politics. It is a history in which perceptions of peace can bring untimely death. It is also a history in which, as the next chapter will show, brutal and deadly war brings expectations of health.

Chapter 1

Drugs for the tengatenga: the beginnings of government medicine in Nyasaland in an era of war, 1914-1929

Abstract

As unpaid forced labor on settler farms, as carriers supplying the British in the East African theatre during the First World War, and as transporters of European officials, Africans were made to carry loads throughout the colonial era. Less remembered by historians of Malawi (and, as it was known under British rule, Nyasaland), though, is that the colonial administration's reliance on African subjects as beasts of burden impelled its initial expenditures on medical care. Whereas before the First World War the only source of biomedical care in Nyasaland were the scattered mission hospitals, the intense demands for African labor during the war spurred the construction of government-run hospitals and dispensaries. These ill-equipped facilities were tasked with the care of the hundreds of thousands of "carriers" forced to carry munitions, rations and other supplies to troops fighting near the border of Nyasaland and German Tanganyika.

In the aftermath of war, experience with biomedicine at these hospitals led native authorities and colonial medical officers to call for the construction of additional health facilities. By 1923, Nyasaland had a system of 70 rural dispensaries. These facilities were staffed by poorly trained African auxiliaries and operated under extreme economies, and according to colonial officials they had not secured the confidence of most Africans. But the hospitals and dispensaries owed their very existence to the even more threadbare carrier hospitals that inaugurated the era of biomedical care for Africans in Nyasaland.

Using archival records and oral histories from Malawi and the United Kingdom, this chapter seeks to explain the beginnings of government medicine for Africans in colonial Nyasaland. The need of massive human labor supplies during the Great War, and the perceived need to demonstrate imperial concern for sick subjects in the years that followed impelled a pennywise Treasury to begin spending on health services.

Prelude: Memories of carrying

"They were always carrying the colonists," remembered "Francis," a 48-year-old farmer in Nyanza, a lakeshore village near the town of Monkey Bay in southern Malawi. Taking a brief respite from his daily labors to drink tea in the living room of his home one hot morning in March 2015, Francis recounted stories of the colonial era told by his parents and grandparents. He had heard from them that whenever a district commissioner would travel through the village on *ulendo* (tour) to meet with local leaders or collect taxes,

villagers would have to carry his *machila* (hammock-stretcher) on their shoulders. “The people complained about it, a lot, (*anadandaula kwambiri*)” he said.

Memories of carrying have even been etched into the names Malawians have given to the landscape. In the southwestern province of Neno, the poorest district in the world’s poorest country, a schoolteacher explained the meaning of the name of a hill called *Caliwoni* near his home. It was not, he said, a Chichewa word. Rather, *Caliwoni* harkened back to a command uttered often in that place by a British official whenever he visited on tour. Villagers carrying the *machila* on which he rode would inevitably slow when they reached the long, steep hill. “Carry on! Carry on!” the official would command. The villagers so associated that hill with this command that they Chewa-ized the command and named the hill *Caliwoni*.¹

All kinds of forced labor remain vivid in Malawian memories of colonization. Still sipping his tea, Francis reminisced about the demands of *thangata* labor. *Thangata* was a system by which, in return for the privilege of living as squatters on the massive estates granted to European settlers by the colonial government, Africans were made to perform at least one month of unpaid labor for the settlers each year as “rent.”² In colonial days (*ku nthawi atsamunda*), Francis remembered, people were beaten for refusing to perform

¹ The suffix *-ni* in Chichewa, the most commonly spoken language in Malawi, is used to denote a command.

² George Shepperson, *Independent African: John Chilembwe and the Origins, Setting and Significance of the Nyasaland Native Rising of 1915*, 1969, Page 179; John McCracken, *A History of Malawi : 1859-1966*. (Woodbridge, Suffolk: James Currey, 2012). Page 80.

thangata labor. They were sometimes beaten just because a settler found their work too slow for his liking.³

As bearers of European officials' *machilas*, as *thangata* laborers on European estates, and—as this chapter will detail—as carriers supplying troops in the East African theater during the First World War, African men and women were put to work against their will throughout the colonial era. The personal memoirs of former British officials and commentators tend to portray all this labor as ennobling, even enjoyable. The Cambridge Professor of Geography Frank Debenham claimed the first Nyasaland administrators had devised the hut tax for the purposes “of paying for benefits conferred and of keeping the men occupied.”⁴ WTC Berry, a medical officer in Nyasaland between 1936 and 1943, described the invariably jovial disposition of the men who were his means of transport:

In the remoter parts of the Protectorate the *Boma* [government] also kept a team of four ‘*machila* men’ for the doctor’s use if he had to visit a village some miles away, off the beaten track where a car could not go. A *machila* was a wheeled chair with shafts at each end. One man pulled between the shafts in front, another pushed at the back and the other two ran alongside to take over at intervals. Even in the fiercest heat they would not slack off their running and sang, whooped, and turned somersaults as they went. . . They showed extraordinary powers of endurance and arrived at their destination up to eight or ten miles away quite fit and well able to quip along the way with any villagers they might encounter.⁵

These men may or may not have been paid, and the labor may or may not have been forced; Berry did not say. The point here is merely the merry, unburdened attitudes that he attributed to them. Yet for Nyasaland’s Africans, laboring for Europeans—particularly forced labor—was the stuff of bitter memories. Lewis Bandawe, a Lomwe immigrant

³ Personal interview with Francis in Nyanza Village, Mangochi District, Malawi, March 20, 2015.

⁴ Debenham, *Nyasaland*. Page 165.

⁵ W. T. C. Berry, *Before the Wind of Change* (Suffolk, England: Halesworth Press, 1984). Page 17.

from Portuguese Mozambique who would go on to serve as head clerk and interpreter in Nyasaland's High Court from 1934 to 1960, wrote in his memoirs that the British colonial government "was a terror to all people." To Bandawe, the iron collars used on prisoners (most often guilty of nothing more than defaulting on hut taxes) looked just like the ones he had seen on slaves in neighboring Mozambique.⁶ Bandawe claimed (with, perhaps, some exaggeration) that "every European, with the exception of the missionaries, had a *chikoti*—a whip made of hippo's hide—which he used on his domestic servants and labourers."⁷ Ending such practices was an animating force of anticolonial politics. For Francis, the most inspiring promise in the early speeches of Hastings Kamuzu Banda (Malawi's nationalist leader and first president) was his promise to end *thangata*.⁸

Today's rural Malawians relish the absence of such overt systems of forced labor. But even without demands for unfree labor there remains, of course, plenty of work to do. The annual hungry season (December-March), when food from the previous harvest runs short but the work of tending to the next is hardest, is the busiest time. I lived with Francis and his family during this period, and noted the daily routine. Five people (not including me) slept in Francis's home on most nights. Francis and his wife, Edith, slept in one room on a mat of woven banana leaves. Lucia, the couple's eight-year-old daughter, and Monica, their three-year-old niece, slept in another room. Samuel, the 17-year-old

⁶ Lewis Mataka Bandawe, *Memoirs of a Malawian: The Life and Reminiscences of Lewis Mataka Bandawe* (Claim, 1971). Also see Edward Paice, *Tip and Run: The Untold Tragedy of the Great War in Africa* (London: Weidenfeld & Nicolson, 2007). Pages 162-163.

⁷ Bandawe, *Memoirs of a Malawian*, 70-73; Paice, *Tip and Run*, 162.

⁸ Personal interview with Francis in Nyanza Village, Mangochi District, Malawi, March 20, 2015.

son of Francis's late sister, sleeps in the hut adjacent to the house that doubles as Edith's kitchen.

Every morning before daybreak, Francis's wife Edith swept the house and the back yard with a broom made of twigs. She then walked 100 meters to the nearest borehole, where she filled a 50-liter basin. With apparently little difficulty, the slight yet strong Edith lifted the basin and placed it on her head for the walk home. Walking into the dimly lit kitchen, a hut with no ventilation that will soon be filled with smoke, she packed twigs and branches into an earthen cook-stove and started a fire to heat the water. Some of the water would be used to cook *nsima*, the maize porridge that is the staple of the Malawian diet. Much of the rest of the water will be used for bathing. She helped Lucia prepare for school, then tied Monica to her back with a *chitenje* cloth and departed to collect more firewood or to help Francis's disabled parents, who lived next door, with their chores. On many other days helped Francis and Samuel in the fields. Every evening she spent two hours preparing dinner.

Francis also rose before dawn, and during most days in the hungry season he walked two kilometers to the two-hectare field where he grew maize and groundnuts. There he carefully tended to what would be the major source of his family's sustenance for the coming year. Francis was often joined in the field by his late sister's son, Samuel, a 17-year-old who was orphaned three years prior and who slept in the hut that doubled as Edith's kitchen. My rent helped Francis purchase a 50-kilogram bag of fertilizer; this cost 16,500 kwacha (about US\$40) at the nearest agricultural marketing board depot. Though

fertilizer can increase yields by as much as three-fold it also added to Francis's workload. In addition to planting the crops and weeding the fields, he now had to apply fertilizer in a painstaking process two times during the growing season. To me, Francis and Edith's exertions appeared unbelievable, especially because they lived on such a meager diet. Their daily *nsima* satiated hunger, but furnished few calories.

For Francis and Edith, work abounds. The harvest rarely provides much more than subsistence. Still Francis says he enjoys farming. He is one of the few men in the village who does not spend every night in a canoe on the lake, fishing for *kampang* (catfish) or *usipa* (sardine-like fish) by lanterns and moonlight. The family has proved successful enough at farming to live a more comfortable life than others in their village. Their house is made not of wattle and daub (as are many others in the village), but of cement. Their floor is also cement, as opposed to the packed dirt many others have. The roof of their three-roomed domicile is made of corrugated iron, not straw. Francis's family has even amassed wealth, in the form of 10 chickens, four goats and one pig.

If the annual rains do not fall at the right time and in the right amount all their exertions can come to naught. Their home, like the rest in their village, has neither electricity nor running water. Francis once had a working cell phone, but it has been broken for months. The couple derives great satisfaction from the fact that they labor on their own terms. Unlike their grandparents and great-grandparents, they are not colonial subjects. They are no one's beasts of burden.

I. Introduction

Malawian government health care was born of a war in which Africans died in droves. The colonial administration's reliance on African subjects as beasts of burden impelled its initial expenditures on medical care. In the aftermath of war, medical officers began to focus not only on the health of Europeans and research, but also on the wellbeing of Africans. Whereas before the First World War the only sources of biomedical care for Africans in Nyasaland were the few scattered mission hospitals, the intense labor demands during the war spurred the construction of government-run hospitals. In the aftermath of the war, experience with biomedicine led native authorities, and the medical officers who interacted with them, to call for the construction of dispensaries around the country.

The 1920s were the start of a period—which in many ways, never ended—when Medical Department officials and native authorities consistently demanded additional funds from the territorial and imperial Treasuries for medical care for Nyasaland's Africans. As the colonial employees with the most frequent contact with rural African smallholders, doctors saw each day how the UK's claims that it brought health, peace and prosperity to the colonial populace were belied by quotidian realities. Africans, they argued, must be able to expect something in exchange for onerous taxation, forced labor and alien rule. Colonized Africans in Nyasaland received very little government medical care until the era of the Central African Federation (1953-1963, see Chapter 8), but public sector health care was born earlier, after a Great War that took the lives of thousands of the colony's inhabitants.

II. The mirage of hospitals during the Great War

a) Reviewing missionary and government services in Nyasaland before the Great War

Before the Great War, medical care for Africans in Nyasaland was sparse and almost wholly provided by missions. Mission hospitals had been established at Cape Maclear in 1875, Bandawe in 1881, Livingstonia in 1894, and Zomba in 1896. They were important not only for the care they provided, but also because they trained African medical auxiliaries for both mission and government facilities.⁹

Before the First World War, the government medical service was devoted almost entirely to the care of European officials (and, to a lesser extent, non-officials) and scientific research.¹⁰ Nyasaland, like many other colonial regimes in Southern and Central Africa (e.g. Northern and Southern Rhodesia, South Africa, Mozambique, Congo), was originally a for-profit private enterprise. Established in 1891, the British Central African Protectorate was originally a public-private venture funded by Cecil Rhodes' British South Africa Company (BSAC). Rhodes did not think the territory very profitable, and paid His Majesty's Government to administer it on a shoestring budget of £10,000 per year. He agreed to fund the establishment of the "Protectorate" in part to advance his dream of British rule "from the Cape to Cairo," and in part because the British government had agreed that in return for its funding the BSAC would secure the sole

⁹ Michael King and Elspeth King, *The Story of Medicine and Disease in Malawi: The 150 Years Since Livingstone* (Malawi: Arco Books, 1992); Austin C. Mkandawire, *Living My Destiny: A Medical and Historical Narrative* (Limbe, Malawi: Popular Publications, 1998).

¹⁰ African soldiers and prisoners were two exceptions; in early colonial British Africa, they did receive medical attention from the government.

rights to the gold fields in Mashonaland (in present-day Zimbabwe).¹¹ The interest from the start in Nyasaland (so renamed in 1907) was to spend as little as possible, while maintaining a modicum of order and aiding European planters to profitably run estates. The spirit of extreme economy continued even all of the Nyasaland administration's political ties to the BSAC were severed in 1911.¹²

In this era British medical officers came to Africa to build reputations as researchers, to discover new pathogens and disease mechanisms and enter the bacteriological pantheon of Koch and Pasteur, rather than to provide medical care. Michael Worboys and Megan Vaughan have argued that late-nineteenth and early-twentieth century practitioners of tropical medicine were more interested in biological investigation than public health or clinical medicine.¹³ Such was the case for Dr. Hugh Stannus, stationed at Fort Johnston as a medical officer to the King's African Rifles [Nyasaland's military force] from 1905 to 1910. Stannus built a pathology laboratory, started a medical library, and authored scientific publications on sleeping sickness (in humans and animals) yaws, black-water fever, albinism, and ethnological works on African peoples.¹⁴

¹¹ John Reader, *Africa: A Biography of the Continent* (New York: Vintage, 1999). Page 579. A "Protectorate" was a designation of a British imperial holding technically distinct from that of a colony; the pretense was that sovereign chiefs had willingly signed treaties putting themselves under the protection of the British Crown). For the sake of simplicity, and because these treaties were often far from equal exchanges of willing parties, throughout this dissertation I will refer to Nyasaland as a British "colony."

¹² Griffith Bevan Jones, *Britain and Nyasaland* (London: Allen & Unwin, 1964). Page 53.

¹³ And Michael Worboys, 'Manson, Ross and Colonial Medical Policy: Tropical medicine in London and Liverpool, 1899-1914,' in Macleod and Lewis, eds, (1988), pp 21-38.

¹⁴ Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford, Calif: Stanford University Press, 1991). pp 30-32.

From the perspective of the metropolitan government, the role of medical officers in Nyasaland before the First World War was to protect the few Africans, Indians, and Europeans involved in the threadbare administration of the new territory. The contract of the Indian surgeon Dr. Sorabji Boyce, the colony's first medical officer (who accompanied Sir Harry Johnston to the new British holding in 1891 and died only six months later), explained his primary duty was to care for government officials.¹⁵ Almost a quarter-century later, in 1913, Nyasaland's Medical Department had twelve medical officers and five nurses.¹⁶ In 1914, there were only a few small government hospitals providing care for Africans at Port Herald (4 beds), Zomba (46 beds), Fort Johnston (5 beds), and Karonga (2 beds).¹⁷

Public health ordinances passed during the early years of the twentieth century were martial in nature and ill-suited to securing the trust of peoples so recently conquered, often by force of arms. A July 1903 ordinance aimed at limiting sleeping sickness (human trypanosomiasis) required all Africans seeking to cross the border of a district to enter only at specified government stations, where they would be made to submit to a medical examination. These exams focused on palpation of the cervical glands (in the neck). If the glands were not enlarged, the traveler would be issued a pass. If the

¹⁵ Owen J. M. Kalinga, *Historical Dictionary of Malawi*, Fourth Edition (Lanham, Md: Scarecrow Press, 2011); Lwanda, *Colour, Class and Culture*.

¹⁶ WH Mercer, "The Colonial Office List for 1913: Comprising Historical and Statistical Information Respecting the Colonial Dependencies of Great Britain" (London: Waterlow & Sons Ltd, 1913). p 274.

¹⁷ Lwanda, *Colour, Class and Culture*. Pages 47. Control of the country's largest hospital, at Zomba, had been transferred from the UMCA Mission to the Nyasaland colonial administration in 1908. Rennick, "Church and Medicine: The Role of Medical Missionaries in Malawi, 1875-1914." Page 125.

travelers' glands were enlarged, the traveler could be quarantined in a "segregation settlement."¹⁸ Suspected sleeping sickness cases sometimes had their cervical glands punctured for diagnosis, though widespread opposition to this procedure limited its use.¹⁹

If, in the course of sleeping sickness investigations in villages, officials suspected infection or if the residences were believed to lie within the range of the tsetse fly (the carrier of trypanosomiasis), District Residents could evict Africans from their huts or even order the abandonment of entire villages.²⁰ The consequences of disobedience were harsh: "In case of disobedience to such an order the District Resident may, after due warning, destroy such hut, settlement or village and remove the inhabitants thereof in custody."²¹

Smallpox vaccination campaigns involved similarly harsh measures. In 1896, Dr. Neil Macvicar of the Church of Scotland Blantyre Mission had begun training African medical

¹⁸ Charles J Griffin and Walter E Demuth, "No. 4 of 1903, Epidemic and Contagious Diseases, Rules, 117/1911, 21st July 1903, Sleeping Sickness," in *Proclamations, Rules and Notices Relating to the Nyasaland Protectorate in Force on the 31st December 1914* (Zomba, Nyasaland: Government Printer, 1915), 40–43.

¹⁹ "Church and Medicine," pages 308-310. Also see "The diagnosis of human trypanosomiasis," *Sleeping Sickness Bureau Bulletin 2* (1910); 14: 55-60.

²⁰ Markku Hokkanen, "The Government Medical Service and British Missions in Colonial Malawi, c.1891-1940: Crucial Collaboration, Hidden Conflicts," in *Beyond the State: The Colonial Medical Service in British Africa* (Manchester: Manchester University Press, 2016), 39–63. Pages 47-48.

²¹ Charles J Griffin and Walter E Demuth, "No. 4 of 1903, Epidemic and Contagious Diseases, Rules, 117/1911, 21st July 1903, Sleeping Sickness," in *Proclamations, Rules and Notices Relating to the Nyasaland Protectorate in Force on the 31st December, 1914* (Zomba, Nyasaland: Government Printer, 1915), 40–43.

assistants to vaccinate against smallpox using scalpels and lymph.²² These assistants entered the field in time to respond to a fairly short-lived epidemic in 1899-1900—the brevity of this outbreak seemed to confirm to the administration the utility of native vaccinators.²³ The colonial administration began to pay the wages of the native vaccinators and to purchase the supplies of calf lymph.²⁴ As Agnes Rennick argued in her dissertation on missionary medicine in Malawi, both the missionaries and the administration sought to draw additional settlers from Britain by demonstrating that both European planters and African laborers could live healthy lives in the Protectorate.²⁵

Nearly a decade without a serious smallpox epidemic in Nyasaland bred confidence among both missionary doctors and colony's chief medical administrator that their vaccination program was effective. In 1907, Principal Medical Officer Henry Hearsey confidently declared that “epidemics of smallpox, such as were common in the protectorate some years ago, do not now occur.”²⁶ But when large outbreaks struck Nyasaland the very next year, the colonial administration issued the Vaccine Ordinance

²² A 1900 letter by a coffee planter to the Blantyre Mission indicate that smallpox vaccination lymph was administered person-to-person, rather than from tubes. See Rennick, “Church and Medicine: The Role of Medical Missionaries in Malawi, 1875-1914.” Page 205.

²² Ibid. Page 299.

²³ Rennick, “Church and Medicine: The Role of Medical Missionaries in Malawi, 1875-1914.” Page 299.

²⁴ These payments from the colonial administration began in 1904. In 1913, Hearsey reported that the government paid “about £200 per annum for the wages of Native Vaccinators, and an additional £100 for the purchase of lymph.” Ibid. Page 301. Also see Megan Vaughan, “Health and Hegemony: Representation of Disease and the Creation of the Colonial Subject in Nyasaland,” in *Contesting Colonial Hegemony: State and Society in African and India* (London: British Academic Press, 1994), 173–201. By 1921, the government spent £400 per annum on calf lymph. See *Approved Estimates, Nyasaland Protectorate, 1921-22* (Zomba: Government Printer, 1921), 27, in T161/91, UKNA.

²⁵ Rennick, “Church and Medicine: The Role of Medical Missionaries in Malawi, 1875-1914.” Page 298.

²⁶ Ibid. Page 300.

of 1908, which made vaccination compulsory. By 1913, the Government reported that the African assistants had administered 143,502 vaccinations in that year alone.²⁷

Yet Rennick provides ample evidence that these vaccination campaigns may have been less effective than advertised. Even Hearsey doubted the accuracy of the vaccinators' returns. The few medical officers in the employ of the government did little to verify them. Doctors also recognized that their lymph was often stored so long that it lost its capacity to stimulate immunity. At times some of the vaccinators' efforts seemed worse than useless. In 1909, a District Resident reported that the high frequency of severe ulcers on the arms of the recently vaccinated might have something to do with a local vaccinator's wont to use a blood-soaked, dirt-stained scalpel to carve gaping wounds into patients' arms.²⁸

On the other hand, these campaigns were definitely effective at demonstrating to African subjects the similarities between public health and the recent wars of colonial conquest. The *Central African Times* reported in 1899 on the government's response to a smallpox outbreak in the Ntcheu District village of Ntonda: "Every house in which a case was found was burned and the natives compensated. A cordon of *askari* [African soldiers in the employ of the colonial administration] is on duty day and night." Even missionaries joined in the arson. Dr. Walter Elmslie of Universities' Mission for Central Africa Livingstonia Mission reported that after unsuccessfully "hunting for a case of small pox

²⁷ Ibid. Page 301.

²⁸ Ibid. Page 305.

which is being hid away by the people,” he “burnt down several houses where we knew he had been, so the stupid people may begin to see their own interests and help us.”²⁹

Such tactics would do little to secure the trust of Africans that vaccination campaigns were, in fact, helping them. As early as the 1908 epidemic, a movement emerged that appeared dangerously subversive to colonial officials. The moment seemed to augur upheaval. In addition to smallpox, the years 1907-1908 brought other unusual occurrence. Nyasaland’s: minor earthquakes shook the earth, a comet appeared in the sky, and cattle were felled in large numbers by an epidemic.

Into this tumult stepped Elliot Kamwana, a mission-educated 26-year-old from Nkata Bay. In 1908 Kamwana returned home from his studies to baptize his neighbors into the Watch Tower Church. His sermons proclaimed, “*Kwacha, Africa yuka*” (“It is dawn, Africa rise.”). Kamwana spoke of a future where “all Kings, Kingdoms and Governments would cease.” Within six months of beginning his ministry, he had already baptized over 9,000 people. Seeing in his message a political challenge “under the cloak of religion,” Nyasaland’s authorities arrested Kamwana. In 1909 he was deported to the Seychelles.³⁰

Decades later, colonial measures against smallpox would continue to engender opposition. The frequent recurrence of smallpox in the coming decades, and the often-

²⁹ Ibid. Page 304.

³⁰ Even in exile, Kamwana continued to cause trouble for authorities. In 1914, pamphlets predicting the apocalypse and bearing his name appeared in Nyasaland. Henry Donati, “A very antagonistic spirit: Elliot Kamwana: Christianity and the World in Nyasaland, *The Society of Malawi Journal*, 64 (2011);1: 13-33.

unexplained brutality of the measures taken in the name of disease control, would spur a backlash against vaccination campaigns. Vaccinators lamented villagers' refusal to cooperate during a 1936 outbreak.³¹ Resistance would take on special importance in the late 1950s, when the Federation Government claimed that the leadership of the Malawi Congress Party had frightened the people into rejecting vaccinations (Chapter 8).

Coercive public health measures, and not curative medicine, were the only introduction most Africans received to government medicine before the Great War. Removals from villages by armed police in the name of sleeping sickness prevention resembled nothing so much as the battles only recently fought by some of Nyasaland's peoples against British and BSAC troops during the 1890s before they submitted to "protection."³² The most profound impact of Europeans in most African lives was in the hut taxes they were made to pay each year, which compelled thousands of men to leave their villages to in search of waged labor on plantations and in mines. Curative health care was not a meaningful part of this experience of being governed. Unless they lived near a religious mission, most Africans never saw a doctor or nurse.

b) "Invited to die for a cause which is not theirs": Nyasaland Africans in the Great War

³¹ Vaughan, "Health and Hegemony: Representation of Disease and the Creation of the Colonial Subject in Nyasaland." Pages 185-186.

³² For a brief account of the wars of conquest led by Harry Johnston between 1891 and 1894 while in the employ of both the British government and the BSAC, see McCracken, *A History of Malawi*. Pages 57-67.

It was not until the Great War reached Nyasaland that many Africans had contact with government-employed British or Indian medical providers or African auxiliaries. For the Africans patients, this introduction to European medicine came during a period of profound upheaval. The *nkhani chiwaya* (war of the big gun) has long been remembered as a time of excruciating forced labor and mass death. WTC Berry, a medical officer in Nyasaland during the 1930s, recalled an aphorism coined by “an observant Bantu chief,” summing up the chronicity of European presence in Africa: “First the missionary, then the trader, then the gunboat.”³³ Indeed, it was a gunboat that heralded the start of hostilities between the UK and Germany in East Africa. On August 8, 1914—four days after Germany invaded neutral Belgium prompting the British to declare war on Germany—British warships fired on a wireless installation and railway station at the German East Africa capital, Dar es Salaam. On August 13, the war reached Nyasaland; sitting in dry dock in the German port of Sphinx Hafen on the northeastern shores of Lake Nyasa, the German ship *Hermann von Wissmann* was demobilized by a shot from the British gunboat *Guendolen*. This was no great battle, as the German captain had not even been alerted to the outbreak of war.³⁴ From then on, a long war would be fought in each of Nyasaland’s neighbors: German East Africa (today’s Tanzania), Portuguese East Africa (today’s Mozambique), and Northern Rhodesia (today’s Zambia).³⁵

³³ Berry, *Before the Wind of Change*. Foreword.

³⁴ McCracken, *A History of Malawi*. 148

³⁵ Paice, *Tip and Run*. 13-15 East Africa was, in many ways, an unlikely theatre of war. The 1885 Berlin Act excluded the colonies of the Congo Basin from any universal war, and the few troops stationed in German and British colonies were there for internal security. The borders were porous, and prior to the war there was no great appetite on either the British or German side for the East African territory held either by the other side.

Africans in Nyasaland did not immediately feel the most terrible exactions of war, but in time they would toil, and die, in droves. Opposition to the war surfaced early. In an unpublished letter he sent to the *Nyasaland Times* shortly before he led an armed uprising in January 15, the preacher John Chilembwe decried the lot of Africans in “this present world.” They were, he declared, “invited to die for a cause which is not theirs.”³⁶ This was, of course, a dramatic understatement, for Africans were not so much invited as forced to join the war. But after leading a short-lived rebellion, Chilembwe would be shot dead by a police patrol in February 1915, so he would not live to see the worst of the wartime conscription.

In the aftermath of Chilembwe’s bloody but abortive uprising, British officials were reticent to arm the newly restive African population. This would change later in the war, when the demand for reinforcements led to the conscription of many African soldiers (*askari*). But in early 1916, British commanders were far more desperate for human carriers than armed troops. In February 1916 Brigadier-General Edward Northey arrived as commander of the Nyasaland-Rhodesian forces to find his troops desperately short of food. *Askari* and carriers were receiving “starvation rations” of 1.25 pounds of maize each day, as supplies ran short near the front lines.³⁷ Food, munitions, medicines, mail and even whiskey were supplied via a route that demanded vast quantities of human labour.³⁸ Ocean, river and rail transport from South Africa only reached as far as

³⁶ Shepperson, *Independent African*.

³⁷ McCracken, *A History of Malawi*. 149

³⁸ Paice, *Tip and Run*. 265 The main British supply line to the East African theatre began at Durban, South Africa, where supplies were shipped to the port of Beira in Portuguese East Africa. There they were put aboard smaller steamers to a British concession at Chinde, where the

Blantyre (along the main supply line) and Livingstone, Northern Rhodesia (on a subsidiary route). Pack animals could not survive in the tsetse-infested regions, as they were quickly killed off by trypanosomiasis (sleeping sickness).³⁹ So all along the 120 miles from Blantyre to Fort Johnston, and along a 700-mile route from Livingstone to Fife in Northern Rhodesia, and up mountains and through the dense brush of German East Africa, African carriers were the British army's beasts of burden. Among Africans the carrier service was known as *tengatenga*; *kutenga* means "to take" in Chichewa; *tengatenga* translates, roughly "to take very far."

Northey made constant demands for additional carriers from Nyasaland Governor George Smith. Smith set quotas for each of the chiefs; some who failed to supply the allotted numbers of carriers were put to the lash.⁴⁰ Police who failed to conscript sufficient carriers would have their pay withheld. The pay for carrier service was not sufficient to draw Africans into the service; carriers were paid six shillings per month, the same amount white settler volunteers earned in a single day. Turning to coercion, the administration first went after Africans who had defaulted on the hut tax (then six shillings per year per hut) were the first to be forced into service.⁴¹ When defaulters went

Zambesi River flows into the Indian Ocean. There supplies were they were sent aboard riverboats up the Zambesi and Shire Rivers to Chiromo, at the southern tip of landlocked Nyasaland. Transport from Chiromo to Blantyre was aboard a railway.

³⁹ Daniel R. Headrick, "Sleeping Sickness Epidemics and Colonial Responses in East and Central Africa, 1900–1940," *PLoS Neglected Tropical Diseases* 8, no. 4 (April 24, 2014). See also Paice, *Tip and Run*, "As the availability of livestock for transport proved incapable by mid-1916 of matching the deprivations of disease, the onus fell on the only alternative—human portage."

⁴⁰ Melvin E. Page, *The Chiyawa War: Malawians In The First World War*, First edition (Westview Press, 2000). Pages 46-47.

⁴¹ Even with so many Nyasaland Africans compelled into war service, the Nyasaland government continued to rely heavily on the hut tax for its revenues. During fiscal year 1917-18, the native

into hiding, police kidnapped their wives until they surrendered. But these conscripts were not sufficient to supply the war effort. Facing demands for additional carriers, police conducted night raids in villages to kidnap any able-bodied men they could find.⁴²

Estimates of the number of Nyasaland Africans in the carrier service during the war vary widely; the historian Melvin Page's figure of 200,000 is neither the lowest nor the highest. Population figures for this period were based not on careful census data but rather on administrative conjecture. Nevertheless, using the official estimate of Nyasaland's African population in 1918 (1.218 million), we can estimate that *16 percent* of Nyasaland's African population worked in the carrier service during the war.⁴³ But even this figure does not adequately convey the scale of disruption that the carrier service brought to some parts of the colony, particularly those along the major transport routes. An administrative census of military labor in 1918 found that the number of people engaged in military labor in South Nyasa district (18,615) was equal to 54.7 percent of the adult male population of the district.⁴⁴ This district, on the southern shore of Lake Malawi, includes the village where Francis lived in 2015—small wonder, then, that a century after the Great War, collective memories of carrying remained pervasive.

hut tax accounted for over half of the revenues of the Protectorate government (£75,448 out of a total of £144,239). *Nyasaland Blue Book, 1917-1918*, CO 525/82/50, UKNA.

⁴² Ibid. Pages 45-46, 52. Melvin Page sought out records about carriers during the First World War from a wide range of sources to reconstruct the historical narrative during this period, but some of the lengths to which Governor Smith and police went to conscript carriers are difficult to establish, as are many features of colonial governance in Nyasaland before the end of the First World War. This is because a large fire consumed government buildings in Zomba in 1919, destroying many of the archives. Medical officer WL Gopsill even recounted clerks throwing papers *into* the fire to relieve themselves of paperwork. WL Gopsill, "A Few Notes on My Life in Zanzibar and Nyasaland from 1926 to 1945" MSS.Afr.s.883, BLOU. Page 11.

⁴³ Baker, "The Government Medical Service in Malawi." 106

⁴⁴ Page, *The Chiwaya War*, 52-54. Some of these laborers were women and children, not adult males.

Tengatenga brought extreme privations. Even the pro-British *Nyasaland Times* reported that maize was “ground up, husks and all, and then issued as rations.”⁴⁵ Men (and sometimes women and children) were made to carry loads through swamps and up 9,000-foot peaks. Conductors, including missionary priests, beat carriers with whips, and often left them to die of exposure and exhaustion along these seemingly interminable supply routes.⁴⁶ Dysentery and pneumonia were rampant, and there were documented outbreaks of smallpox and plague.⁴⁷ Many of the sick and exhausted were abandoned along the road to die.⁴⁸ FC Baily, a convoy officer in German East Africa during the war, remembered carriers thus:

A carrier is one of the lowest forms of life (except a machine gun carrier, who is a picked man) and he is always more or less in a state of misery, as well he may be, for his job is to carry forty pounds’ weight on his head, and as he takes no interest whatever in the war, he does not find this very amusing. The mortality among carriers was extremely high, because, contrary to the popular idea, the native is no more immune to local diseases than anybody else, and goes down with malaria, dysentery and diarrhea very much the same as a white man.⁴⁹

Even Governor Smith, who had orchestrated the brutal recruitment campaign of carrier labor, estimated a mortality rate for carriers of 4-5 percent during 1917-1918, when conditions were worst.⁵⁰

⁴⁵ Page, *The Chiwaya War*. 110-111

⁴⁶ *Ibid.* Page 112-113.

⁴⁷ *Ibid.* 110-111

⁴⁸ Paice, *Tip and Run*. Page 346.

⁴⁹ Francis Evans Baily, *Twenty-Nine Years’ Hard Labour* (London: Hutchinson & co., Ltd., 1934),. 95-96.

⁵⁰ Page, *The Chiwaya War*. 113-114.

In a final stroke of suffering, survivors of carrier service returned home to two more scourges: epidemic and famine. Thousands who had survived carrier service died on the walk home at the end of the war in the 1918-1919 influenza pandemic.⁵¹ Then, by April 1919, villages across the Protectorate found themselves without food. According to Nyasaland Governor Hector Duff, the famine was due in part to the failure of the early grain harvest, but he admitted the cause was “chiefly the fact that immense quantities of stored native grain had been requisitioned for the use of the troops and that scores of thousands of able bodied natives had been withdrawn from their homes to serve as military porters...leaving few but old men, women and children to attend to the cultivation of the land.” Thus, the effects of the war on health rippled far beyond even the hundreds of thousands compelled into years of forced labor.⁵²

c) Carrier hospitals in the East African theater

In an attempt to maintain supply lines, the British military set up “carrier hospitals” near the front lines in German East Africa. In some accounts these medical facilities appear quite impressive. The official history of the First World War, commissioned by the UK Government, claims “the supply of medical stores and drugs, ordnance stores and comforts was...sufficient for the needs of the force.” According to this chronicle, medical care for carriers was provided at “twenty-eight mixed rest stations, five casualty clearing hospitals, and seven carrier hospitals.”⁵³ In August 1917 these facilities were staffed by “80 medical officers, 3 sub-assistant surgeons, 14 Roman Catholic priests, 23 nursing

⁵¹ Paice, *Tip and Run*. Page 395. Rough estimates of the number of deaths from the 1918-1919 Spanish influenza pandemic in Sub-Saharan Africa place the total at 1.5 to 2 million.

⁵² Hector Duff to Secretary of State for the Colonies, 14 April 1919, CO 525/82, No 135, UKNA.

⁵³ *Medical History of the War*, Vol IV, 477-8.

sisters, 24 dispensers, and 123 British other ranks.”⁵⁴ The history notes the “excessive death-rate” of the carriers, but attributes this primarily to “the poor physique of the African native.”⁵⁵

But recent historians do not paint the same portrait of a robust carrier medical service. In his *Chiwaya War*, Melvin Page explains, “Government authorities published impressive lists of hospitals, personnel ‘available,’ and lists of medical supplies. Most of these were only last minute and meager efforts and even then did not often operate as the organizational plans projected.” A missionary without any medical training who treated many of the carriers on the routes in southwest Tanganyika, remembered most of his medicines came from “a fine assortment” looted from a German mission, “but nearly all with German titles” he did not understand. He mostly gave sick patients “salts, Livingstone’s rouser pills [an antimalarial pill containing quinine and a mixture of purgatives, marketed by Burroughs Wellcome], quinine, boric powder and dressings and bandages.” Even hospitals with trained nurses were overwhelmed by sick carriers. “Our hospital is so crammed that patients sleep on top of one another,” remembered a Catholic nun posted at one of the carrier hospitals. At another hospital in Mwenzo the facilities were so small, and the sick so numerous, that many cases were turned away.⁵⁶

Within Nyasaland the war left medical services even more depleted than before. Seven of the twelve doctors employed by the government were called up to serve on the front in

⁵⁴ *Medical History of the War*, Vol IV, 492.

⁵⁵ *Medical History of the War*, Vol IV, 490.

⁵⁶ Page, *The Chiwaya War*. 113

German East Africa.⁵⁷ “Owing to the extreme shortage of staff it was not possible to keep open more than three civil stations, namely, Port Herald, Blantyre and Zomba.”⁵⁸

Another hospital remained in operation at Fort Johnston, but was under military control. Even obtaining medical staff for Nyasaland’s troops proved extremely difficult. On January 4, 1917, Governor Smith sent a telegram to the UK’s Secretary of State for the Colonies requesting five Indian sub-assistant surgeons immediately.⁵⁹ Robert Hollowell Headley, an official in the Military Department of the India Office in London, explained, “In view of the shortage of this class of medical personnel in India it is very doubtful whether the men can be supplied.”⁶⁰ Two months later a British General in Dar-es-Salaam cabled the Secretary of State for the Colonies, lamenting the sub-assistant surgeons were an “urgent need” yet were still “not received.”⁶¹ The records do not indicate whether the sub-Assistant surgeons ever arrived.

Yet despite the shortcomings of medical care for carriers and *askari*, more of Nyasaland’s Africans came into contact with government-run British medical facilities during the war than at any time previously. “For the first time,” claims the historian Colin Baker, “hundreds of thousands of Nyasaland Africans had access to Government medical

⁵⁷ King and King, *The Story of Medicine and Disease in Malawi*. 106

⁵⁸ H Hearsey, “Annual Medical Report on the Health and Sanitary Condition of the Nyasaland Protectorate for the Year Ended 31st December, 1918” (Zomba, Nyasaland: Government Printer, 1919).

⁵⁹ “Governor George Smith to Secretary of State for the Colonies,” January 4, 1917, 10R: Military Collection No 322, File 17, MNA.

⁶⁰ “RH Headley to Secretary of State for the Colonies,” January 10, 1917, 10R: Military Collection No 322, File 17, MNA.

⁶¹ “General Hoskins to the Secretary of State for the Colonies,” March 13, 1917, 10R: Military Collection No 322, File 17, MNA.

services.”⁶² This might be an overstatement, depending on one’s definition of “access” and “medical services.” But Baker is correct when he argues “this was bound to lead to pressure—whether voiced or not—to extend medical facilities after the war.” Though Baker does not explain how this “pressure” manifested, the next section of this chapter will do so. The popular memory of carrier hospitals and clinics, and officers’ desire to maintain some semblance of attention to Africans, impelled the construction of dozens of dispensaries throughout Nyasaland in the early 1920s.

III. Bringing medicine back from the war: government dispensaries and auxiliary training in the 1920s

a) Rural government dispensaries: a postwar demand of Nyasaland chiefs

In 1921, three years after the war’s end, Nyasaland’s Principal Medical Officer, Dr. Henry Hearsey, drafted a Circular and sent it to the Chief Secretary in Zomba for comment. Hearsey, who had occupied his position as Principal Medical Officer since 1902, wrote: “A not unimportant part of the scheme for providing medical aid to the native population is the provision of Rural Dispensaries in areas distant from stations where Medical Officers and Sub-Assistant Surgeons are posted.” Such provision of medical care in rural areas had not previously been a part of government medical policy—certainly not an important one—so Hearsey explained his inspiration. “That there is an urgent need for such Dispensaries was forced on my mind when I closed down those which had been erected on Lines of Communication during the late War. Various Headmen and others enquired of me what they were now to do with their sick who

⁶² Baker, “The Government Medical Service in Malawi.” 301

needed treatment.” Even though the health facilities for African carriers maintained during the war were sparse, poorly equipped and staffed with minimally trained personnel, Africans remembered them as one of the few parts of the war effort worth keeping. In response to the enquiries of native authorities, Hearsey announced his plans:

It is my intention to indent this coming year for a quantity of concentrated stock mixtures for easy dispensing, which together with simple dressings, etc., would be supplied to these dispensaries. They would be placed in charge of intelligent native Hospital and Dispensary Attendants who had received some training and experience in our native hospitals.⁶³

Hearsey’s circular asked each of Nyasaland’s “Residents” (British officials in charge of administering each district) to send him a number of locations that would be appropriate for these new dispensaries. The criteria for selection of sites should, he explained, be the density of the population in that area, and the distance from a Mission health facility for natives. Hearsey sought, then, not to situate the rural dispensaries only in areas of commercial activity or military importance, but rather to reach the largest native population possible.

Two weeks later, when the Chief Secretary sent a copy of the circular to district officials, he changed both its content and tone. No longer did the circular open with a declaration of the importance of medical care for Africans. The Chief Secretary’s language was less enthusiastic, lacking any indication he thought Hearsey’s plan important: “I am directed to inform you that a proposal has been put forward by the Principal Medical Officer for the establishment of dispensaries in rural areas.” The Chief Secretary’s revised circular also added a criterion for the site of rural dispensaries, namely that “accessibility to the

⁶³ H Hearsey, “Medical Treatment of Natives. Rural Dispensaries, by Office of the Principal Medical Officer,” August 25, 1921, S40/1/3/2, MNA.

medical headquarters of the District should also be taken into consideration.” Ready access to administrative centers, then, compromised the ideal of serving the most people in areas remote from extant health services. The Chief Secretary also added “not more than four sites in your district should be reported upon.”⁶⁴

Similar stipulations would become a recurring theme in Nyasaland’s medical service—central administrators constantly stressed cost containment. When the Principal Medical Officer stressed the need for greater provision of medical services to Africans, the Chief Secretary revised his circular to ensure limits on transport costs and in the number of sites chosen. When the District Residents responded with their potential sites some, including the Resident of South Nyasa (later known as Fort Johnston District) proposed only three dispensary sites rather than the Chief Secretary’s limit of four. Seeking to maximize the number of dispensaries overall, Hearsey and the Medical Officer at Fort Johnston argued for the addition of a fourth site.⁶⁵ As will be evident in the coming chapters, directors of medical services and medical officers, were almost always encouraging more health facilities, more rapid expansion, more spending, while administrators holding the purse strings in Zomba and London tried to quell these demands.

When Hearsey sent his proposal to the Chief Secretary in 1921, there were already plans afoot, and funds indented in the budget, to build seven health facilities for Africans to be staffed with sub-assistant surgeons. Recognizing the extreme economies under which the

⁶⁴ “Chief Secretary, Zomba to District Residents,” September 6, 1921, S40/1/3/2, MNA.

⁶⁵ “Principal Medical Officer H Hearsey to Chief Secretary, Zomba,” November 18, 1921, S40/1/3/2, MNA.

colonial budget operated at the time, Hearsey admitted that his plan might have to wait. Still, he believed that with the information provided by the districts, he would be able to gradually expand the dispensary system “as opportunities occur,” eventually building 64 new dispensaries (four in each of Nyasaland’s sixteen districts).⁶⁶

Initially, prospects for Hearsey’s proposal did not appear to be very good. The Treasury Department in London demanded that Nyasaland cut its proposed 1922-23 budget in order to attain an operating surplus of £80,000. This surplus would permit Nyasaland’s government to cover expected losses on the privately owned Trans-Zambesi Railway, whose profits Nyasaland had been compelled by officials in Whitehall to guarantee in 1919 (see Chapter 3). In order to meet these demands for austerity, Acting Governor Richard Rankine cut £39,000 from his 1922-23 budget, including £500 he had originally allocated for construction of the new dispensaries.⁶⁷ Upset at being forced to make these revisions, Rankine lodged a protest with Winston Churchill, Secretary of State for the Colonies. He explained that although “it has not been possible in the past to provide to any extent for medical attendance of natives,” there remained “a great need for this,” particularly “if we are to prevent the large waste of human life and energy which goes unchecked at present among the natives.”⁶⁸

⁶⁶ “Principal Medical Officer H Hearsey to Chief Secretary, Zomba,” May 1, 1921, S40/1/3/2, MNA.

⁶⁷ “Richard Rankine to Secretary of State for the Colonies Winston Churchill,” December 12, 1921, T161/156, UKNA. Also see “Acting Chief Secretary to Principal Medical Officer H Hearsey,” December 3, 1921, S40/1/3/2, MNA.

⁶⁸ “EA Estimates 1010: Acting Governor to Secretary of State,” 5 January 1922, T 161/156, UKNA.

In February 1922, Undersecretary of State for the Colonies Gilbert Grindle passed this plea to the true arbiter of budgetary matters, Chancellor of the Exchequer Robert Home. Grindle added that “information obtained in connection with the recent census and the latest annual medical report of Nyasaland emphasize the urgent need for increased medical attention to the native population.”⁶⁹ Eventually the Treasury relented, if only slightly, in its demand for economies. Their justification here seems to have been a forecast by a Treasury official, who predicted that Nyasaland’s tariff and income tax revenues in 1922/23 would be higher than originally estimated, thereby reducing the scale of budget cuts needed.⁷⁰ In March, Controller of Supply Services George Barstow informed Grindle that the Treasury was prepared to allow the reinsertion of £12,500 of Rankine’s proposed cuts.⁷¹ Ultimately, Nyasaland’s 1922-23 budget did include £768 for dispensary attendants’ salaries, £580 for supplies for both hospitals and dispensaries, and £500 for dispensary construction.⁷² An enthused Hearsey requested the expeditious construction of the new dispensaries, and reported he had already begun recruiting attendants.⁷³

The significance of these new dispensaries, for the health of the populace or for the colonial coffers, should not be overstated. The first year’s indent for the new attendants’ salaries (£768) represented less than one percent of the £100,000 collected from the

⁶⁹ “Undersecretary of State Gilbert Grindle to Chancellor of the Exchequer Robert Home,” 8 February 1922, T 161/156, UKNA.

⁷⁰ Untitled Treasury Department Analysis, February 21, 1922, T 151/156, UKNA.

⁷¹ “GL Barstow to Undersecretary of State for the Colonies Gilbert Grindle,” 9 March 1922, T 161/156, UKNA.

⁷² “Richard Rankine to Principal Medical Officer H Hearsey,” April 12, 1922, S40/1/3/2, MNA.

⁷³ “Principal Medical Officer H Hearsey to Acting Chief Secretary,” April 18, 1922, S40/1/3/2, MNA.

annual hut tax.⁷⁴ Even in the Principal Medical Officer's initial plans, the dispensaries were to be austere and inexpensive. Each facility, he explained, would consist of two huts of wattle and daub, one for the dispensary and another for the living quarters of the dispensary attendant. The inside walls of the dispensary hut would be equipped with shelving made of reeds or split bamboo.⁷⁵ Together, he estimated the two huts could be built for £10. The only other cost would be the wages of the dispensary attendant; he thought these should begin at £20 per month, rising each year by £2 and 6 shillings to reach a maximum of £30 per month.⁷⁶

Beyond the lingering memory of carrier hospitals, there were other forces impelling the British administration to pay greater attention to the health of natives. Historians Richard Rotberg and Colin Baker both note that British missionaries complained often to government officials about the inadequacies of medical care for Africans, while European landowners began to see the potential for greater output from healthier laborers.⁷⁷ There was also a newfound focus on social service provision in the major treaties and justificatory doctrines of the British Empire. Former Governor-General of Nigeria Lord

⁷⁴ Colin Baker, "Tax Collection in Malawi: An Administrative History, 1891-1972," *The International Journal of African Historical Studies* 8, no. 1 (January 1, 1975): 40-62. Page 62. In 1921, a flat tax of 6 shillings was due from the inhabitants of every hut on October 1 of every year. Most of the Nyasaland's government expenditure went to pay the salaries of administrators, which absorbed 60 percent of the total budget during the early 1920s. See Ewout Frankema, "Colonial Taxation and Government Spending in British Africa, 1880-1940: Maximizing Revenue or Minimizing Effort?," *Explorations in Economic History* 48, no. 1 (January 2011): 136-49.

⁷⁵ "Principal Medical Officer H Hearsey to Acting Chief Secretary."

⁷⁶ "Principal Medical Officer H Hearsey to Chief Secretary, Zomba," May 1, 1921.

⁷⁷ Robert I. Rotberg, *The Rise of Nationalism in Central Africa: The Making of Malawi and Zambia, 1873-1964* (Harvard University Press, 1965). Also see Baker, "The Government Medical Service in Malawi."

Frederick Lugard, architect of the principle of indirect rule that became official policy throughout British Africa, published *The Dual Mandate in British Tropical Africa* in 1922. Lugard explained, “The white man was at first engaged in consolidating his own position, and making the tropics healthier for Europeans engaged in their own development. He has now accepted the principle that they must be made more healthy for the native population.”⁷⁸ As evidence, Lugard cited the testimony of then-Undersecretary of State for the Colonies L.S. Amery from a debate in the House of Commons on the Colonial Office Vote in August 1919. Because his was one of the earliest official articulations of imperial responsibility for native health, Amery’s words are worth quoting at some length:

The whole problem of the development of the tropics is in fact largely a problem of coping with disease. Remember that the deadliness of the tropics is not merely the deadliness to the white man. If he suffers it is entirely, or almost entirely, because he catches diseases with which the native community around him is already infected, and which lowers his vitality. Our problem is not merely to make East Africa and West Africa healthy to the white man, but to make them healthy to the whole population, to undertake out there, as here at home, a campaign for dealing with the diseases of those countries in a much more comprehensive and bolder spirit than we have ever undertaken before.⁷⁹

Amery’s speech drew upon the concerns with contagion that had spurred segregationist city planning in the name of sanitation.⁸⁰ But in his case, the possibility that African sickness could lead to European illness was a reason to improve native health, not separate their dwellings.

⁷⁸ Lord Frederick J. D. Lugard, *The Dual Mandate in British Tropical Africa* (Routledge, 2013). Pages 92-93

⁷⁹ Great Britain Parliament House of Commons, *The Parliamentary Debates (official Report): House of Commons* (H.M. Stationery Office, 1919). Pages 2177-2178.

⁸⁰ Curtin, “Medical Knowledge and Urban Planning in Tropical Africa.”

b) The realities of government medicine for Africans, 1921-1930

Unsurprisingly, the visions of healthy, well-served native populations evoked by this rhetoric remained far from the daily experience of colonial medicine. At the few native hospitals in Nyasaland during the early 1920s, medical officers wrote scathingly about the conditions in which they were made to practice. A 1921 annual report authored by Dr. Raymond Busy, the Senior Medical Officer in Blantyre, explained:

The present position of the Native Hospital is unsatisfactory from all points of view. It is situated right on the road side... There is only one ward, which has to be used for all classes of cases... Government should build a proper new Native Hospital... with separate wards for medical, surgical and female patients and with good rooms for outpatients and for operations... Failing this it would be better to give a large government grant to the large, well-established and well-staffed hospital at the Church of Scotland Mission for the treatment of Natives and send all cases to that institution.⁸¹

Busy's proposal was not approved. Three years later, in his new post as Nyasaland's Principal Medical Officer, Busy forwarded the Chief Secretary another complaint about Blantyre's native hospital, this one written by A.G. Eldred, his successor as Blantyre's Senior Medical Officer. Eldred's report was even more vivid, describing the hospital's "one large ward, in which all patients, prisoners, and the general native public have to be herded." Lacking even a room to treat outpatients, "the dressing of wounds and ulcers is at present performed practically in the main road."⁸² In his own minute, the Director of Public Works added his opinion that the present Native Hospital was "in a very unsanitary condition... and, if retained, would involve such expenditure on improvement

⁸¹ Raymond Busy, "Blantyre Government Hospitals and Dispensary General Report 1921," 1922, 1728/27, MNA. Page 3.

⁸² "Letter from AG Eldred, Senior Medical Officer, Blantyre to Acting Principal Medical Officer Raymond Busy," July 10, 1924, 1728/27, MNA.

as, in my opinion, is unjustifiable.”⁸³ In 1925, citing the hospital’s “disrepair,” FE Whitehead, Nyasaland’s new Director of Medical and Sanitary Services, simply shuttered the building and paid the Blantyre Mission Hospital to treat African inpatients referred from government dispensaries.⁸⁴

Nyasaland was not the only colony in British Africa where the medical administration sought increased facilities for natives in the years after the First World War. In 1922, Dr. John Gilks, Kenya’s Principal Medical Officer, wrote of his Department that it was “no longer considered merely as an organization maintained by Government to facilitate administration by maintaining the personnel of the executive in health, but as a Department of Government responsible for the carrying out of the most important function for which Government itself is established, namely the maintenance in health of the general population of the country and the improvement of the conditions under which that population lives.”⁸⁵ In Tanganyika (most of what was formerly German East Africa), the British administration began rural dispensary construction in 1926 in response to what historian Ann Beck described only as “popular demand and political pressure.”⁸⁶

In Nyasaland, Government dispensers were recruited from the small cadre of young African males who had received some education at mission schools; these recruits were

⁸³ “Minute by Director of Public Works to Nyasaland Chief Secretary, SMP 1268/1924,” July 31, 1924, 1728/27, MNA. Eldred proposed that the medical department should be given permission to repurpose the abandoned Blantyre Sports Club Pavilion for use as a Native Hospital.

⁸⁴ F.E. Whitehead, “Annual Medical Report on the Health and Sanitary Condition of the Nyasaland Protectorate for the Year Ended 31st December, 1925” (Zomba, Nyasaland: Government Printer, June 11, 1926). Page 13.

⁸⁵ Beck, *Medicine, Tradition, and Development in Kenya and Tanzania. 1920-1970*. Pages 15-16

⁸⁶ *Ibid.* pages 15-16

trained at native hospital in Zomba, where they apprenticed for a few months under African dressers and dispensers before being sent out. Though a few African auxiliaries in the government service had received months or even years of medical training at mission hospitals, there was no formal didactic instruction for the new dispensers training in Zomba in the 1920s⁸⁷. When they reached their rural outposts, the new dispensers did not draw in droves of sick patients. Attendance figures belied the Medical Department's claim that dispensers were "giving the natives confidence in European medicine."⁸⁸ In 1927, the average number of new cases presenting daily at each of the 78 rural dispensaries was only 3 to 4.⁸⁹

Though dispensaries and African hospitals made some bare minimum of care available to the general African population in Nyasaland, members of the colonial administration did not take great pride in them. In 1925 the government claimed to provide 14 "hospitals" for natives, though it counted the Blantyre Mission as one such hospital, and only seven of the 14 had a medical officer. The other seven each had a sub-assistant surgeon, though at two of these the sub-assistant surgeon was present only two or three months each year.⁹⁰ As Nyasaland Governor Shenton Thomas lamented in a dispatch to the Colonial

⁸⁷ F.E. Whitehead, "Annual Medical Report on the Health and Sanitary Condition of the Nyasaland Protectorate for the Year Ending the 31st December, 1928" (Zomba, Nyasaland: Government Printer, July 10, 1929)., page 6

⁸⁸ Ibid., page 6

⁸⁹ F.E. Whitehead, "Annual Medical Report for the Year Ended 31st December, 1927" (Zomba, Nyasaland: Government Printer, June 16, 1928).

⁹⁰ Whitehead, "Annual Medical Report on the Health and Sanitary Condition of He Nyasaland Protectorate for the Year Ended 31st December, 1925." Pages 13-14.

Office in 1930, native hospitals were so poorly maintained that “Africans of the better type flatly refused to enter.”⁹¹

There were few diseases for which European medicine was thought, among the general African population, to be effective. During the early 1920s, the new native dispensaries joined mission hospitals in attempting to cure yaws, a treponemal infection closely related to syphilis, though spread via non-sexual contact.⁹² Yaws was not a fatal infection, but it caused disfiguring and often debilitating ulcers that could erode skin, tissue and even bone. The dispensaries and hospitals initially used “Castellani’s mixture,” a combination of tartar emetic, sodium salicylate, and potassium iodide that had been used by David Livingstone in the 1860s. But the treatment was “disappointing,” as relapses were common and advanced cases were rarely cured.⁹³

In 1925, medical officers in the districts of Karonga and Dedza introduced an intramuscular injection of sodium bismuth tartrate that seemed, at least initially, more effective. “The natives, once they realized the value of the new treatment, flocked to the

⁹¹ Lwanda, *Colour, Class and Culture*. Page 30.

⁹² The causative agent in yaws is *Treponema pertinue*, whereas the causative agent in venereal syphilis is *Treponema pallidum*. There is evidence of cross-protective immunity between yaws and venereal syphilis. See T Guthe, “Clinical, Serological and Epidemiological Features of Frambosia Tropica (Yaws) and its Control in Rural Communities,” *Acta Derm-Venereol* 49 (1969): 343-368.

⁹³ For more on Castellani’s mixture, see “Internal Treatment of Yaws, Condensed by The Journal of Tropical Medicine and Hygiene,” *Journal of the American Medical Association*, April 17, 1915, 1363.

dispensaries,” wrote medical officer HB Follit.⁹⁴ Various preparations of bismuth had been used to treat syphilis and yaws in other British colonies since 1922. It eventually appeared to demonstrate some efficacy as a treatment for yaws; six injections over three weeks suppressed the disfiguring and painful ulcers (though, unbeknownst to the investigators of the 1920s, this suppression would usually not be permanent).⁹⁵ The injections were intramuscular (not intravenous, as were other treatments such as salvarsan), so some of the dressers staffing native dispensaries were permitted to administer them by themselves.⁹⁶ But the injections were not without side effects. The most common was stomatitis, a painful inflammation of tissue in the mouth. This side effect was more commonly seen with the higher doses administered to patients with syphilis. For yaws patients, for whom side effects were less frequent, the injections

⁹⁴ HB Follit, “Some Notes on the Treatment of Yaws in Nyasaland,” in *Annual Medical Report on the Health and Sanitary Condition of the Nyasaland Protectorate for the Year Ended 31st December 1925* (Government Printer, 1926).

⁹⁵ The 1928 Nyasaland Medical Department Report gives conflicting accounts of the treatment course of bismuth sodium tartrate for yaws. Director of Medical and Sanitary Services FE Whitehead claims that “the treatment usually consists of two injections... with an interval of about a week between the injections. The two injections,” he continued, “are generally sufficient to clear up the symptoms.” But in an appendix on yaws treatment in the same report, HG FitzMaurice, a Medical Officer stationed in Karonga, stated that the routine treatment at his facility was “consists of six intramuscular injections each given twice a week.” FitzMaurice complained that the three-week injection course was “irksome to the native patient, particularly as the lesions have all disappeared after the first two or three doses, with the result that he often fails to come for the final two or three injections.” FitzMaurice favored this longer course, he explained, because “cases not infrequently recur if only four doses are given.” See Whitehead, “Annual Medical Report for the Year Ended 31st December, 1928.” Pages 11, 43.

⁹⁶ H.G. FitzMaurice, “Appendix IV: Notes on the Treatment of Yaws with Novarsenobillon and with Sodium Bismuth Tartrate,” in *Annual Medical Report on the Health and Sanitary Condition of the Nyasaland Protectorate for the Year Ended 31st December 1928* (Zomba, Nyasaland: Government Printer, 1929), 43.

proved quite popular. Outpatient attendances for yaws climbed from 479 in 1925 to 2227 in 1928.⁹⁷

Few Nyasaland Africans had access to what was generally believed to be the safest, most effective yaws treatment available. Yaws symptoms could be even more quickly suppressed by injections of neosalvarsan. Discovered in the laboratory of German physician Paul Ehrlich in 1912 (and an improvement on salvarsan, which his laboratory had discovered in 1909), neosalvarsan was first used in Europe as a treatment for venereal syphilis.⁹⁸ A few missions and native hospitals in Nyasaland began using this injection in 1920s for both syphilis and yaws. The drug proved fairly painless, and within weeks after completing the course of two injections, administered one a week apart, most patients' outward manifestations of yaws had disappeared. But the Medical Department

⁹⁷ The number of patients treated for yaws were much higher in Tanganyika than in Nyasaland. In 1926, John Owen Shircore reported that more than over 113,000 cases of yaws had been treated by bismuth injection by early 1926. The reason for the discrepancy is likely the number of facilities where treatment was available. Shircore does not list the number of districts where yaws was treated in Tanganyika, but in Nyasaland it was only two (Dedza and Karonga). See CJ Hackett, "Consolidation Phase of Yaws Control: Experiences in Africa," *Bulletin of the World Health Organization* 8 (1953): 299–343. Pages 305-306.

⁹⁸ Klaub Strebhardt and Axel Ullrich, "Paul Ehrlich's Magic Bullet Concept: 100 Years of Progress," *Nature Reviews Cancer* 8 (June 2008): 473–80. Neosalvarsan contained less arsenic than Salvarsan, and was water-soluble (Salvarsan was not). Neosalvarsan also caused less frequent and less serious adverse effects than Salvarsan (which was associated with liver damage and other life-threatening complications).

deemed neosalvarsan too expensive for “general use.”⁹⁹ In 1921, a missionary in Tanganyika reported that neosalvarsan cost him 10 shillings per dose.¹⁰⁰ Five years later, writing in the pages of the *Lancet*, John Owen Shircore (then Tanganyika’s Director of Medical Services), reported that for 10 shillings he could prepare over 300 doses of his favored bismuth injection.¹⁰¹ In addition, because neosalvarsan had to be administered intravenously, it was used only at stations staffed by medical officers.¹⁰²

Despite the popularity of yaws treatment, most Africans did not begin to seek care at government or mission facilities for every kind of serious illness. As Terence Ranger explained, “there was remarkably little of the predicted carry-over effect. Readiness to come for yaws treatment did *not* break down a more general ‘mistrust of European methods.’”¹⁰³ I will argue in Chapter 7 that Nyasaland Africans were skeptical empiricists in their therapy-seeking behavior. This is anything but a novel argument—though, as I will argue, its veracity and import have not yet been fully appreciated. Dr. JB Christopherson, a missionary physician working in Tanzania, made the same case in the UMCA’s journal in 1921 when he declared: “the native only judges by results.”¹⁰⁴ In the late 1920s European medicine seemed effective at treating yaws, though the popularity of

⁹⁹ See J.O. Shircore, “Yaws and Syphilis in Tropical Africa: Mass Treatment with Bismuth-Arsenic Compounds,” *Letter to the Editor of The Lancet*, July 3, 1926, 43–44.

¹⁰⁰ Terence O. Ranger, “Godly Medicine: The Ambiguities of Medical Mission in Southeastern Tanzania, 1900–1945,” *The Social Basis of Health and Healing in Africa*, no. 30 (1992): 266.

¹⁰¹ Shircore, “Yaws and Syphilis in Tropical Africa: Mass Treatment with Bismuth-Arsenic Compounds.”

¹⁰² FitzMaurice, “Appendix IV: Notes on the Treatment of Yaws with Novarsenobillon and with Sodium Bismuth Tartrate.”

¹⁰³ Ranger, “Godly Medicine.” Page 265

¹⁰⁴ JB Christopherson, “The UMCA and Medical Work at Magila,” *Central Africa* 39, no. 86 and 91 (1921). Also see Ranger, “Godly Medicine.”

these injections would abate as the disfiguring lesions reappeared in previously treated patients. This was due to at least three factors: the inefficacy of the treatments themselves (truly effective therapy would come only with the arrival of penicillin); the difficulty in completing full treatment courses, which required multiple visits by patients in whom lesions had already begun to resolve; and the lack of a focus on treating latent cases, in addition to patients with clinically manifest disease.¹⁰⁵

Beyond the deficiencies in yaws campaigns, an even more important reason for the dearth of African attendance at medical facilities was that European medicine had not yet demonstrated any efficacy at treating many other common illnesses, from tropical ulcer to tuberculosis. The total number of African and Asian outpatient attendances did rise during the 1920s, markedly after the construction of dispensaries, from 19,089 in 1921 to 96,088 in 1923, then more slowly, to 168,181 in 1928. By 1928, there was still barely one outpatient admission per year for every ten Africans in Nyasaland.¹⁰⁶ Christopherson may have been right when he claimed that “every case cured is placed in the native mind to the credit of the government”—as we will see in later chapters, this was the assumption underlying investments in health care throughout the British Empire during periods of tumult—but in the 1920s such cases remained relatively few and far between.¹⁰⁷

¹⁰⁵ Guthe, “Clinical, Serological and Epidemiological Features of Yaws,” 345-347.

¹⁰⁶ Whitehead, “Annual Medical Report for the Year Ended 31st December, 1928.”

¹⁰⁷ Christopherson, “The UMCA and Medical Work at Magila”; Ranger, “Godly Medicine.”

In any case, government medicine was not the most pervasive fact of colonial rule for African subjects in Nyasaland during the first interwar decade. During the early 1920s, a flat hut tax of 6 shillings was due from inhabitants of each hut every October 1. Default on this tax carried penalties including a prison term of six months, the demolition of one's hut, and even the seizing of the defaulter's wife as a hostage until payment (a tactic born in the impressment of carrier labor during the Great War).¹⁰⁸ As late as the mid-1930s, tax-defaulters held as prisoners in Mlanje were even made to perform the daily task of removing buckets of feces and urine from the latrines in the homes of Europeans.¹⁰⁹

Beyond the conscription of wartime carriers and punishments for tax defaulters, the government was known among Africans for its neglect during times of want. During a terrible famine in 1922-1923, British administrators set the price of imported maize at more than two times the rate the government had ever paid to peasant producers, and refused to release stored maize from granaries.¹¹⁰

¹⁰⁸ Baker, "Tax Collection in Malawi." Page 48

¹⁰⁹ Berry, *Before the Wind of Change*. Page 17. During most of the colonial period, male Africans in Nyasaland were technically subject to two taxes (hut tax and poll tax) that were collectively and colloquially known as the "hut tax." In 1938, an unmarried man over the age of 16 or a man with one wife had to pay 6 shillings each year. This was the "poll tax." A man with more than one wife had to pay another 6 shillings for each, regardless of how many huts they occupied. These taxes were due by September 30 of every year. Defaulters could be imprisoned for 6 months and see their huts destroyed. Some exemptions were given to widows, as well as men who could not work due to age or disability. See Malcolm Hailey, *An African Survey: A Study of Problems Arising from Problems Arising in Africa South of the Sahara* (Oxford University Press, 1938). Page 566.

¹¹⁰ Elias Coutinho Mandala, *The End of Chidyerano : A History of Food and Everyday Life in Malawi, 1860-2004* (Portsmouth, NH: Heinemann, 2005). Pages 49-51.

The Nyasaland government was also known for its seemingly endless preferences for European settlers. In 1928, when a 20-year old European man named D’Arcy shot and killed an African boy, D’Arcy claimed he had merely intended to show off the gun but it had accidentally gone off. Nyasaland’s High Court ruled that this act was “that of a youth who considers it grand and manly to be seen carrying a firearm” and, though finding the defendant guilty of manslaughter, Judge Haythorne Reed felt he could “pass on...only a sentence of a fine” of forty pounds. “I hope,” the judge advised D’Arcy, “you will shew that this is justified by becoming a useful member of society, and by living up to the highest ideals of our race.”¹¹¹ Contrast this to the sentence imposed upon an native cook, who was convicted of disobedience to his master’s orders when, instead of drowning “two sick puppies” as ordered, he gave them away as a present. A lower court sentenced the cook to three months imprisonment with hard labor; on appeal, the High Court showed the extent of his forbearance for natives by lowering the cook’s sentence to 2 ½ months.¹¹² So while the Principal Medical Officer succeeded in garnering some funds to make government medicine for Africans more widely available, this was a small and, in many ways, anomalous departure from colonial policy of the era.

IV. Conclusion

Whereas before the First World War the only source of biomedical care in Nyasaland were the scattered mission hospitals, the intense demands for African labor during the war spurred the construction of government-run hospitals and dispensaries. These ill-

¹¹¹ J Haythorne Reed, “Rex v. D’Arcy, Case 1 of 1928 (Criminal),” in *Law Reports Containing Cases Determined by the High Court of Nyasaland, Vol III, 1927-1933* (Zomba: Government Printer, 1934).

¹¹² J Haythorne Reed, “Rex v. Ferriat, Case No. 1 of 1929 (Criminal), in Revision,” in *Law Reports Containing Cases Determined by the High Court of Nyasaland, Vol III, 1927-1933* (Zomba: Government Printer, 1934).

equipped facilities were tasked with the care of the hundreds of thousands of “carriers” forced to carry munitions, rations and other supplies to troops fighting near the border of Nyasaland and German East Africa. Many conscripted carriers and soldiers had their first contact with hospitals during the Great War, though these facilities were far more impressive in official records than in reality.

In the aftermath of war, experience with biomedicine at these hospitals led native authorities and colonial medical officers to call for the construction of additional health facilities. These facilities were staffed by poorly trained African auxiliaries and operated under extreme economies. According to colonial officials of the 1920s, these healthcare facilities had not secured the confidence of most Africans. But the hospitals and dispensaries owed their very existence to the even more threadbare carrier hospitals that inaugurated the era of biomedical care for Africans in Nyasaland. During the early 1920s, persistent advocacy by the Director of Medical Services, who invoked the recent war, helped prompt the construction of rural dispensaries around the colony.

The next chapter will show that in the decades that followed the Great War, healthcare for Africans would continue to be dictated by colonists’ labor demands, in particular the need for healthy laborers on European-owned agricultural estates. For most other Africans in Nyasaland, health remained a small part of the experience of being colonized. Still, the feverish demand for labor during the Great War, the colonial government’s first great crisis, had helped spur medical provision that reached Africans even in some rural areas.

Chapter 2

Legacies of interwar nutrition research: from veterinary medicine to economic growth in Nyasaland, 1920-1953

Abstract

This chapter chronicles the efflorescence, decline and enduring effects of interwar-era nutrition research in British colonial Africa. During the interwar era, experts in a diverse array of scientific fields, including nutrition, entomology, agriculture, and anthropology investigated the health of Africans in British holdings in eastern and southern Africa. These studies were inspired by—and in some cases led by—veterinarians who had previously conducted animal studies in Africa. In both the veterinary and human studies, investigators were interested in growing and maintaining productive bodies. Such bodies, they found, could only be forged with diets consisting of sufficient quantities of vitamins, minerals and calories. The researchers were also concerned about parasites' ability to sap productivity. One of the most ambitious such investigations was the Nyasaland Nutrition Survey (1938-1940), which buttressed officials' claims that improving productivity among colonized subjects demanded increased spending on health services and agricultural extension. During the interwar years this research showed little immediate impact on colonial expenditures for either health or agriculture. But later, in the postwar dawn, economic researchers would use the Nyasaland Survey data to calculate colonial national incomes. After the Second World War, the Survey's agriculturalist advocated radical changes to agricultural policy. Ultimately, a research agenda originally aiming to help transform Africans into more effective laborers was repurposed to try to make them into more ambitious capitalists.

Prelude: Flood, drought, and living in uncertainty

“If you could leave this place, you would,” explained an elderly man waiting in line to see a nurse operating a mobile clinic out of the back of a Toyota Landcruiser. The man (who declined to give his name because he had just cobbled together a shoddy grass hut outside the camp and did not want to be disqualified from relief offered in the camp) was one of thousands in the area who had lost homes and livelihoods in recent floods. But for the many who continued to sleep in Red Cross tents or church pews or hastily converted schoolrooms, the danger that roused the greatest fear was not continued homelessness, but famine.

In early January 2015 large swaths of the southern African nations of Malawi and Mozambique suffered the region's worst flood in at least a half-century. The United Nations estimated 170,000 people were displaced, while at least 150 people died. Budding crops on an estimated 89,000 hectares of cultivated fields were washed away, while 195,000 livestock were drowned. One week after the rains ended, some areas were still only accessible by helicopter. Thousands sought shelter from the waters in hastily constructed camps. Camp residents complained they had little food, and nurses operating out of Red Cross ambulances reported seeing cases of scabies, diarrhea, malaria, and scores of women complaining of non-specific and diffuse body pain.

The annual rains are usually a welcome sight and, initially, their arrival was a relief. After applying fertilizer and planting crops in November 2014 farmers waited anxiously for the rains, which usually start by mid-November but only started this year in mid-December. But over the holidays the rains did not relent. By the second week of January, the Shire River had flooded its banks and began to fill the surrounding valley. Refugees in Nchalo, a town in Malawi's southern district of Chikwawa, recounted waters that rose to the necks of full-grown men. Clothing, pots, and livestock were washed away. Malawians described the scene with a refrain repeated so often that one wondered if everyone had read Coleridge: "Water, water everywhere."

By February 2015 in Nchalo a shifting cast of NGOs provided *ad hoc* relief to the thousands housed in two contiguous camps with a combined 3,000 people. The tents had been cobbled together from UNICEF, the Red Cross and the Malawi Army, but many

leaked in the heavy rains. The World Food Programme and World Vision distributed soy, beans and cooking oil. Médecins Sans Frontières built latrines and began offering a daily mobile clinic. Illovo, a sugar company with a plantation nearby, parked a tank of potable water at the side of the road and offered to treat more medical cases referred to the company clinic free of charge. One afternoon, without any notice, shopkeepers in a local Muslim charitable society unloaded a truck full of groceries right in front of the camp. Realizing immediately that this donation was unlikely to be repeated, hungry men and women jostled for the sudden windfall. Government officials conducted head counts of camp residents. Sundry NGO administrators visited every day to assess the situation and deliver sundry supplies. But aside from the higher-level meetings in the country's capital, there seemed to be little coordination; NGO employees interviewed in the camps had not met with other groups working there.

A week after the waters began to subside, more and more refugees tried to return to their homes. The tents in the camps were too crowded with unwashed, unfed bodies, and the site itself was miserable. Located in the middle of barren soccer field without trees for shade, the tents became ovens in the hot midday sun.

Neatly clad in a brown dress, a young girl in a camp alongside thousands displaced by recent floods repeated a daily chore seen often in nearby villages. Bent at the hip, her body folded in two, she used a small broom of bundled twigs to sweep away the dirt outside her tent. But this was a Sisyphean task. The tent was surrounded only by a barren

expanse of dust. It seemed a quiet attempt to recover some sense of normalcy in the midst of an unfolding disaster.

There was relative comfort nearby. Across the tarmac road from the camp was an outdoor market where brightly colored clothing was sold. A half-mile away, a quaint lodge offered ample shade and breakfast to NGO administrators with per diems and SUVs. The camp residents lived in a squalor surrounded by normalcy.

Outside the official disaster area, further north along the Shire River in the village of Matope, the flood inflicted similar damage. *Matope* means “mud” in Chichewa, a nod to its low-lying locale. A smallholder farmer named John Lucia returned to his brick house after the water receded to find a wall collapsed. After his neighbor found his home destroyed as well, both of their families (comprising 11 people) moved into a single wattle-and-daub hut nearby. They were the lucky ones; families without recourse to spare huts slept on church pews and on schoolroom floors.

While the destruction of housing was a disaster, the most fearful sight came when the waters subsided and people surveyed their fields. The entire valley was usually lush with maize, cotton and rice by late January. But they saw only a thick layer of silt and sand that promised to suffocate their crops. Though the region’s semi-subsistence farmers were accustomed a precarious existence and seasonal hunger, this was an unbearable shock. Most families had already run out of food stored up from the May 2014 harvest. The months from January through April are commonly known in Malawi as *nyengo njala*

(the hungry season). Dedicated malnutrition wards in district hospitals fill with infants on the verge of death, children with crispy orange hair, distended bellies, edematous feet and twig-like arms. So concentrated is the suffering here that the hungry season draws an annual pilgrimage of medical researchers, studying either the effect of acute-on-chronic malnutrition, or devising biomedical interventions to address it.¹

During these months, people toil on empty stomachs to produce the next harvest. “We are poor people,” explained Ruthina Medisani, an elderly woman in Matope whose home had been felled and fields laid waste by the flood. “We must rely only on what we can grow.”

Those able-bodied poor who cannot grow enough for themselves must begin the sojourn for *ganyu* (piecework labor) in the fields of wealthier farmers. But in the floods of early 2015, even this work had disappeared. Crops had been destroyed across the valley. The quest for meager pay now forced many to make the long walk into the highlands where some farms have been spared. A well-built young man named Denies Bonongwe, who had lost his house and was living with friends, says these sojourns for *ganyu* earned him no more than 200 kwacha (US\$0.43) per day.

Although no Malawians I interviewed could remember floods of this magnitude, they did point to recent history for predictions of what could come next. In 2002 the country had

¹ This research includes a 2013 study that found that antibiotic treatment in severely malnourished children could, alongside standard-of-care protein-based “therapeutic food,” decrease the risk of death. This finding was published in the *New England Journal of Medicine*. Indi Trehan et al., “Antibiotics as Part of the Management of Severe Acute Malnutrition,” *New England Journal of Medicine* 368, no. 5 (January 31, 2013): 425–35.

endured a deadly famine after a poor harvest (spurred, in part, by cuts to a government program that provided free agricultural inputs). The famine was worsened by the bungled response. The recently privatized agricultural marketing board (ADMARC) had sold off the government's reserves of grain, the president was late to declare a state of emergency, and disaster relief from outside the country was late and insufficient. Many baby boys born during this period were given the name Mavuto (translated literally, "misfortune"). Patrick Mwale, an elected ward councilor representing the area around Matope, remembers 2002 as the year "nobody came to help." He hoped that his year his constituents' cries were heard, both by the Malawi government and by outside donors.

For their part, Malawians affected by the floods were quick to list exactly what they needed. Mwale reported that his constituents' demands were varied, but amounted to a comprehensive program of relief and rehabilitation. In the immediate term, they called for emergency food relief and expanded public works programs to keep families fed. They also demanded a rapid distribution of seed and fertilizer to allow them to make one last-ditch attempt to replant their crops before the rains stopped for the year. They called for tarpaulins to cover their collapsed roofs, and assistance rebuilding their homes. Most of the displaced dreaded the prospect of sitting idle in sweltering camps or church floors, subject to the whims of whatever NGO decided to visit. But most of this relief did not come. As the window for replanting crops closed rapidly, many Malawians had nothing left to their names but ruined fields and collapsed homes.

Two months later the scale of devastation looked worse than ever. Parts of the country spared the torrential rains were struck by drought. Francis's village was one such place. On the morning of February 21, Francis looked relieved by rains overnight. He smiled more than he had during the past three weeks. His nascent maize crop was about to enter a crucial phase. Without sufficient moisture in the soil over the coming weeks, the silken tassels that signaled a healthy crop would not emerge on time. "I was worried," Francis admitted. He hoped the rains would continue.

But his hopes would soon be dashed. Over the coming weeks, unrelenting sunshine parched the soil and scorched the stalks. Tassels, those hoped-for harbingers of full stomachs, sprouted late or not at all. By mid-March Francis was worried once more that even if rain fell again, the year's harvest would still be paltry.

Sure enough, the joyful spirits that accompany a strong harvest season came to few Malawians in 2015. Smaller crops of pumpkins proved hardy in the face of continued drought, but Malawians' reliance on high-risk, high-reward maize—a crop that can yield bounteous harvests but is dangerously susceptible to drought—did not pay off that year. After a record 2014 harvest of 3.93 million tons, the floods and droughts during the 2015 growing season depressed the annual harvest to only 2.88 million tons. The market price of maize barely dipped after the harvest; by December 2015 short supplies and a depreciating currency had pushed the maize prices to record levels.² Even fishermen

² "Malawi: GIEWS Country Briefs" (United Nations Food & Agriculture Organization, January 14, 2016), <http://www.fao.org/giews/countrybrief/country.jsp?code=MWI>.

shared in the misery, as unusually strong winds on the lake kept fish outside the reach of their nets.

These disasters revealed the nature of wealth in rural Malawi. Malawians determined their neighbor's wealth not by their conspicuous consumption of superfluous luxuries (few had any), but rather the number of misfortunes (sickness, flood, drought, changes in government programs) they could withstand before tumbling into utter penury. When, for instance, Francis's neighbor Bamusa developed cataracts so advanced he could scarcely see, he was able to afford surgery at Zomba's Central Hospital. Both the surgery and food for inpatients were free (as are almost all services at government hospitals). Bamusa also had livestock he could sell to pay for transport and other ancillary expenses. When Francis's nephew William could no longer afford school fees following the death of both his parents, he could turn to Francis to pay them. Wealth, in this village, entailed networks of support that allowed individuals to deal with tragedy and disaster. Francis and his family had the means to shield themselves against the coming onslaught of hunger, but without public action to ensure access to food, many Malawians did not.

I. Health as wealth from the 1920s to the 1940s: entomology, nutrition, and labor productivity

The first iteration of academic concern for the health of the general population of African subjects in the British Empire was driven by a diverse array of scientific fields, including nutrition, entomology, agriculture and anthropology. Improvements in health were understood to stem from a diet containing enough vitamins, minerals and calories and a living environment sufficiently free of parasites to build and maintain hardy, productive

bodies. Together these investigations buttressed the claim that increased production from colonial subjects—a boon for colonial exports of primary materials and purchases of industrial products from the metropole—depended on increased investment in the health of colonized Africans. These proposed investments included agricultural extension services and vector control campaigns, but also improved health care facilities.

One of the most significant scientific investigations of the connection between health and productivity was the Nyasaland Nutrition Survey, begun in 1938. For a brief moment, Nyasaland was the center of imperial expectations for cutting-edge research and novel interventions in the effort to make colonized labor healthier and, consequently, more productive. Proposals for dramatic expansions in colonial interventions in the health of natives arose from this survey, interventions which at full scale would have impelled significant increases in health and agriculture department budgets and a wholesale imperial commitment the “health is wealth” argument. But this moment faded quickly; the exigencies of wartime—including the secondment of doctors and agricultural experts from Nyasaland and other African colonies to military service elsewhere—halted efforts in Nyasaland and elsewhere. When imperial concern for colonial development reemerged in the postwar era, it had far more resources but a waning belief in the connection between health and economic growth.

This chapter draws upon archival research in Malawi and the United Kingdom to demonstrate both the efflorescence—and enduring effects—of interwar-era nutrition research in British colonial Africa. During the interwar era, experts in a diverse array of

scientific fields, including nutrition, entomology, agriculture, and anthropology investigated the health of Africans in British holdings in eastern and southern Africa. These studies were inspired by—and in some cases led by—veterinarians who had previously conducted research in Africa. In both the veterinary and human studies, investigators were interested in growing and maintaining productive bodies. Such bodies, they found, could only be forged with diets consisting of sufficient quantities of vitamins, minerals and calories. The researchers were also concerned with the role of parasites in sapping productivity. One of the most ambitious such investigations was the Nyasaland Nutrition Survey (1938-1940), which buttressed officials' claims that improving productivity among colonized subjects demanded increased spending on health services and agricultural extension. During the interwar years this research showed immediate impact on colonial expenditures on either health or agriculture. But later, in the postwar dawn, economic researchers would recycle this research in calculating colonial national incomes. Agricultural experts, for their part, revived the research to advocate for radical changes in colonial land tenure and agricultural policy. Ultimately, a research agenda originally aiming to help transform Africans into more effective laborers was repurposed to try to make them into more ambitious capitalists.

a) From livestock to natives: nutrition science in British Africa, 1925-1928

Much of the knowledge of how to produce a more productive African laborer drew from the veterinary sciences. One of the first to propose that disease could result from deficiencies in micronutrient deficiencies (or, to use the early-twentieth-century category, “accessory factors”) was the University of Cambridge biochemist Frederick Gowland

Hopkins, who in a 1912 paper demonstrated that young rats fed diets lacking specific vitamins grew only slowly, while others fed diets lacking the amino acids tryptophan died within 14 days.³ In 1919, Hopkins chaired a Committee on Accessory Food Factors, which produced a report for the UK Medical Research Committee (itself chaired by Member of Parliament and dairy farmer Waldorf Astor). The report claimed that deficiencies of accessory factors produced similar manifestations in humans and animals. Among other examples, the report pointed to the visual impairments caused by the lack of Vitamin A in both animals and humans.⁴

When, in time, British nutrition researchers sought to study human diseases more directly, colonized subjects seemed ready human subjects. The transition from animals to Africans was apt, given the uses to which Africans had been put in the recent war. During the First World War, hundreds of thousands were forced to work as “beasts of burden” in the East African theater (see Chapter 1).⁵ Many veterinary researchers quickly transitioned to African subjects in nutritional studies. One such researcher was John Boyd Orr, the head of a veterinary research institute in Aberdeen, Scotland. In 1925 while on assignment for the Colonial Office in Kenya, he worked with John Gilks, the director of

³ This research helped win Hopkins the Nobel Prize in Physiology for Medicine in 1929. F Gowland Hopkins, “Feeding Experiments Illustrating the Importance of Accessory Factors in Normal Dietaries,” *The Journal of Physiology* 44, no. 5–6 (July 15, 1912): 425–60; Celia Petty, “The Impact of the Newer Knowledge of Nutrition: Nutrition Science and Nutrition Policy, 1900–1939.” (PhD Dissertation, Department of Human Nutrition, LSHTM, 1987). Pages 54–55.

⁴ “Medical Research Committee Report on the Present State of Knowledge Concerning Accessory Food Factors (Vitamines),” Special Report Series (London: His Majesty’s Stationary Office, 1919), <https://ia802607.us.archive.org/28/items/reportonpresents00commrich/reportonpresents00commrich.pdf>.

⁵ Paice, *Tip and Run*; Page, *The Chiwaya War*.

the Medical Department, on a survey of the diet and health of the Maasai and the Kikuyu. Their findings, published in the *Lancet* in 1927, stressed the poor nutritional status of both groups (though the meat-consuming Maasai were thought to have better nutrition) and the investigators' confidence that greater efforts to improve African diets would improve the value of "the native as an economic factor."⁶

In Nyasaland, medical officers echoed this concern with diet, while pointing as well to parasitic infections as another major cause of native "indolence." In the 1925 Medical Department Annual Report, medical officer W. Milne-Tough contended poor diet was partly responsible for Africans' deficient labor on European-owned agricultural estates, but he also blamed the high prevalence of ankylostomiasis [hookworm].⁷ Among the appendices included in Milne-Tough's report was a study from Mlanje—a southern district filled with European-owned tea estates—in which medical officer HG Wiltshire found that even among (presumably better-fed) Africans employed as police and hospital attendants the prevalence of *Ankylostoma duodenale* in feces was 23.3 percent, while the prevalence of the ova of *Ascaris lumbricoides* was 43.3 percent.⁸ Milne-Tough allowed that some part of the problems with African labor productivity could be attributed to the "natural indolence" of natives (they were, he said, "content with a hand-to-mouth existence"), parasitic infections and diet were major contributors. "The first step towards

⁶ JL Gilks and John Boyd Orr, "The Nutritional Condition of the East African Native," *Lancet* 12 (n.d.): 560–63; Michael Worboys, "The 'Discovery' of Colonial Malnutrition," *Society for the Social History of Medicine Bulletin* 40 (June 1987): 23–26. Also see Osaak A. Olumwullah, *Dis-Ease in the Colonial State: Medicine, Society and Social Change among the AbaNyole of Western Kenya* (Westport, Conn.: Greenwood Press, 2002). Page 229, footnote 56.

⁷ Whitehead, "Annual Medical Report on the Health and Sanitary Condition of He Nyasaland Protectorate for the Year Ended 31st December, 1925.," pages 8-11.

⁸ "Appendix II: Some observations of intestinal parasites of natives at Mlanje," in *Ibid.*

an improvement in the existing state of affairs,” he insisted, “must be taken by the employers of labour.”⁹

Three years later, in his 1928 annual report, Director of Medical and Sanitary Services FE Whitehead made these same links between labor productivity, diet, and hookworm infection. He remarked that native labourers were given “physiologically insufficient, monotonous, and ill-balanced” rations of maize, beans and salt. The main element missing from this diet, Whitehead believed, was meat. Boyd Orr and Gilks had made the same claim with regard to the agricultural Kikuyu people while contrasting them with the pastoralist Maasai. But in his report, Whitehead admitted that “the Government rightly hesitates to enforce an adequate scale of diet,” as employers might not be able to afford to provide a regular ration of meat to African laborers.¹⁰

In addition to such rationalizations, this medical discourse also served to de-politicize (at least in official discourse) the problem of labor productivity, and to ignore the possibility that African laborers might be working slowly in part because they resented the conditions under which they toiled. William Cecil Botttomley, a clerk in the Colonial Office, wrote in 1912 that the prevailing wage rate for African laborers on Nyasaland estates (four to five shillings per month, without food) was “a record for any settled part of Africa.” Hungry for labor to work their fields, many planters turned to the *thangata* system devised by Nyasaland Governor Alfred Sharpe in 1902.¹¹ Under this system

⁹ Ibid. Page 11.

¹⁰ Whitehead, “Annual Medical Report for the Year Ended 31st December, 1928.”

¹¹ McCracken, *A History of Malawi*. Page 80.

African “tenants” on land alienated to Europeans were required to work for at least one month on Europeans’ crops in lieu of rent, and another month in order to meet hut tax obligations. The historian John McCracken has argued that African tenants often had to spend even longer on landlords’ fields, as landlords were wont to abrogate verbal agreements “by the simple expedient of refusing to provide workers with the vouchers required to demonstrate to the government that they had met their obligations.”¹² While parasites and diet were much-studied causes of low productivity of African labor on European-owned estates, the problem could also have been a result of foot-dragging. In the absence of any real incentives to work harder, these African laborers (like many subject peoples) might have seen little reason to strain every fiber.¹³ But the colonial medical officials did not raise this possibility, perhaps because acknowledging it might detract from their ongoing efforts to prove to potential European settlers that they could turn an easy profit using low-paid or unpaid African labor.

b) Anti-hookworm campaigns: medical popularity and danger, 1928-1931

While solutions to problems with the native laborer’s diet appeared expensive, the Nyasaland government helped planters attempt a more frugal biomedical remedy for parasitic infections. Whitehead observed in 1928 that hookworm did “not appear to cause severe symptoms, and beyond a feeling of lassitude and discomfort suggestive of dyspepsia there is little to make the patient suspect his trouble. These slight symptoms are

¹² Ibid. Page 130.

¹³ James C. Scott, *Weapons of the Weak: Everyday Forms of Peasant Resistance*, Reprint edition (Princeton, N.J.: Yale University Press, 1987).

sufficient, however, to interfere with his output of work.”¹⁴ The Nyasaland Medical Department responded to this problem by providing carbon tetrachloride free of charge to European employers of native labor. The use of this drug marked another repurposing of veterinary medicine. Just as veterinary researchers like Boyd Orr had helped spark concern with African diets, they had also helped devise a cure for native lassitude caused by parasites. Carbon tetrachloride had first been tested for use as an antihelminthic on dogs by American pharmacologist Maurice Hall in 1921.¹⁵

Such government aid for estates marked one of the Nyasaland government’s first interventions into the health of natives. Outside the sparsely placed mission hospitals, which tended to charge fees for care, Africans in the protectorate had few options for government healthcare, other than the few poorly equipped native hospitals in major towns and the recently established rural dispensaries constructed from wattle-and-daub and staffed by attendants with very limited diagnostic skills (see Chapter 1). Though Whitehead claimed in 1928 that hookworm was “nearly universal amongst the natives of the country,” he confessed he had not yet begun mass campaign against it “owing to a lack of staff.”¹⁶ The government did undertake such a campaign following an increase in imperial grants for native health the early 1930s (Chapter 3), but in the 1920s the

¹⁴ Whitehead, “Annual Medical Report for the Year Ended 31st December, 1928.”

¹⁵ Maurice Crowther Hall, “The Use of Carbon Tetrachloride for the Removal of Hookworms,” *Journal of the American Medical Association* 77 (1921): 1641–43. Drugs originally used in veterinary medicine continue to be an important source of drugs for “tropical diseases,” for which there is generally little focused research and development. Praziquantel, ivermectin, and albendazole were originally developed for animals, and later repurposed for humans. Piero L Olliaro, Annette C Kuesel, and John C Reeder, “A Changing Model for Developing Health Products for Poverty-Related Infectious Diseases,” *PLoS Neglected Tropical Diseases* 9, no. 1 (January 8, 2015): e3379.

¹⁶ Whitehead, “Annual Medical Report for the Year Ended 31st December, 1928.”, pages 12, 15.

government focused its limited medical budget on improving the health of laborers on Native estates.

c) Pharmacies versus estates: elite battles over labor productivity and profits, 1928-1932

Early in the colonial era, concern for maintaining productive labor led some European planters to pay for health services for their African laborers. In 1901, the Church of Scotland mission hospital in Blantyre began to supply health services to employers of African labor—including planters, traders, and transport agents—in the Shire Highlands. African hospital assistants examined sick patients on an outpatient basis, and referred serious cases to the mission’s hospital.¹⁷

By the 1920s, the government Medical Department had supplanted missionaries as the major supplier of medicines to European employers. In addition to supplying carbon tetrachloride to estates free of charge, the Nyasaland Government sold estates other medicines at their “landed cost” (at the cost of importing drugs); these prices were far below those prevailing at privately owned pharmacies in the territory. In a February 1928 letter to the Chief Secretary in Zomba, Percy Skerett of the Nyasaland Merchants’ Association objected to this policy. He noted that the Government enjoyed much lower transport costs than private importers; government paid railway transport rates one-third lower than the private sector, and did not pay any wharfage fees at ports. “The Trader is therefore handicapped,” Skerett argued, “at once by the difference between the Government and his landed costs to the extent that he cannot compete at a price to get his

¹⁷ Rennick, “Church and Medicine: The Role of Medical Missionaries in Malawi, 1875-1914.” Page 124.

actual outlay back.”¹⁸ Three months later, the Nyasaland Planters’ Association responded with its own letter, in which it contended “the scheme...is working well—to the benefit of the native who gets the proper medicine when he is sick and to the benefit of the Planter who thus manages to keep his workers in better health.”¹⁹

The Government sided with the planters, and continued the policy—over the pharmacists’ objections—for years. Skerrett persisted in protesting the government’s sale of drugs to estates. He even penned a June 1932 letter to the editor of *East Africa*, a newspaper published in Kenya, decrying the policy as “most unfair competition” and a burden on the taxpayer. Repeal would, he said, “relieve the Government from their present invidious position, whereby they charge a license to those who deal in drugs and medicines and then, by supplying those stores themselves, deprive them of such business as would accrue.”²⁰ But the government had already reaffirmed its position; in an April 1932 memo to the Chief Secretary, Whitehead wearily explained that “this matter has been fully dealt with in previous minutes...I know that there is a very strong desire amongst planters to continue this arrangement.” The political power of estates—the main source of export revenue for Nyasaland—gave the cash-strapped government an interest in their prosperity—and support for medical provision on the estates was thought to be a cost-efficient way to improve their output.

¹⁸ “Percy Skerrett to Chief Secretary,” February 1, 1928, “Supply of medicines and drugs by government to agricultural companies and individuals at prices lower than those at which traders can import them,” 1728/27, MNA.

¹⁹ “Nyasaland Planters’ Association to Chief Secretary,” May 21, 1928, “Supply of medicines and drugs by government to agricultural companies and individuals at prices lower than those at which traders can import them,” 1728/27, MNA.

²⁰ Percy Skerrett, “Government Supply of Medicines to Estates in Nyasaland,” Letter to the Editor of “East Africa,” (June 23, 1932), 1728/27, MNA.

d) Building “human material”: nutrition in British development thought, 1932-1938

By the mid-1930s, though, both the myopic focus on chemotherapeutics for estate labor seemed, to a number of colonial researchers and officials, inadequate. In 1932, the British social anthropologist Audrey Richards’ published a revised version of her PhD a study of food and nutrition titled *Hunger and work in a savage tribe: a functional study of nutrition among the southern Bantu*. In the book, drawn from material presented in other ethnographic studies as well as her own fieldwork, she argued that malnutrition in British Africa was not solely a biochemical deficiency remediable with supplements, but the result of social processes legible only upon deeper examination of kinship groups and clans.²¹ But Richards was not averse to biochemical studies of nutrition; in her work among the Bemba in Northern Rhodesia during the mid-1930s she collaborated with Dr. Elsie Widdowson, a biochemist at Kings’ College Hospital in London.²² Richards and Widdowson published their findings in *Africa*, the journal of the London-based International Institute of African Languages and Cultures (IIALC). This institute had, in

²¹ Audrey Isabel Richards, *Hunger and Work in a Savage Tribe: A Functional Study of Nutrition Among the Southern Bantu* (Psychology Press, 1932).

²² A. I. Richards and E. M. Widdowson, “A Dietary Study in North-Eastern Rhodesia,” *Africa: Journal of the International African Institute* 9, no. 2 (April 1, 1936): 166–96. Richardson and Widdowson explained “the biochemist and anthropologist look at native food problems from very different points of view, but it seems clear that research on African diets will be of scientific value only if there is cooperation between the two. Without chemical analysis it is impossible to know the composition of any particular native diet. Without a knowledge of customs and language of any tribal area the necessary facts cannot be collected.” Also see Brantley, Feeding families, 3-4.

1934, established a diet committee, which sought to support investigations of nutrition in British Africa by combining the insights of social anthropology and biochemistry.²³

But the increased interest in the economic underpinnings, and economic consequences, of nutrition during the 1930s was not unique to Britain's holdings in colonial Africa. Studies published in the League of Nations Health Organization's *Bulletin* in 1935 contended that poor nutrition was a truly global problem. Even in wealthy nations, such as the United Kingdom and the United States, the relatively poor continued to go hungry.²⁴ In poor nations and dependencies, the report contended, the problem was an absolute shortage of food. Remedies, the report concluded, demanded the collaborative efforts of experts in health and agriculture.²⁵

The Colonial Office took up this call for combining experts in health and agriculture as part of an overall vision of colonial development. After a 1937 visit to East Africa, Parliamentary Under-Secretary of State for the Colonies, Herbrand Sackville, the Earl de la Warr, declared that "the real 'development' needed in Africa is not in the investment of large sums of capital, but the improvement of the human material. The limiting factor is

²³ Cynthia Brantley, *Feeding Families : African Realities and British Ideas of Nutrition and Development in Early Colonial Africa* (Portsmouth, NH: Heinemann, 2002). Pages 3-4.

²⁴ ET Burnet and WR Akroyd, *Nutrition and public health*, offprint no.2 from *Quarterly bulletin of the health organization of the league of nations*, 4;2 (June 1935), also see Mark Gibson, *The Feeding of Nations: Redefining Food Security for the 21st Century* (CRC Press, 2012). Pages 179-180.

²⁵ In 1936, researchers commissioned by the League of Nations published a globally applicable table of calorie and protein requirements that assumed only age and sex (not nationality, race, or location) were relevant determinants of nutritional requirements. See "Final Report of the Mixed Committee of the League of Nations on the Relation of Nutrition to Health, Agriculture and Economic Policy" (Geneva: League of Nations, 1937).

the low standard of health and intelligence of the average native.”²⁶ To build Africa’s “human material,” improvements in agriculture, health and education would have to be pursued in tandem. Malnutrition—a product, according to a 1939 Colonial Office report, of poverty and ignorance, and a cause of disease and lassitude—was a problem that dealt with all three facets of this notion of development.²⁷

II. The rise and fall of nutrition research in Nyasaland: the Nyasaland Nutrition Survey

a) Conducting the survey, 1938-1940

In the year before the Second World War, Nyasaland was the site of an ambitious study meant to inform future interventions. Leading officials in Nyasaland at the time were eager to obtain additional funding for the medical department emphasizing the link between health and productivity. A March 1936 memorandum penned by ADJB Williams, Nyasaland’s Director of Medical Services and forwarded by Governor Kittermaster to the Colonial Office, stated that “the efficiency and therefore the material prosperity of a people depends to a very large extent on the healthiness of the people.”²⁸ Their timing was auspicious. In 1937, the UK Economic Advisory Council established a Committee on Nutrition to review responses from a questionnaire on nutrition that had been sent to every British dependency by the Secretary of State for the Colonies in 1936. Drawing upon funding from the IALC, the Colonial Development Fund, the British

²⁶ David John Morgan, *The Official History of Colonial Development: The Origins of British Aid Policy, 1924-1945* (Humanities Press, 1980).Page 59.

²⁷ *Nutrition in the Colonial Empire*, Economic Advisory Council, 1939.

²⁸ ADJ Bedward Williams, “Memorandum A: A Memorandum on the Health Policy in Nyasaland, From the Director of Medical Services to the Governor, the Colonial Office, and the Colonial Advisory Medical Committee” (Nyasaland Medical Department, March 23, 1936), No.138/1936: Nutrition and its Relation to Public Health, MNA.

Medical Research Council, and the Colonial Office, the Committee on Nutrition planned to support a series of multi-disciplinary nutritional surveys in colonial holdings throughout the empire.²⁹ Kittermaster made it known that he was eager to have a study conducted among his subjects, and in March 1937 the governors of the East African territories—who had been tasked with selecting the site for the first study—granted his wish.³⁰

The Nyasaland Nutritional Survey began in three villages in Nkhotakota District in September 1938, under the leadership of Benjamin Stanley Platt. Though only in his mid-thirties, Platt was already physician and biochemist of considerable repute. He had spent the previous six years in Shanghai, where he had conducted controlled trials and published findings the links between thiamine (Vitamin B1) deficiency, rice preparation, and the symptoms of beriberi.³¹ The survey team included another doctor, HG Fitzmaurice, who had been the medical officer stationed in Nkhotakota for two years the survey began. He was tasked with continuing his regular clinical work throughout the district while in the three survey villages he was to examine all the adults (using Platt's own 10-page-long form for each exam) and to weigh the infants and young children.³² For the team's nutritionist, Platt chose Jessie Barker, another young researcher who had worked as a recorder on John Boyd Orr's urban surveys in the UK. In Nyasaland Barker's job was to record the weight of all food before cooking and as consumed, and to

²⁹ Berry, *Before the Wind of Change*. page 39-40.

³⁰ Brantley, *Feeding Families.*, 4-5.

³¹ Kenneth J. Carpenter, *Beriberi, White Rice, and Vitamin B: A Disease, a Cause, and a Cure* (University of California Press, 2000).

³² Brantley, *Feeding Families.*, 7-9

pack samples to be sent to Boyd Orr's laboratory in Aberdeen for biochemical analysis. Her nickname in the villages became *Mwadya chiyani* (Chichewa for "what have you eaten") due to the frequency with which she asked the question.³³ Governor Kittermaster had chosen the anthropologist, Margaret Read, who had been conducting fieldwork in central and northern Nyasaland among the Ngoni people as a research fellow of the IALC.³⁴ Richard Kettlewell, an official in Nyasaland's Department of Agriculture—and a man with a dismal view of extant African agricultural practices—was the team's agriculturalist. The final expert on the survey team was the botanist, a role filled during most of the study by Dr. Geoffrey Herklots, an economic biologist whom Platt had met at the University of Hong Kong.³⁵ The other actors in this drama—the Africans in the three villages that were to be the focus of the study—had been promised exemption from the hut tax for the duration of the study.³⁶

Early survey results soon revealed the complexity of nutritional problems in Nyasaland. In Shanghai, Platt's studies of beriberi had shown that simple nutritional supplements, or slight alterations in the preparation of rice, could ameliorate biochemical deficiencies. But to Platt's surprise, medical examinations of in the three villages revealed not a single clear case of any deficiency disease—no beriberi, no scurvy, no pellagra—known to be amenable to cure with a specific vitamin or mineral.³⁷ Platt's dreams of another a silver-

³³ *Ibid.*, 9.

³⁴ *Ibid.*, 4-5.

³⁵ *Ibid.*, 10.

³⁶ Veronica Berry and Celia Petty, *The Nyasaland Survey Papers 1938-1943, Agriculture, Food and Health* (Academy, 1992). Page 98.

³⁷ "There were no cases seen of any of the fully developed classical cases of deficiency diseases, such as beri beri, scurvy or pellagra. There were, however, physical signs of malnutrition, some

bullet nutritional cure—along the lines of the thiamine supplementation for beriberi he helped develop in Shanghai—would go unrealized.

But Platt still believed the subjects in the surveyed villages were anything but hardy. Though they did not exhibit florid deficiencies of any particular micronutrient, many suffered from what William Thomas Charles (WTC) Berry—a medical officer who succeeded Fitzmaurice as the physician on the team—called “seasonal semi-starvation.” Using data from studies of Europeans, Platt assumed a basal metabolic rate (the rate of calorie usage during sleeping), as well as metabolic rates associated with a number of activities (harvesting maize, weeding, etc.) for both men and women.³⁸ Drawing upon the team’s fieldwork studies of time devoted by their subjects to specific types of labor, Platt was able to estimate a number of calories required to meet energetic needs. To calculate the number of calories consumed, the report took Barker’s records of the amounts and kinds of food eaten in a number of the survey households as representative samples, and multiplied these tallies by the per-unit calorie figures for each kind of food that she had sent for biochemical analysis in Scotland. Though the original data collection was disaggregated by age, sex and other categories, in this table Platt used weighted averages

of which might be considered as being sub-clinical manifestations of insufficiency of some dietary factors.” London School of Tropical Hygiene and Medicine, GB 0809 Nut/01/01/12, page 22. Also see Brantley, *Feeding Families*. Page 107. Some of the clinical survey data was lost when, while Platt was driving to Zomba with survey papers in 1940, the door of his car burst open and scattered onto the muddy road and in the bushes. Berry and Petty, *The Nyasaland Survey Papers 1938-1943, Agriculture, Food and Health*. Page 13.

³⁸ Brantley, *Feeding Families*. 100. More evidence that Platt was not prepared to study seasonal food shortages is made evident by the timing of medical exams, which were completed before the rainy season (aka the ‘hungry season’ when maize-growing areas experienced the greatest hunger, as the previous year’s crop ran out and the labor in the fields was hardest).

to offer a single figure comparing calorie requirements to calorie consumption for each village in each month between December 1938 and September 1939 (Figure 2.1).³⁹

In her book on the history of British colonial nutrition research, Cynthia Brantley focuses on the reductionism that went into crafting this table, noting that it does not disaggregate on the basis of age or sex. But Platt's survey does often disaggregate on the basis of age, sex, and types of labor in many other tables. This is evident in a graph charting the average numbers of hours that men and women devoted to work throughout the survey in each village (see Figure 2.2). This graph focused on agricultural labor, and did not count many kinds of "women's work," such as cooking, grinding corn and sweeping the home. It also gave a somewhat unrepresentative picture of the male contribution to the family farm, as the exemption from the hut tax for the study villages meant that fewer men left the village in search of waged labor to pay the tax. Despite these shortcomings, Platt and his team used far less aggregation, than GDP per capita, an estimate of welfare that became globally popular in the decades following his survey (see Chapter 7).

The survey data revealed that in each village there were months in which consumption did not meet requirements; in one village this happened in two months, in another it happened in seven months, and in a third it happened in nine of the months. The "energy deficit" could be astounding; in the maize-growing village of Jere in January 1939, a period during the growing season that demanded long days pulling weeds even as granaries containing the 1938 harvest began to run short, calorie intake was 28.5% below

³⁹ Ibid., 71-73.

AVERAGE CALORIE INTAKE PER DAY PER INDIVIDUAL FOR DIFFERENT MONTHS			
HILL VILLAGE			
Month	Calorie Requirements	Calorie Intake	Percent Surplus
December	2245	2130	-5.1
January	2208	1580	-28.5
February	2022	2006	-0.8
March	2115	1721	-18.6
April	1967	1722	-12.4
May	1573	1401	-11
June	1895	1786	-5.8
July	1966	2304	+17.2
August	1620	1617	-0.2
September	1843	1691	-8.2
Average	1942	1784	-8.2
FOOTHILL VILLAGE			
December	1899	1537	-19.0
January	2051	2108	+2.8
February	1823	2354	+29.2
March	1980	2229	+12.6
April	1760	2004	+13.9
May	1733	1485	-14.3
June	1610	1947	+21.0
July	1771	2958	+67.0
August	1646	2308	+40.0
September	1726	2033	17.8
Average	1784	2050	+14.8
LAKE SHORE VILLAGE			
December	1773	1907	+7.5
January	2001	1895	-5.3
February	1862	1567	-15.9
March	1940	2099	+8.2
April	1812	2154	+18.9
May	1753	1429	-18.5
June	1824	1234	-32.3
July	1729	1460	-15.5
August	1787	1393	-22.1
September	2053	1803	-12.2
Average	1852	1733	-6.4

Figure 2.1: Average calorie intake per day per individual for different months of the year by village. Source: The Nyasaland Survey Papers, 1938-1943: agriculture, food and health. Eds. Veronica Berry and Celia Petty. London: Academy Press, 1992. Page 138.

calorie requirements. This table demonstrated both a chronic *absolute* deficiency and acute seasonal shortages in the number of calories available to villagers. The main problem, then, was that Africans simply did not grow enough food.⁴⁰

b) Nutrition Development Units, 1940-1943

Platt used early results of this caloric budgeting to support his proposed solution, laid out in an April 1939 memo. There he called for the establishment of a pilot “Nutrition Development Unit” (NDU), a multi-disciplinary center that would seek to abolish the energy deficit throughout Nkotakota District by pursuing continued research and interventions in agricultural diversification, fishery, forestry, animal husbandry, healthcare (especially maternity and child welfare centers), sanitation, and handicrafts.⁴¹ Platt believed that the NDU would be a model for the colony and even the rest of British Africa. In fact, there was great enthusiasm about the survey among many administrative and technical officers in Nyasaland. In his autobiography, WTC Berry remembered that upon his appointment to Nkotakota in January 1940, he was grateful to be “presented with a great opportunity.”⁴²

⁴⁰ A 1939 Colonial Office report, entitled *Nutrition in the Colonies* and authored, in large part, by Platt, concluded that the deficiencies in agricultural production led not only to known dietary deficiencies (e.g. beriberi and pellagra) but also “deficiency states which while not resulting in manifest disease prevent the full enjoyment of health.” Writing in 1944, social anthropologist Lucy Mair noted that recent expert opinion blamed such deficiency states for exacerbating many diseases (including ulcers, leprosy, tuberculosis, hookworm disease, malaria), and for increasing rates of maternal and infant mortality. See Mair, *Welfare in the British Colonies*. Pages 95-96.

⁴¹ Berry, *Before the Wind of Change*. 81; Brantley, *Feeding Families.*, 140

⁴² Berry, *Before the Wind of Change.*, 50

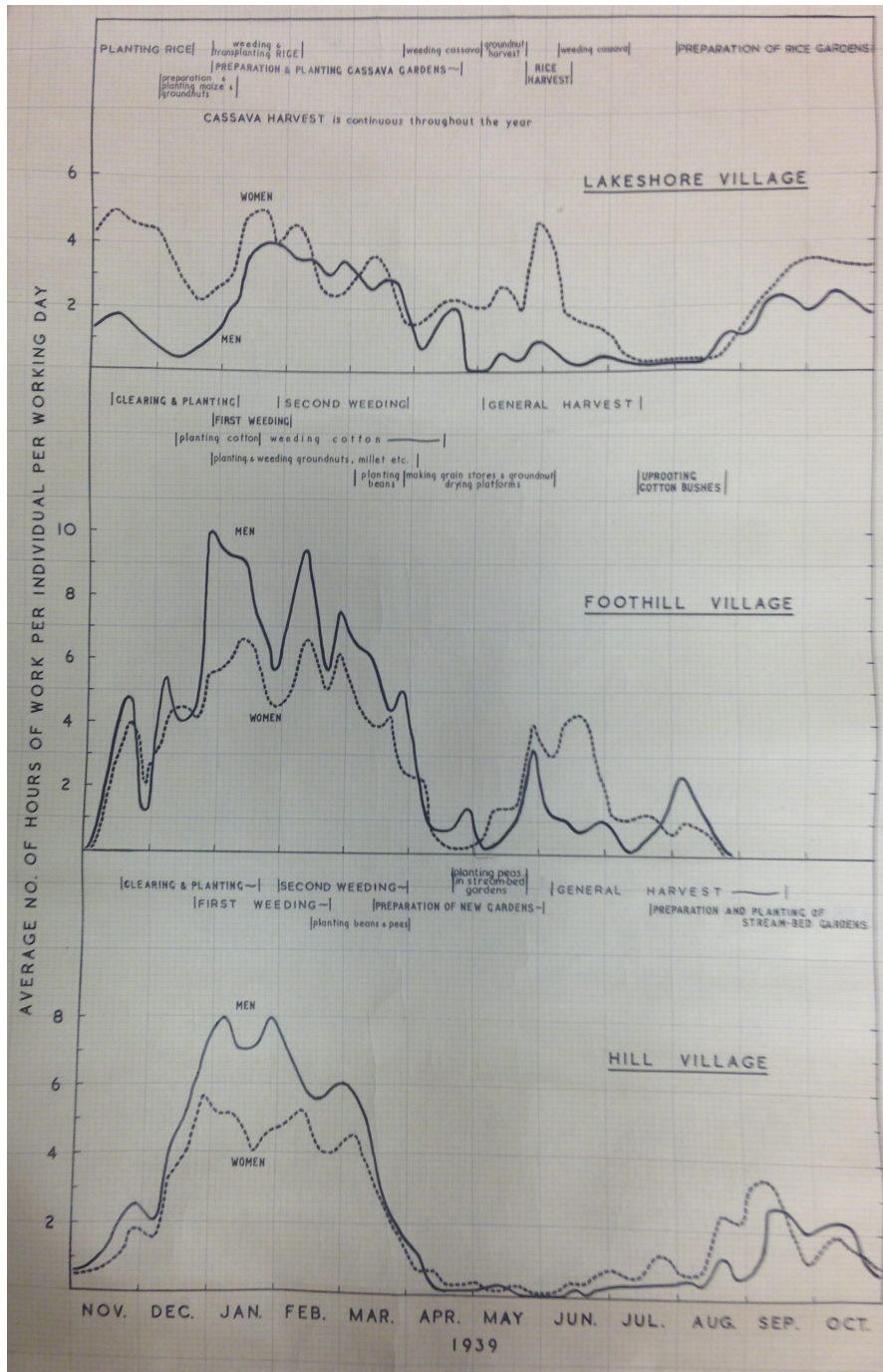


Figure 2.2: Average number of hours of work per individual per working day. Source: London School of Hygiene and Tropical Medicine Archives, GB 0809--Nut 02/04/11.

Yet soon, Berry would come to see his time in Nkotakota as an *ignis fatuus*—that is, a ‘will o’ the wisp,’ a deceptive vision pursued in vain.⁴³ The problem, as ever, was funding, though by 1940 the UK Treasury had a new reason to hoard its money. Berry knew of the September 1939 declaration of war against Germany when he began his tenure in Nkotakota, but he still believed then that the war would amount to no more than “an affair of leaflet raids over Germany.”⁴⁴ When the Provincial Commissioner of Nyasaland’s Northern Province submitted his initial proposal for the NDU to the Colonial Office and Medical Research Council in 1939, he had requested £10,000 per year for three years.⁴⁵ But after the British rout at Dunkirk and the fall of France to the Nazis, officials in London drastically curtailed the budget, to £1,025 per year for three years.⁴⁶ Kettlewell and a new agricultural officer named Dawkins were both seconded abroad for military service, as was the Assistant District Officer, Rangeley—who was supposed to run the NDU. Barker’s role became unclear, as she was supposed to teach women how to cook new crops that the agricultural officer taught men to plant, and to teach crafts such as spinning, weaving, knitting and pottery to women referred by the assistant district officer. Instead, she ended up pursuing research on the pediatric growth and development (continuing the dataset begun by Fitzmaurice) and completed a list of native plants and cooking methods. For his part Berry—disappointed both by the obsolescence of the development unit and his own distance from patriotic battle, tested a number of nutritional remedies for two common medical problems: sores on the lower leg known as “tropical ulcer,” and a painful bleeding of the gums in children known to Africans as

⁴³ Ibid., Foreword.

⁴⁴ Ibid., 50.

⁴⁵ Brantley, *Feeding Families.*, 130

⁴⁶ Berry, *Before the Wind of Change.*, 57

chiseye and to the British medical officers as Vincent's angina. To his chagrin, neither proved susceptible to Vitamin C or the addition of hippopotamus meat to the diet.⁴⁷

As the war continued, and resources grew scarcer, officials in the Colonial Office and new leadership in Nyasaland made clear that there was no more room for heady ideas to improve productivity through nutritional improvements. Nyasaland's Director of Medical Services at the war's outset, H.S. de Boer, had been a fervent supporter of the survey, and had asked Barker to help recommend changes to African diets in government hospitals and prisons and on private tea estates. But by June 1942 the prime advocates of nutritional work in Nyasaland, de Boer and Kittermaster, had left Nyasaland, and Barker's funding was not renewed.⁴⁸ Berry continued his work, though he grew frustrated both by frequent drug shortages (which he attributed to the sinking of ships by German submarines) and by what he perceived as the obstinacy of the villagers to the unit's schemes. The latter he blamed on the inherent limits to social engineering imposed by the system of indirect rule, where African chiefs retained significant authority over land issues. When the NDU's three-year budget ran out in 1943 it, too, was terminated, its staff scattered to other duties.⁴⁹

The war also led Platt to delay, and ultimately abandon, his plans to produce a final report on the Nyasaland Survey. Upon his return to England in late 1939 to aid in plans to ensure troops had adequate nutrition, Platt had compiled the survey's raw data but had

⁴⁷ Brantley, *Feeding Families.*, 135-136.

⁴⁸ *Ibid.* 134-135.

⁴⁹ *Ibid.*, 63.

yet to write a conclusion or even to analyze the final results. He deposited the papers in the archives of the London School of Hygiene and Tropical Medicine's (LSHTM's) Department of Human Nutrition. These survey papers were not published in any form for a half-century, until Veronica Berry (widow of the late WTC Berry, who had died in 1983) and a recent graduate of the Department of Human Nutrition named Celia Petty edited them into a book in 1992.⁵⁰

c) Government healthcare becomes a “lavish” expense

This whimper of a denouement to the nutrition survey was, in part, a product a slow waning of interest among London-based officials in funding efforts to remedy parasitic infections and nutritional deficiencies in Nyasaland. As early as 1936, Thomas Stanton, Chief Medical Adviser to the Colonial Office opined that after Nyasaland's medical entomologist, Dr. William Lamborn, retired, the post should be abolished in order to save money.⁵¹ Lamborn had authored of dozens of studies of insect- and rodent-borne diseases (including sleeping sickness, plague, and leprosy) in Nyasaland. But the scientific merits of the position were not enough to save it; after Lamborn's retirement in 1941, Nyasaland's Medical Department abolished the position.⁵²

⁵⁰ Berry and Petty, *The Nyasaland Survey Papers 1938-1943, Agriculture, Food and Health*.

⁵¹ S. Stanton, 24/11/1936, minute in Medical Services Organisation and Administration, CO 525/161/4, “Extract from dispatch from Governor's Deputy, No 379 of the 22nd October 1935, on the estimates for 1936,” M.A. Greenhill, 19.12.35, MNA In his 1939 report, De Boer agreed that the remaining entomologist employed by the Agricultural Department could continue Lamborn's locally relevant studies, but he did not come up with this idea himself. It is clear from correspondence between Zomba and London that the impending abolition of this post was, by 1939, a *fait accompli*. H.S. De Boer, “Medical and Health Services,” June 17, 1939, CO 525/178/1, UKNA.

⁵² Medical Department Annual reports, and John Kemp, “Dr W A Lamborn: A Medical Entomologist in Nyasaland,” *Society of Malawi Journal* 67, no. 1 (2014): 57–63. Though not directly employed by the Nyasaland government, a number of colonial entomologists did work in East and Central African research stations after the Second World War. These entomologists continued to conduct research in Nyasaland after Lamborn's retirement. See Sabine Clarke, “The

More evidence that London remained chary of increasing healthcare spending came while Platt's team was in the midst of its survey. In June 1939 de Boer sent a report to the Colonial Office detailing deficiencies in the Protectorate's hospitals and dispensaries, and calling for greater investment in health services. Nyasaland Governor Donald Mackenzie-Kennedy, Kittermaster's successor, added a supportive letter in which he contended "health and allied services, directed to the development of a physically fit population, should be extended slightly in advance of schemes for the promotion of education and economic prosperity."⁵³ But officials in the Colonial Office and Treasury responded with skepticism, calling his proposals "prohibitively expensive." One Colonial Office official even derided the free provision of food to hospitalized Africans as an unduly "lavish" expense (see Chapter 4).⁵⁴

When development grants restarted after the Second World War, the rhetoric supported the "health is wealth" argument, but linking healthcare to agricultural policy no longer seemed as potent in mobilizing financial resources for the government medical services. A 1944 report produced by Nyasaland's Postwar Development Committee argued that production would not rise so long as "a large proportion of the Native population suffers from the debilitating effects of malaria, hookworm, bilharzia and other parasites" and while "malnutrition exists to a certain degree." The authors declared: "We do not

Research Council System and the Politics of Medical and Agricultural Research for the British Colonial Empire, 1940-52," *Medical History* 57 (2013); 3: 338-358.

⁵³ "Memo from Governor DM Kennedy to Chief Secretary, Zomba, Re: Dispatch to Be Sent to Colonial Office Concerning De Boer Report," May 8, 1939, S40/1/8/1, Document No 204, MNA.

⁵⁴ "Minute by Gerard Clauson Re: De Boer Report," August 8, 1939, CO 525/178/1, UKNA.

consider that medical problems are separate and distinct in a tropical country from other social problems.”⁵⁵ Yet the only immediate postwar development grants for health proposed by the committee—and eventually funded by the UK Colonial Development and Welfare Act—was a chemotherapeutic intervention to treat demobilized soldiers and other Nyasaland Africans for venereal disease. The Medical Department’s share of total government recurrent expenditure declined from 9.0 percent in 1935 to 4.3 percent in 1946. Expert investigations into health and agriculture would continue with the “second colonial occupation,” but these did not lead to the prioritization of either sanitation or curative medicine in Nyasaland (Chapter 5).

III. The legacies of an aborted report: Afterlives of the nutritional link between health and wealth

a) Kettlewell’s sequel: *malimidwe*, coercion and the nationalist battle

But the Survey, and the interwar focus on nutrition throughout the Empire, was never solely focused on public health and curative medicine. Given Platt’s finding of “seasonal semi-starvation,” one would expect that the Survey might spur greater spending on agricultural interventions. Indeed, despite the fact that the Nyasaland Survey Papers sat unpublished in a London archive, and even though the Development Units were never fully realized, both the study data and the researchers who helped to collect it greatly influenced Nyasaland’s future agricultural policies. During the survey Richard Kettlewell, the Survey team’s agriculturalist, came to favor major changes in extant

⁵⁵ “Post War Development Committee, Draft Interim Report No. 3- Public Health, Nyasaland Secretariat,” August 9, 1944, FS/1/6/20, MNA. Members of the postwar development committee included Juxon Barton (chairman), GH Adams, W Tait Bowie, MP Barrow, HG Duncan, AF Barron, JA Lee, J Marshall), page 1.

African agricultural techniques. Less than a decade after his work on the survey, Kettlewell became director of Nyasaland's Agriculture Department. From this post he sought to put into practice his plans for improved smallholder agriculture. Yet by the 1950s the intrusive regulations that he implemented would prove so unpopular that politicians would use them to drum up opposition to the colonial government (see Chapter 8).

Kettlewell's involvement in the Nyasaland Survey made him a vocal proponent of soil conservation measures. He said his experience led him to recognize that insufficient food production and resulting malnutrition would be an "inescapable consequences of increasing soil erosion." The dangers of erosion were, to him, great enough to justify "the compulsory introduction of basic conservation practices."⁵⁶ Kettlewell was particularly interested in mandating the construction of "contour planting ridges." This would entail a rule that all maize was to be planted atop 2-foot-high ridges of soil; African smallholders were to build these ridges using hoes. In his portion of the Nyasaland Nutrition Survey report, Kettlewell had lamented agricultural agents' inability to convince smallholder farmers to take up ridging:

The advantages of contour planting ridges have been appreciated for some time, and considerable propaganda has been devoted to their introduction; but where maize and other food crops are concerned, the native exhibits a rigid, and not unnatural conservatism against which relatively little progress has been made so far. It is frequently agreed that the change in method involves a great increase in the amount of work, but although this is scarcely true yet laziness, indifference

⁵⁶ Richard Kettlewell, "Personal thoughts on the future of Africa," March 1988, LSHTM Nut/01/05/04, Page 11.

and not knowing how else to set about it are probably the chief reasons for lack of response.⁵⁷

Kettlewell was firmly convinced not only that ridging would prevent erosion, but also that the perils of erosion merited coercive policies. Later in life, Kettlewell said he found a good part of his zeal after reading *The Rape of the Earth: a World Survey of Soil Erosion*, a 1939 book written by the British soil scientists GV Jacks and RO White.⁵⁸ During the Second World War Kettlewell could not secure the funds, the staff, or the support of his superiors to enforce a compulsory ridging campaign. But he found a kindred spirit in 1947, when Geoffrey Colby became Governor of Nyasaland. Colby transferred Director of Agriculture PB Garnett to the Gambia and, appointed Kettlewell to lead the department. Beginning in 1948, thousands of cultivators were arrested and tried in native courts for failing to construct ridges in their fields; those found guilty received punishments that varied from a 5-shilling fine to 6 months in jail.⁵⁹

⁵⁷ Berry and Petty, *The Nyasaland Survey Papers 1938-1943, Agriculture, Food and Health*. Page 238

⁵⁸ “I well remember, early in my tropical career, reading in the classic on soil erosion (“The Rape of the Earth”) that ‘an inch of soil that took a thousand years to produce can be lost for ever overnight.’” Richard Kettlewell, “Personal thoughts on the future of Africa,” March 1988, LSHTM Nut/01/05/04, Page 3. Also see William Beinart, *The Rise of Conservation in South Africa: Settlers, Livestock, and the Environment 1770-1950* (Oxford University Press, 2008); McCracken, *A History of Malawi*. Pages 317-320.

⁵⁹ Writing in 1965, Kettlewell explained that the Nyasaland Government “concluded that if it waited for the slow enlightenment of education to change age-old practices the loss of soil in the interim might well prejudice the whole future well-being of the Protectorate. It was felt that a measure of compulsion was necessary and justified for the common good, and accordingly in 1946 the government enacted legislation to prescribe soil-conserving methods of land use, entrusting regional boards with the power to enforce them...Incorrigible offenders were fined and those who deliberately or persistently opposed its implementation or incited others to resist were, in some cases, given short prison sentences.” Richard Kettlewell, “Agricultural Change in Nyasaland: 1945-1960,” *Food Research Institute Studies* 5 (1965). Page 240.

Kettlewell thought Africans opposed ridging because it entailed “extra hard work,” but the historian Elias Mandala (who himself grew up in a rural Malawian village) has argued that there was an agriculturally sound reason behind smallholder resistance to ridging.⁶⁰ Aside from the immense work required to construct the ridges, many farmers believed ridging actually hastened soil erosion. Particularly on the flat, low-lying areas near Lake Malawi and in the Lower Shire Valley, farmers contended that wind would denude the sandy soil from high ridges.⁶¹ In a 2013 interview, a smallholder farmer from the rural Neno district remembered the anger this caused: “Any garden without contour bunds and ridges, people were punished, and even taken to the prison...that’s why people were not happy to go along with white people, we rebelled against their ruling...An African was under pressure with the Europeans ruling...why should they dominate? We wanted freedom, so we fought for it, even died for it.”⁶²

Indeed, in the coming years, opposition to Kettlewell’s campaign (popularly known as *malimidwe*, the Chichewa word for conservation) became a potent plank of African nationalist propaganda. In 1953 over a thousand people attacked the courthouse of Chief Mlolo, who had supported the regulations. That same year, the Nyasaland African Congress linked opposition to ridging to the campaign to stop the upcoming formation of a federation government that would place Nyasaland’s Africans under the control of white settlers in Northern and Southern Rhodesia (see Chapter 8). In the Lower Shire

⁶⁰ Richard Kettlewell, “Personal thoughts on the future of Africa,” March 1988, LSHTM Nut/01/05/04, Page 11.

⁶¹ Elias Mandala, *Work and Control in a Peasant Economy: A History of the Lower Tchiri Valley in Malawi, 1859-1960* (Madison, Wis: University of Wisconsin Press, 1990). Pages 90-91.

⁶² Interview with SJ Kaphale, Matandani Village, Neno District, July 14, 2013.

Valley, women could be heard singing a song promising “death” to the “Federation *capitaos*” and to the “contour ridging *capitaos*.”⁶³ Facing unrelenting opposition and without the support of Governor Colby, who departed Nyasaland in 1956, Kettlewell’s Agricultural Department relented; between 1957 and 1960, the number of court cases relating to ridging declined, even as many farmers refused to obey the regulations.⁶⁴ In the years following Hastings Kamuzu Banda’s return to Nyasaland in 1958, his speeches before audiences of rural Africans consistently linked his opposition to the “stupid Federation” to the unpopular *malimidwe* regulations.⁶⁵

Thus did an idea (compulsory ridging) born partly of the Nutrition Survey help spur anti-colonial protests two decades later. And these protests, in turn, led Federation officials in Salisbury to devote far greater sums (both in absolute terms and relative to overall government expenditure) to Nyasaland’s health sector than the colony had ever before seen (see Chapter 8). So, in the most roundabout of ways, one legacy of the Nutrition Survey was increased spending on government health services, but this only arrived decades later.

b) Colonial income accounting and the fetishization of GDP

The Nyasaland Nutrition Survey had another surprising legacy. The survey data formed the basis of the earliest “colonial national income” estimate not only in Nyasaland, but in all of colonial Africa. Though the survey was not intended for use in what we now call

⁶³ *Magomero: Portrait of an African Village* (Cambridge: Cambridge University Press, 1989). Page 217.

⁶⁴ Kettlewell, “Agricultural Change in Nyasaland: 1945-1960.”

⁶⁵ Lawrence AB Malekano, “Peasants, Politics and Survival in Colonial Malawi” (PhD Dissertation, Dalhousie University, 1999). Page 142. Also see Philip Short, *Banda* (Boston: Routledge & Kegan Paul, 1974). Page 92.

Gross Domestic Product, an economic researcher named Phyllis Deane would use it for this purpose. In later years the GDP would come to be heralded, by both Malawi's government statisticians and by cosmopolitan economic experts, as the chief barometer of human welfare. This epistemology, which erased important distinctions through aggregation, stood in stark contrast to the epistemology of the Nutrition Survey. Platt's survey methodology demonstrated, in numerous tables, differences in food consumption by age and sex within each village. Other tables (such as Figure 2.1) demonstrated stark inter-temporal differences in food consumption, thereby drawing attention to what Berry called "seasonal semi-starvation"—and what Malawians still call "hungry season" (*nyengo njala*). GDP, on the other hand, is a technology of aggregation. By summing production into a single annual index, it obscures both unequal inter-personal and seasonal distributions of production and consumption. Malawi's GDP statistics did not, for instance, reveal the depths of despair faced by many of the most destitute during the worst of the 2015 and 2016 hungry seasons, after floods washed away crops and drought scorched the rest. The use of Nutrition Survey data for Africa's earliest national income calculation is, then, another example of the malleable, even ironic uses to which the survey was put.

Deane's task, upon being hired by the UK National Institute for Economic and Social Research in 1943, was to experiment with a method of triple-entry national income accounting devised by Cambridge economists James Meade and Richard Stone.⁶⁶ Meade and Stone believed their system was a tool not only for economic planning in a single

⁶⁶ Austin Robinson, 'Foreword,' in Phyllis Deane, *The measurement of colonial incomes: an experiment*. (Cambridge University Press, Cambridge, 1948), p. v.

country, but also as a universal method capable of comparing nations and imperial holdings around the globe.⁶⁷ For Deane the task was to attempt to measure ‘certain colonial incomes,’ first using sources available in London and, later, by conducting fieldwork. Initially, Deane and her advisors chose Northern Rhodesia (today, Zambia) and Nyasaland (today, Malawi) for her study (Jamaica was added later). Robinson wrote that the team chose Northern Rhodesia in part because he had worked on studies in the territory and knew of some sources of statistical material. He explained that Nyasaland, an adjacent colony, was chosen because Platt’s Nutrition Survey data could be used to estimate subsistence agricultural production as well as native incomes and consumption.⁶⁸

Working from London, Deane estimated the “national” income of these territories. The earliest date for which she had any sort of reliable data in Nyasaland was 1938. For this year, her estimate relied heavily on extrapolations from the Nyasaland Nutrition Survey.⁶⁹ Deane hoped that her estimates would be used to guide economic policies, with two ends in mind. “We start,” Deane explained, “from the assumption that for all communities an increase in the volume of economic goods and services produced, and an improvement in its distribution over time and among persons and groups, are important

⁶⁷ James Meade and Richard Stone, “The Construction of Tables of National Income, Expenditure, Savings and Investment,” *The Economic Journal* 51, no. 202/203 (June 1941). Page 216.

⁶⁸ Austin Robinson, ‘Foreword,’ in Phyllis Deane, *The measurement of colonial incomes: an experiment*. (Cambridge University Press, Cambridge, 1948), p. vii-viii.

⁶⁹ A seemingly arbitrary substitution of ‘colony’ and ‘nation’ is evident throughout Deane’s writings on national income accounting in colonial settings.

ends of economic policy.”⁷⁰ Hers was not a minority position among economists; as early as 1934, Simon Kuznets and John Blair claimed, “Economic welfare cannot be adequately measured unless the personal distribution of income is known.”⁷¹

But by the 1960s, in economic policy discourse in Malawi and elsewhere, the goal of increasing aggregate production was paramount. “The simplest indicator of economic progress of a community,’ explained a 1968 report produced by Derek Blades, a recent Oxford graduate then serving as Malawi’s Director of Census and Statistics, “is the movement of real income per head of the population. This is not an unqualified measure of improvements in the standard of living for the average inhabitant of a country but has been found a useful guide.”⁷² In Malawi, where wealth had long been concentrated among the owners of large agricultural estates, Blades’ assertion had great political import. Once the distribution of wealth was rendered invisible by the myopic focus on aggregate production, planners could easily justify extracting resources from smallholder farmers to finance export-oriented, large-scale, elite-owned agricultural estates. Indeed, Anne Conroy and colleagues have illustrated the ways in which Malawian policies have favored the estates in the decade following independence:

⁷⁰ Phyllis Deane, *Colonial social accounting* (Cambridge University Press, Cambridge, 1953), p 120.

⁷¹ Simon Kuznets and John Blair, *National income, 1929-1932: Letter from the Acting Secretary of Commerce transmitting in response to Senate resolution* (US Government Printing Office, 1934), p. 7.

⁷² *Malawi National Accounts Report, 1964-1967* (Government of Malawi, Zomba, 1968), p. 7. It should be noted that Blades’ choice to use Billington’s method for imputing prices runs counter to this narrative of modernization theory’s erasure of peasant production. But, as will be made clear in the next section, Blades possessed a greater curiosity about the economic contribution of non-monetary production and methods of measurement than most statisticians.

Customary land was annexed from the smallholder subsector; smallholders were legally prevented from growing important high-value crops (burley tobacco, tea and sugar were reserved for the estate subsector); smallholder producers of export crops were paid less than the export parity price by the state marketing board...with most of the resulting profits channeled into the development of the estate subsector.⁷³

During the post-independence decades such policies impoverished large portions of the population even as GDP growth figures remained strong (see Chapter 10). Once again, then, the Nyasaland Survey data came to be used to advance political goals never foreseen by Platt.

c) WTC Berry and the Population Bomb

A third surprising sequel to the Nutrition Survey was the change in thinking of WTC Berry. Berry had been a leading administrator and a vocal proponent of the Nutritional Development Units, and was dismayed and frustrated when their funding was not renewed in 1943. But in his memoirs, published posthumously in 1984, Berry wondered whether his efforts to save the lives of the sick and hungry in Nyasaland had only sped the descent into a Malthusian trap. After recounting a campaign to stem an outbreak of cerebro-spinal meningitis (CSM) in southern Nyasaland in 1937, Berry added the following note:

The containment of the CSM outbreak changed nothing much and even less was changed for the better. Population pressure was all the greater for the survival of five hundred or so Africans who might otherwise have died. Because of this pressure forest land around the foot of Chiradzulu mountain had to be yielded for Agriculture with all that entailed, but that was another story, as Kipling might have said.⁷⁴

⁷³ Anne Conroy, Malcolm Blackie, Alan Whiteside et al. *Poverty, AIDS and hunger: breaking the poverty trap in Malawi* (Palgrave Macmillan, New York, NY, 2006), pp. 17-18.

⁷⁴ Meade and Stone, "The Construction of Tables of National Income, Expenditure, Savings and Investment." Page 25.

No such fatalism appears in the Nyasaland Nutrition Survey. In his agricultural studies, Kettlewell documented the relatively low ratio of arable land to land currently under cultivation near one of the survey villages.⁷⁵ The medical reports—authored by Fitzmaurice and Berry—mention population only briefly. There the authors note that while “reference has been made to the fact that by comparison with Africa as a whole, Nyasaland is a relatively densely populated country...By European standards... Nyasaland is only sparsely populated.”⁷⁶ During their brief tenure (1940-43), Nyasaland’s Nutrition Development Units were far more concerned with increasing child and maternal survival than with lowering birth rates.⁷⁷ In short, population pressure was not a major concern in interwar Nyasaland.

The idea that the country was locked in a Malthusian trap gained credence among Nyasaland officials during a 1948-1949 famine.⁷⁸ Population control was a major focus of international development discourse in the 1960s and 1970s (see Chapter 9). By the end of his life, it seems, Berry had become convinced of the danger of the “population bomb.” His work early in life was dedicated to improving survival among rural Africans, but eventually he came to doubt that this would effect change “for the better.”

⁷⁵ Berry and Petty, *The Nyasaland Survey Papers 1938-1943, Agriculture, Food and Health*. Pages 66-68.

⁷⁶ *Ibid.* Page 174.

⁷⁷ “Data on births and childbearing,” LSHTM Nut/02/05.

⁷⁸ Megan Vaughan documents how, during the famine, Nyasaland officials deployed neo-Malthusian to obscure the recent alienation of arable land from African smallholders. Megan Vaughan, *The Story of an African Famine : Gender and Famine in Twentieth-Century Malawi* (New York, NY, USA: Cambridge University Press, 1987).

By the time Berry made his late-life reflections of his medical work in Nyasaland, the nutrition paradigm had come full circle. The measures advocated in the 1960s and 1970s in the name of population control, including forcible mass sterilization and even inaction in the face of mass die-off (see Chapter 9), seemed to harken back to the days when nutrition was primarily a veterinary concern. Africans, Asians, and Latin Americans were, in this iteration of nutrition discourse, a herd grown too large. Whereas in 1920s and 1930s nutrition science had seemed to unite medical and agricultural specialists, later in the twentieth century concerns about the “population bomb” and “demographic entrapment” insinuated that doctor’s tools had outrun the agriculturalists, and were making their work harder. Medicine was saving people who could not be fed. Health services and population health were, in this logic pitted against one another. In their survey reports, neither Platt nor any of the other researchers even entertained such ideas.⁷⁹

IV. Conclusion

This chapter has charted the rise and fall of a certain iteration of the “health is wealth” argument. In this paradigm, an interdisciplinary group of experts became increasingly concerned with labor productivity among African wage earners and farmers. Africans’ reputed lassitude, they believed, could be attributed to toll exacted by parasites and inadequate diets. Researchers proposed programs to remedy these problems. Their prescriptions were focused largely on improving agricultural production and increasing

⁷⁹ For a critique of these theories, see Paul Farmer, Matthew Basilio, and Luke Messac, “After McKeown: The Changing Roles of Biomedicine, Public Health and Economic Growth in Mortality Declines,” in *Therapeutic Revolutions: Pharmaceuticals and Social Change in the Twentieth Century*, Eds. Jeremy Greene, Flurin Condrau, Elizabeth Watkins (Chicago: University of Chicago Press, 2016).

access to health services. Given this focus, and given Nyasaland's centrality to nutrition research, one would think that during this period Nyasaland's Medical Department would have received a growing—or at least a steady—share of government spending.

But when it came to dollars and cents, the interwar period of interest in nutrition as a determinant of productivity, and the oft-repeated claims that health spending was a down payment on development, did not materially affect government outlays for the Nyasaland Medical Department. Despite the enthusiasm expressed by WTC Berry and other researchers, their science did not increase recurrent spending on either medicine or public health. Between 1924 and 1939, the Medical Department's share of total recurrent spending fell, inexorably, from 10.1 percent to 6.5 percent. The slide continued during the Second World War, as the Medical Department's share fell further to 4.1 percent by 1945. The percentage then rose briefly in the immediate postwar dawn, to 7.5 percent in 1946, before falling to a new low of 4.2 percent in 1951 (see Figure 0.2).⁸⁰ The absolute figures of current pounds sterling spent on health generally rose every year during this period, but they increased more slowly than general domestic revenues (derived in large part from ever more enthusiastic campaigns to collect hut taxes from subject African populations) and expenditures. Health spending may have been relatively more important part of colonial budgets during the early twentieth century, when the Colonial Office employed physicians to try to protect the health of the few officials making up the “thin

⁸⁰ Published figures to calculate the share of capital (development) spending devoted to Nyasaland's health sector are not available for each year, but the general paucity of funding to build and renovate hospitals, dispensaries, and training institutions during this period is detailed in Chapter 3.

white line” of the colonial administration.⁸¹ But once the worst of European mortality in the tropics had passed, the argument that “health-is-wealth” was not enough to save the Medical Department from becoming a shrinking priority in colonial budgets.

Of course, the interwar focus on labor productivity did not lead experts to call only for greater spending on medicine. As this chapter has demonstrated, some colonial physicians and planters were enthusiastic about treatments for hookworm and other intestinal parasites. But few thought that African laborers would become more productive by pills and injections alone. The Nyasaland Nutrition Survey was not solely, or even primarily, focused on health care provision. Though Platt initially hoped for a magic-bullet solution to malnutrition (along the lines of his discoveries about beriberi in China), ultimately he and his team focused on “seasonal semi-starvation.” This problem would not be solved by pills or injections, but by increased agricultural production. Yet the survey’s favored strategy to improve both health and agricultural production—the Nutrition Development Units—did not survive wartime austerity. After the Second World War agricultural production became a major focus of the Nyasaland Government (Chapter 6), but public health and medicine would not become a major priority of the colonial government until the anti-Federation movement of the 1950s. Popular politics, and not economic logic, would be the force that drove up government spending for medical care.

⁸¹ Reader, *Africa*; Vaughan, *Curing Their Ills*.

But even during the interwar era, there were political forces that helped increase medical spending in Nyasaland. The next two chapters will demonstrate that officials deciding the health budgets of interwar Nyasaland were more responsive to labor militancy in the UK and the Empire than to scientific treatises on the relationship between health and economic growth. Investments in health resulted from perceived threats to legitimacy, especially labor strikes in Britain and in her Colonial Empire. Budget cuts, on the other hand, often coincided with periods when officials with control over budgets (namely, officials in the UK Treasury) perceived no such threats. Health spending was, almost invariably, a function of unrest.

Chapter 3

“Territories of vast potentiality”: British unemployment, colonial debts, and the subversion of intent to expand Nyasaland’s medical services, 1919-1936

Abstract

Using archival sources from both the United Kingdom and Malawi, this chapter argues that unemployment within the UK was, indirectly, a major impetus for increased spending on health in colonial Nyasaland during the interwar years. Nyasaland’s public finances had been mired in debt since 1919, when a railroad financier convinced the UK government to force Nyasaland’s government to guarantee an onerous loan for a doomed railway line. This debt kept the UK Treasury from approving any sizable increases in expenditure on health care in Nyasaland throughout the 1920s. This only began to change with the 1929 Colonial Development Act. Before the 1929 UK General Election, both Conservative and Labour politicians argued that government spending on roads and railways in the colonies could increase employment in the UK, both by spurring orders from British factories and by opening new markets. During the debate over the 1929 Colonial Development Act, a few backbench MPs worked to ensure that the new funding could be used to build hospitals and clinics in the colonies. At the same time, officials in the Colonial Office in London convinced the Treasury to lessen the spending controls it had placed on Nyasaland as a result of the railway debt. As a result of these two lobbying efforts (and following a 1930 report on Nyasaland’s health sector by Dr. John Owen Shircore), the colony’s Medical Department was able to increase both its recurrent and development expenditure. Many of the district hospitals in Malawi today were built with funds made available by the 1929 Colonial Development Act. Thus did a handful of moral entrepreneurs in the British administration subvert a law’s original intent (to increase employment in the UK through the purchase of British manufactures) in order to ameliorate dismal colonial medical provision. This episode is another demonstration that the history of government health care in Malawi can only be told through a global, contingent and even ironic history of crisis politics.

Prelude: Missing surgeons and a rotting leg

It was not a clean space. Cockroaches scuttled about the floor and on bedframes in the men’s ward of the Mangochi District Hospital. Minutes after the floors were washed each morning, the roaches were back. The nightstands next the beds were cluttered with half-empty bottles of the orange soda hawked by vendors outside the hospital gates.

Nor was the ward a space where anyone could seek privacy. In the large, open green-walled room almost everyone's words were audible, and actions visible. That morning in early February 2015, patients occupied all 36 beds—that is, until an attendant and a nurse wheeled away the covered body of a just-deceased patient. A dozen family and friends followed the stretcher to the morgue. An elderly man with a distended abdomen sat upright, talking to a family member who had just fetched his hospital-provided lunch of *nsima* (maize porridge) and beans. On a nearby bed, a cachectic man with glassy eyes stared blankly at the roof.

But neither the cockroaches nor the other people were of much concern to a 15-year-old boy named Innocent in the ward that morning. Innocent had a far more serious problem: his right leg was rotting. He had been shot a week earlier when, while walking his sister home from school, he happened upon a protest in Monkey Bay and was hit by a stray bullet fired by the local police (for more on the protest, see the prelude to Chapter 4). The bullet had torn straight through his knee, injuring the popliteal artery, which carries much of the blood supply to the lower leg and foot. Friends had taken Innocent to Monkey Bay's government hospital, where he was transferred by ambulance to the larger district hospital an hour drive away at Mangochi. Upon arrival he had undergone emergent surgery to ligate (tie off) the popliteal artery. The site of the injury had been wrapped in gauze. Then he was put into a bed to recover.

This surgery helped prevent him from bleeding to death. But what Innocent really needed in those crucial hours was a vascular surgeon. Though hemorrhaging blood from the torn

artery could have become the life-threatening without ligation, Innocent was almost certainly doomed to lose his leg if blood flow to the lower leg was not restored. Popliteal artery trauma is “the most limb-threatening of peripheral vascular injuries,” but in the United States gunshot victims with this injury can have their limbs salvaged—and blood flow restored—with prompt surgical repair involving a vein graft. Outcomes are particularly good if surgery is performed within seven hours of injury.¹ Vein graft has been the standard of care for American soldiers with popliteal artery injuries since the Korean War in the early 1950s. A 2002 review of 24 published series of 678 penetrating popliteal artery injuries found a mean amputation rate of 11 percent, with lower rates in the more recent series.² Yet this review drew from patients treated mostly in the United States and Europe. On the day Innocent was shot, there were no vascular surgeons in the whole of Malawi, a country of 15 million people.³ There were able vascular surgeons in South Africa, but emergent air evacuations were reserved for expatriate aid workers and government officials, not the children of subsistence farmers. Instead of receiving a procedure that could save his leg, Innocent was literally left in a bed to rot.

Innocent’s right leg steadily deteriorated. First he lost feeling below the knee. Then the skin began to blacken. The toes shriveled and the toenails turned a ghostly silver hue (see Figure 3.1). Ten days after he had been shot, Innocent’s attending physician (who made rounds three times per week) warned him he would likely have to have the leg amputated

¹ Philip Mullenix, Scott Steele, and Charles Andersen, “Limb Salvage and Outcomes among Patients with Traumatic Popliteal Vascular Injury: An Analysis of the National Trauma Data Bank,” *Journal of Vascular Surgery* 44, no. 1 (2006): 94–99.

² Eric Frykberg, “Popliteal Vascular Injuries,” *Surgical Clinics of North America* 82, no. 1 (February 2002): 67–89.

³ Personal communication with Dr. Luckson Dullie, February 2015.



Figure 3.1: Innocent's leg two days before amputation, two weeks after shooting.

soon, to prevent gangrene from ascending from the necrotic tissue to the rest of his body. Two weeks after the shooting doctors wheeled Innocent into the surgical suite and amputated his right leg just above the knee.

After the amputation Innocent was calm, but quiet. He deferred to his ever-present mother when I posed questions. When I asked if he planned to get a prosthetic leg, Innocent looked forlorn. "We would like one," his mother explained, "but it is too much money." A wheelchair would be of little use on the uneven and sandy trails near his home. The doctors in Mangochi had advised Innocent that he would have to let his stump heal for a few months, then he could travel to Queen Elizabeth Central Hospital in

Blantyre to be fit for a new prosthesis. He would have to pay for the prosthesis himself. The cheapest leg available would cost \$250. To Innocent's mother, who farmed a small plot of land just outside Monkey Bay, the idea that she could ever find so much money was absurd. Innocent faced the prospect of a bleak future with no mobility, and—as a consequence—no more school and no more work.

For much of his admission, Innocent lay beside two fellow victims of the Monkey Bay shootings. Felix, 25 years old, had been shot through his right shin, fracturing the tibia in multiple places. The leg had been placed in a cast. Over the coming weeks his condition improved steadily, eventually regaining the use of the toes in his right foot. His biggest complaint was that the medicine he had been given for pain relief lacked *mphamvu* (power). The nurse on duty explained that he was being given pethidine, a powerful synthetic opiate commonly used in Africa even decades after concerns about toxicity and drug interactions have limited its use in the United States. Though this drug should have been strong enough to hold Felix's pain at bay, the nurse administered it at irregular intervals, whenever she got around to seeing him in the course of tending to a ward full of seriously ill patients on her own. But even with this poorly managed pain, Felix seemed on course to make a complete recovery.

The same could not be said for David, a 23-year-old recent graduate of a teachers' training college in Lilongwe. On the day of the shooting, David was back home in Monkey Bay, living with his wife and newborn son and looking for work as a teacher. From his hospital bed he claimed he had not intended to become involved in the protests,

but was caught unaware when the crowd came by. When the police opened fire, a bullet struck David's right leg behind the ankle, rupturing his Achilles tendon. At first glance David's injury did not appear very grave. He had ruptured no major arteries, and had broken no bones. But without a functioning Achilles his leg would be severely weakened for the rest of his life. An avid football (soccer) player, David feared he might never run again. And he would be far less useful in farm labor without two strong legs.

Seeking a remedy, David asked a clinical officer visiting from Queen Elizabeth Hospital if he had any ideas. The clinical officer (a medical provider with more training than a nurse, but less than a doctor) was in a training program for plastic surgery, and claimed some experience in relevant procedures. He said he could try to re-attach the two torn ends of David's tendon (a procedure known as reanastomosis). But, the clinical officer continued, he would only do so "in private"—that is, in exchange for an under-the-table payment. David hurriedly cobbled together 8000 kwacha (about US\$30). He obtained most of it from his *malume*, his mother's brother, a relation who held great responsibility among the matrilineal, matrilocal peoples of southern Malawi.

But the operation had failed. The surgeon explained later that the gap between the two pieces of tendon was too long to allow for reanastomosis. In such cases, surgeons in the United States and Europe often use tendons harvested from elsewhere in the body (such as the bottom of the foot) to reanastomose ruptured Achilles' tendons, but the clinical officer admitted he was unfamiliar with these procedures. In the coming months David

would continue to seek a surgical remedy. The visiting clinical officer offered to try again, “in private.”

The absence of surgeons trained in orthopedics and vascular procedures worsened the outcomes for David and Innocent, respectively. If they had lived near such specialists, both might have left the hospital with full use of both legs. As it turned out, neither would. David departed for home with a much-weakened right leg, and Innocent was discharged with a stump. Innocent said he hoped for a prosthetic leg, but he was not at all certain he would ever have one. For his part, David sounded surprisingly world-weary for a man so young. I asked whether he would seek a tendon transfer. “We will see,” he shrugged.

I. Introduction: subversion of intent in metropolitan politics

While the previous two chapters kept focused largely on events within Nyasaland, in the next four chapters the lens will turn increasingly to metropolitan Britain and other parts of the Empire. These chapters will re-examine an older historiography (written mostly in the 1970s and 1980s) on the politics of interwar and immediate postwar British colonial development spending. I will argue that, in both eras, the main enemies of colonial physicians and African medical assistants were not microbes of the gut and blood, but the longstanding parsimony of the UK Treasury. Officials seeking the funding increases they needed to purchase chemotherapeutic agents, diagnostic equipment, and even food and bed sheets could do so only through the deft manipulation of political crises elsewhere.

The first such manipulation occurred during and after the passage of the 1929 Colonial Development Act (CDA), discussed in this chapter. The Act was the culmination of a long-standing project of Conservative Colonial Secretaries Alfred Milner and Leo Amery. Their intent was to free up funds from a famously obstinate Treasury to build railways, roads and bridges in Britain's Colonies, thereby increasing trade and employment both in Britain and her dependencies. Much of the historiography on the CDA has evaluated to what extent the act fulfilled this original aim. But what much of this work overlooks is the subversion of the law's original intent by moral entrepreneurs, including British politicians and colonial administrators with an interest in improving colonial health services. A few little-known Members of Parliament amended the CDA to allow the Fund to be used to improve and expand health services. Once the bill was passed, the Colonial Office sought to use the new funding to build more hospitals and health centers, particularly in Nyasaland. A colonial physician and administrator named John Owen Shircore wrote both a critique of the low quality and poor reach of Nyasaland extant health services, and a plan to improve them. This report helped garner funding sufficient to fund the construction of 12 new district hospitals and 36 additional dispensaries. Even today, most of Malawi's major hospitals can trace their construction to this tranche of funding. This chapter recounts a history of constructed scarcity, punctuated by a brief moment of increased infrastructure spending.

II. The yoke of an odious debt

a) Larcenous development: the Trans-Zambesi Railway loan guarantee, 1919-1922

The paucity of government medical provision in Nyasaland only began to change in the early 1930s, after the colony became a major beneficiary of the 1929 UK Colonial Development Act. Most histories of colonial development in Africa tend to downplay the significance of the 1929 Act; its passage did not mark a newfound willingness by the UK Treasury to spend much greater sums on African colonies, especially after the Great Depression led to further budget controls.⁴ But for Nyasaland's Medical Department, funding from the Colonial Development Act was a major windfall. Many of Malawi's current district hospitals were first constructed with funds from this Act. The government health sector in Nyasaland saw such a disproportionate share of the Act's funding because of persistent advocacy from medical officials in Nyasaland.

In order to understand the profound departure that the Colonial Development Act funding represented for Nyasaland, it is necessary to review the fiscal administration of the Protectorate by the British during the interwar years. Just after the First World War, UK Colonial Secretary Lord Milner and Chancellor of the Exchequer Austen Chamberlain agreed to guarantee debt taken on by Mozambique Company (a private corporation funded by British investors) for the construction of a railway line (known as the Trans-Zambesi Railway, or TZR) to run entirely outside Nyasaland, from the port of Beira to the southern bank of the Zambesi River in Portuguese East Africa.⁵ The railway line was an impractical one, creating a route too long to transport goods for a reasonable price

⁴ L. J. L. Nthenda, "H.M. Treasury and the Nyasaland Administration, 1919-40" (Thesis PhD--Oxford University, n.d.); D. J. Morgan, *The Origins of British Aid Policy, 1924-1945* (BRILL, 1980); E. A. Brett, *Colonialism and Underdevelopment in East Africa: The Politics of Economic Change, 1919-1939* (London: Heinemann, 1973).

⁵ From the south bank of the Zambesi, goods would be transported across the river, and then loaded onto an existing rail line connecting Beira to Port Herald (today, Nsanje).

between Nyasaland and the Indian Ocean. It was a route much longer and costlier than another possible route terminating further north, at Quelimane. The uneconomical nature of the line is evidenced by the company's failure to raise private capital sufficient to finance its construction.⁶ But Libert Oury, the Mozambique Company chairman and financier who deliberately kept a low profile, lobbied hard for British government financing; a line commencing at Beira would increase the profitability of his company, which had a number of financial interests in Beira. Oury appealed to Colonial Secretary Alfred Milner, arguing that the line would run entirely through British-held territory.⁷ Milner was also concerned about rumors of American financiers planning to build a different railway in the region held by the Mozambique Company, and sought to preempt them with a British railway in order to cement British dominance in the region.⁸

Not for nothing was Oury known as "the other Rhodes." The British Consul in Mozambique called him "a financial spider sitting in the midst of his web in London."⁹ In

⁶ Leroy Vail, "The Making of an Imperial Slum: Nyasaland and Its Railways, 1895–1935," *The Journal of African History* 16, no. 1 (1975): 89–112. Page 100.

⁷ Landeg White, *Bridging the Zambesi: A Colonial Folly* (London: The MacMillan Press, 1993). Pages 42-44, 57-59.

⁸ A letter from HJ Read, Under-Secretary of State for the Colonies, to the Treasury Department explained that while the Colonial Office had publicly offered reasons the construction of the TZR line was in the interests of Nyasaland, "there are other considerations (which can be stated only confidentially) which led Lord Milner to propose, and the Chancellor of the Exchequer to accept, the arrangement now made" without the knowledge or consent of the Nyasaland Government. "On grounds of high policy it is very necessary that this country should lose no opportunity of strengthening its position in Portuguese East Africa, and the construction and operation of this line under what, in practice, will amount to British control is an important step in that direction. It is known that American capital is beginning to interest itself in this region, and there was good ground for suspecting that if the present arrangement could not be completed, and completed very promptly, the Portuguese Government would turn to American financiers." HJ Read to Secretary to the Treasury Department, 18 August 1919, T 1/12467, UKNA.

⁹ White, *Bridging the Zambesi*, Page 43. For a broad overview of the ties between finance capital and British colonial policymakers during this era, see PJ Cain and AG Hopkins, "Gentlemanly

the course of his campaign Oury plied a former Nyasaland governor, Sir Alfred Sharpe, with partnerships in a few of his many firms, including the Mozambique Company.¹⁰ Sharpe had many friends in the Foreign and Colonial Offices, and was a member of the St. Stephen's Club, a famous Westminster watering hole for Conservative Party politicians. Oury also organized regal dinners in Zomba to curry favor with officials. Yet he could not secure the support of Governor George Smith, nor could he win over most of the white settlers in Nyasaland. The latter feared (correctly, as it turned out) that they would ultimately bear a much of the cost of such an unprofitable venture. Oury did not despair, though, for he knew that the decision would ultimately be made in London (Figure 3.2).

Indeed, by 1919 Oury had convinced Milner to support his plan. In decision pivotal to Nyasaland's future finances, Milner decided—without consulting the Nyasaland administration—to guarantee the railway financiers an annual rate of return of at least 6 percent for 25 years. Milner claimed, initially, that the UK Treasury would underwrite the guarantee. But the Treasury decreed that Nyasaland would guarantee the debt itself. If Nyasaland's government should be unable to cover the losses from current revenues (80

Capitalism and British Expansion Overseas II: New Imperialism, 1850-1945," *The Economic History Review* 40, no. 1 (February 1987): 1–26.

¹⁰ White, *Bridging the Zambesi: A Colonial Folly*. Oury made Sharpe a director of the Mozambique Company, the Zambesia Mining and Development Company, and Beira Works Ltd. See Robert B Boeder, *Alfred Sharpe of Nyasaland, Builder of Empire* (Blantyre, Malawi: Society of Malawi, 1981). Sharpe continued to promote the interests of railway financiers (to the detriment of Nyasaland's government finances) after 1922. See Charles Ponsonby, "Nyasaland," *Journal of the Royal African Society* 74, no. 3839 (June 18, 1926): 734–52.



Photo: E. N. A.

TRANS-ZAMBEZIA RAILWAY

Not only has this railway inaugurated a new epoch of economic prosperity for Nyasaland by providing it with direct access to an ocean port, but it has also opened up a region of great forests, a sportsman's paradise wherein the elephant, the lion, the rhino and the antelope have roamed since the beginning of Time.

Figure 3.2: Trans-Zambesi Railway poster, 1925. Source: Exclusive News Agency, London. The caption reads: "Not only has this railway inaugurated a new epoch of economic prosperity for Nyasaland by providing it with direct access to an ocean port, but it has also opened up a region of great forests, a sportsman's paradise wherein the elephant, the lion, the rhino and the antelope have roamed since the beginning of time."

percent of which were derived from the African hut tax in 1917), the Protectorate would be forced to take out loans at 7 percent interest.¹¹

c) Treasury control and starving social services

Sure enough, the railroad quickly racked up operating losses.¹² As early as 1921, a junior Treasury official gave a pessimistic appraisal of the line's financial prospects, and blamed the Colonial Office for misunderstanding—and even misrepresenting—the project. “When the question of the guarantee was under consideration [the] Colonial Office expressed the opinion that the guarantee would cease to be operative after the line had been working a year or two. I understand however it is now expected that the guarantee will be operative for many years.” After insinuating that Lord Milner had deceived the Chancellor of the Exchequer about the line's future profitability, the Treasury dismissed the Colonial Office's plea that the Imperial Exchequer indirectly assume responsibility for payments that would otherwise be a tremendous burden on Nyasaland's budget for the foreseeable future.¹³

¹¹ Vail, “The Making of an Imperial Slum.” The upshot, as Leroy Vail, was that “in spite of the fact that Nyasaland had not been consulted, in spite of the fact that the railway was to lie wholly outside the Protectorate, and in spite of the fact that the line gave no promise that it would ever pay its own way, the imperial authorities, without consulting Parliament, compelled the Nyasaland government to guarantee the interest at 6 percent for £1,200,000 worth of debentures for twenty-five years.” Page 102. Also see White, *Bridging the Zambesi: A Colonial Folly*. Pages 58-59.

¹² GH Pirie, “The Decivilizing Rails: Railways and Underdevelopment in Southern Africa,” *Journal of Economic and Social Geography* 73, no. 4 (August 1982): 221–28.

¹³ F. Skevington “Memorandum by Mr Skevington re: Estimates of the Nyasaland Protectorate for the year 1921-22,” February 9, 1921, T 161/91, UKNA. The insinuation that Milner had been misleading came in this passage: “It is not clear whether all the facts were put before the chancellor by Lord Milner.”

Nyasaland's government suddenly faced a future of inordinate payments for a loan guarantee that they had had no hand in crafting, and that would scarcely benefit either its African or European population. Following a 1921 agreement between the UK Colonial Office and Treasury, Nyasaland was forced to devote one-half of annual revenues over a protected "standard revenue" of £275,000 toward the loan guarantee. Whenever Nyasaland's Governors wrote to complain about the burdens of this arrangement, and the impediments it placed on sorely needed increases in expenditures (including spending on the medical department), Treasury officials repeated their calls for further tax increases and spending cuts.¹⁴ By 1928, the protected 'standard revenue' that Nyasaland could devote toward its own expenditures before spending half of additional revenues on the paying off the TZR loan had only been raised slightly, to £300,000.¹⁵ As Harold Philips, who had worked as both assistant district commissioner and Financial Secretary in Nyasaland, remembered, "Treasury control [was] a horrible thing...they couldn't spend a penny unless it had first been approved by some backroom boy in London [who] didn't know a thing about it."¹⁶

In July of 1928, Colonial Secretary Leo Amery complained to Chancellor of the Exchequer Winston Churchill that Nyasaland's "social services are at a scandalously low ebb" and the "death rate is disgraceful." Reporting the results of a meeting between his subordinates and lower-level Treasury officials, he recounted, "We asked for some little mitigation. But we were turned down by the Treasury pretty stiffly." Churchill's Treasury

¹⁴ L. J. L. Nthenda, "H.M. Treasury and the Nyasaland Administration, 1919-40." Page 256.

¹⁵ Ibid. Page 258.

¹⁶ Glyn Jones et al., Colloquium on Nyasaland Finance, April 23, 1980, Mss.Afr.s.1742, Box 1, File 27, BLOU.

offered a slight increase in the protected revenue to £325,000, but demanded in return increases in customs duties on “native” goods such as matches, salt, and beads as well as an increase in the hut tax. John B Sidebotham, a budget official in the Colonial Office, said this would place an overly burdensome tax on the people, particularly considering “about 20 percent leave the Protectorate to earn it and the rest suffer from debility.” No agreement was reached. Nyasaland’s Africans seemed doomed to remain impoverished, indebted, and without any robust social services.¹⁷ Such was the assessment of Parliamentary Under-Secretary Ormsby-Gore, who lamented, “The Treasury have for years resisted...any attempts to get Nyasaland out of the slough of despond.” Referring to the desperate need for “wise expenditure on public health, scientific agriculture,” and “education,” Ormsby-Gore declared, “The history of all grant-aided, i.e. Treasury-controlled, dependencies in the last thirty years has always shown the starvation of these life-giving services.”¹⁸

III. The 1929 Colonial Development Act

a) Colonial Development as a remedy for metropolitan unemployment

Nyasaland’s budget and health sector only began to be cleared from the “slough of despond” in 1930 thanks, strangely enough, to rising unemployment in Britain. The succeeding chapters will show how much Nyasaland relied not so much as ideas as on crises (both nearby and far-flung) for boosts in health spending. Such was the case here, where, as the historian Rudolf von Albertini notes, “It was the advent of the economic

¹⁷ L. J. L. Nthenda, “H.M. Treasury and the Nyasaland Administration, 1919-40.” Page 260.

¹⁸ Morgan, *The Official History of Colonial Development*. Pages 39-40.

crisis that brought these proposals into public discussion.”¹⁹ In the months prior to the 1929 UK General Elections, leading members of the governing Conservative Party cast about for ideas to include in their election platform. The election was to be fought largely on the issue of unemployment; widely publicized statistics published by the Board of Trade every month showed the number of Britons registering for unemployment insurance rising in late 1928 (from 1.37 million in August to 1.57 million in December).²⁰ Particularly in northern industrial constituencies, Conservative Members of Parliament (and the Unionist Party MPs in their governing coalition) worried about losing their seats to voter frustration over rising unemployment.²¹ Only two years earlier, in 1926, the entire nation had ground to a halt for eight days during a General Strike in which millions of workers took to the picket lines.²² Although labor unrest had quieted significantly since 1926, and even though unemployment was not nearly as grave as it would become in the early 1930s with the onset of the Great Depression, the rising unemployment figures in late 1928 and early 1929 seemed to bolster the electoral prospects of the opposition Labour Party.

In discussions of unemployment measures that the Conservatives might propose, Colonial Secretary Leo Amery repeated an idea that he and his mentor and predecessor, Lord Milner, had been advocating since 1922: to spend Treasury funds to build up

¹⁹ Rudolf von Albertini, *Decolonization: The Administration and Future of the Colonies, 1919-1960* (Holmes & Meier Publications, 1982). Page 103.

²⁰ Paul Denman and Paul McDonald, “Unemployment Statistics from 1881 to the Present Day,” *Labour Market Trends*, January 1996, 5–18.

²¹ Philip Williamson, “‘Safety First’: Baldwin, the Conservative Party, and the 1929 General Election,” *The Historical Journal* 25, no. 2 (June 1982): 385–409. Page 397.

²² Eric L. Wigham, *Strikes and the Government, 1893-1981* (Macmillan, 1982).

transportation networks in colonial holdings. Such a “colonial development fund” would combat domestic unemployment in two ways: first, road and railway construction paid for by the fund would spur orders for factories in Britain, and; second, the new infrastructure would open up new markets for British producers and consumers.²³ A memorandum circulating in Whitehall in October 1928 promised that orders of millions of pounds of railway materials from the UK would reduce “industrial irritation” that could otherwise affect “the Ballot Box to the detriment of the government in power.”²⁴

But Prime Minister Stanley Baldwin was initially non-committal, and Chancellor of the Exchequer Winston Churchill adamantly opposed the departure such a fund would entail from the longstanding policy restricting colonies from accessing UK Treasury funds.²⁵ Churchill proved so obstinate that Amery asked Baldwin to remove Churchill from the Treasury (and to name as his replacement either Neville Chamberlain or Amery himself). Amery did not conceal his derision for what he saw as Churchill’s myopically martial understanding of the Empire: “If Winston could only be induced to go away and wage war somewhere something might perhaps be done.”²⁶

²³ Ian M. Drummond, “More on British Colonial Aid Policy in the Nineteen-Thirties,” *Canadian Journal of History*, no. 6 (1971): 189–95. For Milner’s proposal of an “Imperial Development Fund,” see Viscount Milner, *Questions of the Hour* (London: Hodder and Stoughton Limited, 1923). Page 155.

²⁴ Vail, “The Making of an Imperial Slum.” Page 108.

²⁵ For more on the history of Treasury control over the colonies, see Richard M Kesner, *Economic Control and Colonial Development: Crown Colony Financial Management in the Age of Joseph Chamberlain*, Contributions in Comparative Colonial Studies 7 (Westport, Conn.: Greenwood Press, 1981).

²⁶ Constantine, *The Making of British Colonial Development Policy, 1914-1940*. Page 143.

Eventually, Amery secured the support of other Cabinet members and Party leaders for the colonial development fund. In February 1929 JCC Davidson, Chairman of the Conservative Party and a close confidant of Baldwin's, wrote to the Prime Minister that a large-scale policy of colonial development would not only address domestic unemployment, but also demonstrate that their party was "still full of energy" and "fire the imagination of the country." Amery and Davidson eventually won over their colleagues. In early April, Churchill reluctantly conceded.²⁷

On April 18, Baldwin opened the general election campaign with an address before an audience of 2000 Conservative and Unionist Party loyalists in the Theatre Royal in London's West End. He proposed a Colonial Development Fund as a major part of his party's plan to fight domestic unemployment:

If you sum up what our ideal is—to find permanent employment—you may sum it up in this way, I think: that it is the modernization of industry at home and the multiplication of markets overseas. And that has caused us to look once more at the development of our own Colonies...Overseas, and particularly in Africa, we have territories of vast potentiality, and we want them to develop...and so we shall provide out of our imperial funds such sums as are required—within a maximum, to be attuned by our needs...to pay the interest in the initial years of unfruitful schemes which otherwise must be postponed.²⁸

The Conservatives trumpeted the idea for a Colonial Development Fund in their General Election Manifesto. During Question Hour in the House of Commons in late April,

²⁷ Williamson, "'Safety First': Baldwin, the Conservative Party, and the 1929 General Election." Also see Philip Williamson, *Stanley Baldwin: Conservative Leadership and National Values* (Cambridge University Press, 1999). Page 37.

²⁸ "Stanley Baldwin Speech to Open Conservative General Election Campaign," *The Times (of London)*, April 19, 1929, The Times Digital Archive.

Amery predicted that the fund would be used to build sorely needed roads and railways in British Africa.²⁹

While the Labour Party did not include a Colonial Development Fund in its own election platform, the Fund would come into existence under a new Labour Government. The Conservative Party met defeat in the May 30 General Election, losing 152 of its 412 seats. The Labour Party won 151 new seats to climb to a plurality (though not a majority) of 287. Yet within weeks, the Labour Government took up the Conservative idea of a Colonial Development Fund as an immediate response to unemployment. This was largely the work of “Jimmy” Thomas, a former railway labor organizer and a Colonial Secretary in the first Labour Government (January-November 1924) who had been tasked by the new Prime Minister, Ramsay MacDonald, with coordinating the new government’s response to unemployment. In the first post-election meeting of a committee to address unemployment, Thomas declared his intention to link new development spending in the colonies to job creation at home.³⁰ Thomas did just this in a speech to the House of Commons on July 4, when he previewed an upcoming bill to authorize up to £1 million in annual spending for Colonial development.³¹ By July 11 the Treasury had issued a White Paper explaining the proposal, and on July 12 Thomas moved a resolution to establish both a Colonial Development fund and a Colonial

²⁹ “The Colonial Empire: Lines of Future Development,” *The Times (of London)*, May 1, 1929, The Times Digital Archive.

³⁰ John Gallagher, *The Decline, Revival and Fall of the British Empire: The Ford Lectures and Other Essays*, ed. Anil Seal (Cambridge: Cambridge University Press, 1982). Page 116.

³¹ “Schemes of Work: Mr Thomas on His Plans,” *The Times (of London)*, July 4, 1929, The Times Digital Archive.

Development Advisory Committee to assist the Treasury in judging the merits of applications submitted by colonial governments.³²

b) The fascist vs. the pedant: the debate over including health in the Colonial Development Bill

In their addresses, Thomas as well as Amery and Baldwin had always asserted that physical capital projects—and in particular, roads and railways—were to be the main beneficiaries of this new colonial development funding. Such projects, they promised, would entail large orders of manufactured goods (e.g. steel) for domestic factories, and would decrease shipping costs for primary products (such as cotton) shipped from the colonies to British manufacturers.³³ Health was not in a central feature of either the Conservative or Labour Party leadership’s original vision for the Colonial Development Act.³⁴ Yet historians have noted the curious fact that a surprisingly large portion of the

³² “Colonial Development; Help from Annual £1,000,000 Fund,” *The Times (of London)*, July 11, 1929, The Times Digital Archive; “Parliament: The Colonies and Unemployment; Development Loans,” *The Times (of London)*, July 13, 1929, The Times Digital Archive.; “Memorandum Explaining the Financial Resolution of the Colonial Development Act,” Command Paper (UK Treasury Department, 1929).

³³ Take, for instance, Amery’s address before the House of Commons on April 30, 1929: “If there is to be in East Africa, and, indeed, in other parts of the Empire, a really rapid development of transport, it will be necessary to afford some measure of assistance to the local governments beyond what they can find out of their own slender revenues. The provision of such assistance will be one of the main purposes of the proposed Colonial Development Fund, the creation of which has already been foreshadowed by the Prime Minister. I have no doubt that such a fund...can be made a most potent instrument for accelerating the general development of many regions of the Colonial Empire, and in doing so will contribute not only to the welfare of the inhabitants of the Colonies concerned, but also, both directly in orders for the equipment of railways and other public works, and indirectly in the general expansion of trade, to the creation of much-needed employment in this country.” Leo S Amery, *Colonial Office*, Volume 227 vols., 1929, http://hansard.millbanksystems.com/commons/1929/apr/30/colonial-office#S5CV0227P0_19290430_HOC_279http://hansard.millbanksystems.com/commons/1929/apr/30/colonial-office#S5CV0227P0_19290430_HOC_279.

³⁴ In his April 30 speech before Parliament, Amery mentioned “improving the health conditions of the peoples under our charge” as an activity in which governors were “often splendidly supported by their wives.” It was an ancillary pursuit, important for colonial development only

funding made available by the 1929 Colonial Development Act (16 percent between 1929 and 1940) went to health projects.

Rarely explored in this historiography, however, is exactly *why* such a sizable share of funding originally promoted as a boon for transportation and communication networks was ultimately used to construct hospitals and clinics. To some chroniclers, the use of the Colonial Development Fund for health is evidence of a certain sort of failure. In his five-volume *Official History of Colonial Development*, DJ Morgan writes of the period after the passage of the 1929 Act that “the subsequent move away from emphasis on economic toward concern with social projects serves to confirm the fact that viable economic openings were just not abundantly available in the Colonial Empire as a whole.”³⁵ Yet this characterization overlooks the fact that during the 1929 debates over the Colonial Development Act, a few vocal backbench MPs worked to ensure that the “promotion of public health” was an explicitly authorized purpose of this new funding. The inclusion of health as a major aim of the Colonial Development Fund (CDF) was less a “failure” than a skillful subversion of Amery and Thomas’ original intent to decrease unemployment in the UK. Because CDF health funding would soon prove so important for Nyasaland’s Medical Department, the political maneuvers that effected this subversion of intent will be related here.

insofar as it allowed roads, bridges, and electrical plants to be constructed more expeditiously. One such instance in which health work had proven important took place, Amery recounted, in “the creation of a large hydroelectric power scheme in Perak [in Malaysia],” which was “carried out in a malarial jungle without involving any appreciable sickness among a body of 4,000 workers, a condition which would have been incredible a few years ago.” Ibid.

³⁵ Morgan, *The Official History of Colonial Development*. Pages 41-43.

When the Colonial Development Bill of 1929 was first discussed on July 12, a number of MPs urged that “medical services” should be included in bill’s list of “means” by which the fund could be used to further colonial development. Five days later, when the bill was discussed again, Under-Secretary of State for the Colonies William Lunn addressed these MPs, assuring them that the health services would be provided to laborers on infrastructure projects funded by the Colonial Development Act. Past experience, Lunn claimed, had shown “the wisdom of giving attention to the health conditions of those who labour in these great enterprises, and I think I ought to say that is equally important that health conditions should be considered either in smaller enterprises.”³⁶ He then sought to move swiftly on to other matters.

But one MP was wholly unsatisfied with this clarification. Lord Eustace Percy had served as a Conservative MP from Hastings since 1921. His policy interests lay primarily in health and education, as evidenced by his previous posts as Parliamentary Secretary to the Ministry of Health (1923) and President of the Board of Education (1924-1929).³⁷ Percy argued that the bill, as written, seemed to indicate to future officials (and he might have had niggardly treasury officials in mind) that health projects were not a legitimate use of the bill. If, he explained, grants for development of the health services “are to be permissible under the Bill, [they] will be admissible under Section I (I, 1)—‘any other means.’” But, he continued, “If you mention ‘any other means’ and specify one of those

³⁶ William Lunn, *Colonial Development Bill*, 1929, http://hansard.millbanksystems.com/commons/1929/jul/17/colonial-development-bill#S5CV0230P0_19290717_HOC_354.

³⁷ Philip Williamson, “Percy, Eustace Sutherland Campbell, Baron Percy of Newcastle (1887-1958), Politician and Educationist,” *Oxford Dictionary of National Biography*, n.d.

other means, as is done in the paragraph in the words ‘including surveys,’ we run very great risks of finding that health will be excluded.”

Sir Oswald Mosley, a Labour MP who helped coordinate the new government’s employment policies alongside Jimmy Thomas, answered Lord Percy. “I hope,” he said, “I can give some more encouragement than he found in the bill, because the governing words are—aiding and developing agriculture and industry...It should be clear that, where you are dealing with the promotion of industry, the health of those engaged in industry is of primary concern.”

Yet Percy (who, according to a biographer, had a reputation for being “pedantic” and “always ready to magnify small differences”)³⁸ persisted: “I am afraid that, grammatically, I do not find comfort in those words.”

Mosley tried to quell Percy’s concerns with an example. “It is possible to introduce diseases which affect those engaged in industry, and consequently impair those who are thus engaged. Certainly, such diseases as hookworm, which notably impair the efficiency of those engaged in industry, can be dealt with under this bill...It would be a very narrow and very mistaken reading of the purposes of this Bill if the great human element, upon which, after all, all industrial efficiency rests in the first degree, was excluded from its purview.”

³⁸ Ibid.

At this moment, the physician and Unionist MP Vernon Davies entered the fray.³⁹ “Why not include it specifically?” he asked Mosley.

Mosley was not known for his tolerance of criticism. Within three years, he would leave the Labour Party to found the British Union of Fascists. By the late 1930s, he was best known as Adolf Hitler’s chief British apologist.⁴⁰ On this day, Davies’ challenge brought Mosley to exasperation: “I have been trying for some five minutes to explain that it was included. Perhaps I went into such detail in trying to make that explanation that I mystified the honorable member.”

Dr. Davies, though, remained as unconvinced as Lord Percy: “With great respect to the honorable Baronet [Mosley], I do not agree with him.”

Aided by Davies, Lord Percy pressed ahead with his endeavor to include an ironclad provision to ensure health and education were not excluded from the CDF. He sought not only to further the health of European-employed laborers (as Mosley had assumed), but also the health of general “native” populations. Percy called for Mosley to insert two amendments to the Bill that would add the promotion of both education and health of the “native community” to the explicitly listed purposes of the fund.

³⁹ “Obituary: Arthur Vernon Davies, OBE, MB, ChB,” *The BMJ* 2, no. 4261 (September 5, 1942): 297.

⁴⁰ Robert Skidelsky, “Mosley, Sir Oswald Ernald, Sixth Baronet (1896-1980), Politician and Fascist Leader,” *Oxford Dictionary of National Biography* (Oxford University Press, May 2012).

When debate recommenced on the bill the next day (July 18), Mosley addressed Percy's request. First, he moved to insert "the promotion of public health" as a purpose of the Fund. Second, he contended that the phrase "native community" was not appropriate because it might exclude "white settlers," "Indian settlers" and "Arabs." Finally, Mosley argued that education "does not really fall within the scope of this bill." Education was, he explained, "a most important matter, but it falls under the ordinary colonial administration." Mosley's amendment passed without further discussion. The entire bill was approved by both the House of Commons and the House of Lords, and received the Royal Assent on July 26.

The Commons debate was recounted at such length here because health funding under the Colonial Development Act became such an important part of the subsequent development of Nyasaland's government health sector. In contrast to the previous three decades of colonial rule, the number of government health facilities for Nyasaland's Africans expanded rapidly after the passage of the 1929 act (see below). That the health funding in the act was made possible only by the persistent objections of a "pedant" and a little-known physician in the House of Commons has not yet been fully appreciated in the historiography of the Colonial Development Act. George Abbott critiques the differential treatment of education and public health in the act as one of the "rather glaring inconsistencies" of the Act. This is certainly true; as the next chapter will demonstrate, the absence of funding for education contributed to Nyasaland's shortage of medical providers, even as CDF monies were used to build new hospitals and dispensaries. But Abbott suggests that this exclusion of education was the work of the Colonial

Development Advisory Committee.⁴¹ It was not. The text of the House of Commons debates reveal that the inclusion of health was the work of Lord Percy and Dr. Davies, and the exclusion of education the product of the efforts of Sir Mosley.

The debate also reveals how a few persistent politicians partially transformed a measure sold by Conservative and Labour leaders as an answer to a domestic concern (unemployment) into a fund for the construction of hospitals in the colonies. In 1929 British unemployment was a crisis capable of overcoming the resistance to spending of the UK Treasury (just as colonial labor unrest would prove capable of quelling Treasury objections a decade later, see Chapter 5), but with this “emergency measure” virtually assured of passage Percy and Davies felt no obligation to ensure that the law hewed too closely to this politically potent justification.

IV. The Colonial Development Act in Nyasaland

a) Easing the terms of debt repayment and increased recurrent expenditure

Officials in Nyasaland jumped at an opportunity to secure additional funds. In the autumn of 1929, Nyasaland’s Acting Governor, Wilfred Bennett Davidson-Houston, wrote Lord Passfield, the Labour Government’s Secretary of State for the Colonies (and, prior to his 1929 peerage, a prominent socialist reformer known as Sidney Webb). The Governor informed Passfield that he hoped to submit proposals for funding to the newly established Colonial Development Advisory Committee (CDAC), a group of private eminences and

⁴¹ George C. Abbott, “A Re-Examination of the Colonial Development Act,” *The Economic History Review* 24, no. 1 (February 1971): 68–81. Pages 76-77.

public officials in London tasked with deciding on the merit of submissions to the CDF.⁴² At first prospects did not look good; the CDAC was already considering funding for a massive rail bridge over the Zambesi River, thereby connecting the port of Beira to Nyasaland by a continuous railway line.⁴³ But Nyasaland's new Governor, Shenton Thomas (a former prep school teacher less than three months into his first Colonial Service assignment) insisted that a bridge was not enough. Thomas wrote to the Colonial Office on January 30, 1930, explaining why Nyasaland remained so poor, and what it would take to increase production:

Money is necessary for development and the money has not been forthcoming. And, until the money is forthcoming, the country will not develop, whether the Zambesi Bridge is built or not... Roads in themselves will not produce crops; crops cannot be grown without skilled and systematic agricultural supervision; and that supervision will only be partially effective *unless it is exercised over a healthy population*.⁴⁴

Governor Thomas' main request (upon which he felt the other schemes for assistance were entirely dependent) was to use the Colonial Development Fund to allow for an

⁴² Morgan, *The Official History of Colonial Development*. Page 53

⁴³ This bridge would connect the TZR (which ran from Beira to the southern side of the Zambesi River) with another, older railroad that ran between the northern side of the Zambesi and the southern Nyasaland city of Port Herald. The bridge would obviate the need for ferry transport across the river. Though this project would ostensibly aid producers in Nyasaland, most settlers did not want to see it built; they believed (as it turned out, correctly), that the debts they would be made to pay would vastly outweigh any gains to trade. Colonel Josiah Wedgwood, a Labour MP, channeled these critiques (and pointed to the influence of Oury and other financiers-cum-railroad-boosters) in a speech to the House of Commons in 1929: "Nyasaland is a very small colony, and the people there with one accord have emphatically protested over and over again against being saddled with the Zambesi Bridge. The demand for this work does not come from the people who are to pay, or even from the people whose goods are to be transported over the railway. The demand comes from the vested interests concerned in the railroads, the port companies, and the land companies around the Port of Beira." Josiah Wedgwood, *Clause 1- Power to Make Advances for the Purposes of Colonial Development*, 1929, http://hansard.millbanksystems.com/commons/1929/jul/18/clause-1-power-to-make-advances-for-the#S5CV0230P0_19290718_HOC_391. Also see White, *Bridging the Zambesi: A Colonial Folly*.

⁴⁴ From Morgan, *The Origins of British Aid Policy, 1924-1945*. Page 53 (emphasis added).

increase in Nyasaland Government's 'standard revenue' from £300,000 to £450,000 for ten years (1930-1939).⁴⁵ The ability to devote domestic revenues to domestic expenditures would, Thomas explained, allow him to increase recurrent expenditure on priority areas such as health. In a February 24 debate in the House of Commons, Leo Amery (by this point an opposition MP) spoke approvingly of Thomas' proposal:

Nyasaland has been a Treasury controlled territory, conducted, as such territories are apt to be, on the absolute minimum of expenditure... If we are to open up Nyasaland and its resources by this new connection with the sea [the Zambesi Bridge], it would be well worth while at the same time relaxing a little that extreme rigour which limits its medical services, its sanitary services, and its general administrative services.⁴⁶

The CDAC approved of Thomas' proposal at their meeting in March and urged expedited negotiations with the UK Treasury, who still held sole power over Nyasaland's standard revenue arrangement. Under-Secretary of State for the Colonies Sir Samuel Wilson lobbied Treasury Secretary Philip Snowden in a letter dated April 11. Wilson argued for a clean break with the parsimonious approach of the past decade:

It is recognized that any Power which takes the responsibility of governing uncivilized races should, in the words of the League of Nations, 'apply the principle that the well-being and development of such peoples form a sacred trust of civilization.' In this duty British control has failed. The natives are underfed and under paid... such important social services as medical and sanitary work... have been so restricted as to fall far below the standard normally attained by backward British Dependencies.... The Protectorate should at least be maintained in a condition to avoid the grave public discredit which would attach to Her Majesty's Government, both in this country and abroad, should the present scandalous state of Nyasaland attract attention.⁴⁷

⁴⁵ L. J. L. Nthenda, "H.M. Treasury and the Nyasaland Administration, 1919-40." Page 272.

⁴⁶ Leo S Amery, *Colonial Office*, 234 vols. (February 24 1930, n.d.), http://hansard.millbanksystems.com/commons/1930/feb/24/colonial-office#S5CV0235P0_19300224_HOC_504.

⁴⁷ Morgan, *The Origins of British Aid Policy, 1924-1945.*, 55-56.

This time, the Treasury agreed. Nyasaland's standard revenue rose to £450,000, freeing it to spend more of the customs duties and hut taxes raised within the Protectorate on domestic services rather than on the TZR loan guarantee. Nyasaland's recurrent expenditure on health rose immediately. After barely budging during the 1920s—rising only from £29,804 in 1924 to £33,191 in 1928—it increased to £42,496 in 1930, then to £49,138 in 1934. But the health sector did not receive an outsized portion of the increased domestic spending. Though absolute spending rose, the share of recurrent government expenditure devoted to health fell slightly, 10.1 percent in 1930 to 9.0 percent in 1934.⁴⁸

b) For once, London demands more spending on health

Even more important for Nyasaland's health sector was the development expenditure (spending on new buildings and equipment) made possible by the Colonial Development Fund. During the campaign to raise Nyasaland's standard revenue, Governor Thomas also prepared a set of specific developmental schemes for CDAC consideration. In late 1929, he sent a circular to each of his departments—including the Medical Department—asking for proposals for development schemes consistent with the aims of the Colonial Development Act.⁴⁹ Director of Medical Services FE Whitehead's proposal was included in the Governor's January 30, 1930 despatch to the CDAC, and were considered at a meeting on May 7. Thomas had included proposals for an agricultural laboratory, veterinary extension services, and telegraph and telephone improvements.⁵⁰ Whitehead's

⁴⁸ RD Bell, "Report of the Commission Appointed to Enquire into the Financial Position and Further Development of Nyasaland," Colonial Office No 352 (London: His Majesty's Stationary Office, 1938), Box 3, No 20, SoMA. Page 174.

⁴⁹ L. J. L. Nthenda, "H.M. Treasury and the Nyasaland Administration, 1919-40." Page 263

⁵⁰ Morgan, *The Origins of British Aid Policy, 1924-1945*, 55.

proposal requested a total £80,596 for the Medical Department, with this funding to be split roughly equally between renovation of existing hospitals and dispensaries and construction of new facilities.⁵¹

Not everyone in Whitehall was enthusiastic about the scale of this proposal. Sir John Campbell, financial advisor to Lord Passfield, objected to Governor Thomas' suggestion, included in his letter to the CDAC, that in promoting the cause of European medicine in Africa "we should aim at nothing but the best." Campbell's penned a rejoinder: "Financial considerations cannot be disregarded; they are, in fact, all-important. One must cut one's coat according to one's cloth...If Nyasaland attempts to develop on what one may call 'European' lines, the attempt will fail, for the finances of the country will not stand it."⁵²

But Blakett's CDAC had the opposite reaction; they thought Whitehead's proposal lacked sufficient ambition. While they approved many of Nyasaland's other proposals, the CDACs sent the Colonial Office a request for a more comprehensive four-year program of medical and sanitary improvement in Nyasaland. They hoped for a new plan, more ambitious than Dr. Whitehead's, that would reflect the new reality of increased standard revenue and, as a result, the capacity for higher recurrent expenditure. The CDAC letter indicated that the new plan should expand the government's work in public health and sanitation (though not at the expense of previously proposed expenditures on

⁵¹ FE Whitehead, Memorandum by the Director of Medical and Sanitary Services to the Colonial Development Advisory Committee, January 30, 1930, CDAC 525/136/15, Files 117-148.

⁵² "Minute by Sir John Campbell," April 22, 1930, CDAC 525/136/15, UKNA.

curative medicine).⁵³ This encouragement to request *more* funding for health was unprecedented in Nyasaland's relationship with Whitehall, and would scarcely be repeated again.

The CDAC's appetite for health spending (and, in particular, for public health and sanitation) was, in large part, a result of its members' personal interests. This was particularly true of the CDAC's Chairman, Sir Basil Blackett, the Calcutta-born son of missionaries who had worked for decades as a finance expert in the British civil service. Blackett's interest in health was evidenced by his service as President of the British Social Hygiene Council, a government-funded body known before 1925 as the National Council for Combating Venereal Diseases.⁵⁴ In 1932, Blackett published "A Layman's Plea for a Positive Health Policy," a pamphlet in which he argued for far greater emphasis on health education and preventive measures in the United Kingdom.⁵⁵ During Blackett's years at the helm of the CDAC, proposals for projects to improve curative medicine and public health projects in the colonies were *both* warmly reviewed and frequently approved. For instance, during fiscal 1930-31, health accounted for 18 percent of grants approved by the CDAC. In 1931-32 this figure rose to 44 percent.⁵⁶

⁵³ "Letter from LB Freeston (Secretary to the CDAC) to Under Secretary of State, Colonial Office," 9 May 1930, CDAC 525/136/12, UKNA.

⁵⁴ Jeremy Wormell, "Blackett, Sir Basil Phillott (1882-1935), Civil Servant," *Oxford Dictionary of National Biography* (Oxford University Press, 2008).

⁵⁵ Basil Blackett, "A Layman's Plea for a Positive Health Policy," July 1932, MH 55/2, UKNA.

⁵⁶ Neal R Malmsten, "British Government Policy toward Colonial Development, 1919-1939," *The Journal of Modern History* 49, no. 2 (June 1977): D1249-87. While health schemes would claim a relatively percentage of approved aid in the two years after Blackett's death in a car crash in 1935 (25 percent in 1936-37 and 31 percent in 1937-38), Malmsten argues that does not reflect the CDAC's increasing appetite for health schemes, but rather the approval of two large applications during those years.

The CDAC's request that Nyasaland in particular needed to spend more on health was supported by prominent figures in the Labour Government. Under-Secretary of State for the Colonies Thomas Drummond Shiels, a Scottish physician known for his sympathy for black African nationalists politicians and trade unionists,⁵⁷ chaired a sub-committee of the CDAC devoted specifically to advancing "the use of a portion of the Colonial Development Fund for the promotion of public health in the Colonial Empire."⁵⁸ On June 26, 1930, Shiels spoke in the House of Commons of the need for CDF support for health services in Nyasaland:

The terms of reference of the Fund were broadly drawn, and it has been found possible to include in the schemes towards which assistance can be given schemes to develop and assist the public health service... There is no doubt that we have been hampered, especially in certain Colonies, such as Nyasaland, because of the former parsimoniousness of the Treasury, but we are now hopeful that in Nyasaland and other parts we may be able, with the help of the Colonial Development Fund, not only to assist in public health but also in the training of subordinate medical personnel and of midwives and in other ways to meet the very real need to which honorable Members have called attention.⁵⁹

Even Snowden's Treasury echoed this encouragement, suggesting that Lord Passfield request from Governor Thomas "a complete scheme of development within the additional funds that will be available." Among the priorities set out by the Treasury for the

⁵⁷ WWJ Knox, "Shiels, Sir (Thomas) Drummond (1881-1953), Physician and Politician," *Oxford Dictionary of National Biography* (Oxford University Press, 2004).

⁵⁸ "Report of the Colonial Development Public Health Committee," Colonial Office, July 1930. CO 323/1090/1, UKNA, page 4.

⁵⁹ Thomas Drummond Shiels, *Colonial Office*, Vol 240 vols., 1930, http://hansard.millbanksystems.com/commons/1930/jun/26/colonial-office#S5CV0240P0_19300626_HOC_453.

development scheme were “measures to improve the physical condition of the natives” so as to facilitate increased production.⁶⁰

By this point, neither Shiels, nor Blackett, nor even the Treasury felt compelled to demonstrate any proof that colonial health schemes would aid employment in Britain. With the bill passed, and the funds authorized, the Colonial Office finally felt freed to pursue development as it saw fit. This was a short-lived feeling, as we shall see—by 1931, the deepening of the Great Depression would severely restrict their imaginations. But for the moment, the prevailing sentiment in Whitehall was—for once—to think big. Lord Passfield’s message to all Colonial and Mandated Territories of August 10, 1929 had informed them that schemes need not promise immediate economic returns, but they should be submitted as quickly as possible.⁶¹ In 1930, the CDAC complained, in its first interim report, that the schemes being submitted were both too few and too unambitious. The Colonial Office responded by setting up a special committee to deploy public health specialists to the colonies to devise larger plans for submission to the CDAC.⁶²

V. The Shircore Report of 1930

a) John Owen Shircore

Seeking an ambitious scheme for Nyasaland in short order, the Colonial Office committee requested the assistance of Dr. John Owen Shircore, the Director of Medical Services in Tanganyika. Shircore was, by 1930, an experienced hand. The son of a

⁶⁰ Morgan, *The Official History of Colonial Development.*, Page 55

⁶¹ *Ibid.*

⁶² *Ibid.* Pages 47-48. Also see Shiels, *Colonial Office.*

Captain in the Indian Medical Service, he had studied in Edinburgh, London and Cambridge before joining the Colonial Service in 1908. Shircore had worked in the northern Nyasaland town of Karonga as a medical officer, then in the East African Medical Service during the First World War. After the war Shircore oversaw the establishment of a new Medical Department in the former German territory of Tanganyika, first as Deputy Principal Medical Officer then, beginning in 1924, as Principal Medical Officer.⁶³ There he launched massively popular voluntary chemotherapeutic campaigns, treating more than 374,584 cases of yaws and 72,377 cases of syphilis with a preparation of bismuth sodium tartrate and soamin (an arsenical) that he had devised himself.⁶⁴ Shircore's work in Tanganyika demonstrated that he was by no means blind to persistent Treasury concerns over cost containment; one of the major advantages he saw in his own injection for yaws and syphilis was that its cost was far lower than salvarsan, while being just as effective.⁶⁵ But he was also aware that both cost-cutting measures and ill-conceived mass interventions could do more harm than good. In dealing with sleeping sickness Shircore argued against tryparsamide monotherapy, since in high doses the drug often caused atrophy of the optic nerve (and consequent vision loss) or even death. Instead, he advocated dual therapy with lower doses of tryparasamide alongside suramin, a drug with less frequent, though still serious, side effects. Shircore also advocated individual examination of the sick over "wholesale

⁶³ "Obituary: John Owen Shircore, C.M.G., M.B.Edin., M.R.C.P.E.," *The Lancet*, July 11, 1953, 94.

⁶⁴ Shircore, "Yaws and Syphilis in Tropical Africa: Mass Treatment with Bismuth-Arsenic Compounds."

⁶⁵ *Ibid.*

blood examination of village populations,” which “tends to destroy the confidence of the people...which results in obstruction and the concealment of cases.”⁶⁶

b) A scathing critique and a plan for expansion

Shircore arrived in Zomba on August 9, 1930. Setting immediately to work, he covered more 1000 miles by motorcar in 40 days, visiting native hospitals, European hospitals, and dispensaries across the colony. Decades later, an obituary for Shircore would note that some colleagues had found his demeanor “detached.” But in his report on Nyasaland, submitted on September 20, Shircore’s tone was clear in its appraisal and passionate in its call for far greater funds. “It may be stated,” he stated in his introduction, “that, with the exception of an almost negligible addition of staff and a few beds to some of the hospitals, little progress had been made until the year 1929...The department is merely in embryo.”⁶⁷ He recommended a significant increase in development expenditure, totaling £110,325 over the coming four years.⁶⁸

Shircore explained his recommendations by prefacing them with rather bleak assessments of Nyasaland’s medical personnel and facilities for Africans. Shircore considered European hospitals “adequate for their purpose.” But such was not the case for African hospitals. Taken together, these hospitals contained only 170 beds for an estimated

⁶⁶ Ibid.

⁶⁷ John Owen Shircore, “Report on the Nyasaland Medical Service with Special Reference to a Grant Under the Colonial Development Fund” (Zomba, Nyasaland: Government Printer, 1930), Box 15, No 2, Society of Malawi Archive. Page 3

⁶⁸ Ibid. Page 18

African population of 1.4 million in 1930.⁶⁹ Patients were housed in a wattle and daub hut in Chikwawa and in “dilapidated” buildings in Fort Manning and Kota-Kota. The health facilities were too poorly funded, Shircore believed, to gain the confidence of the native people:

The accommodation at the African hospitals is entirely disproportionate to demand... Drugs are adequate, but medical and domestic equipment, such as beds, blankets, sheets and pillows, require thorough overhauling. Similar remarks apply to the allocation of funds for the upkeep of patients. Africans, unless dangerously ill or destitute, will not apply for the treatment as in-patients or stay in hospital unless reasonably well provided with food and comfort. Additional wards at the established centres, likewise new hospitals, are urgently required.⁷⁰

Shircore proposed substantial increases in facilities, staff, equipment and training over the four-year period covered by the report. The largest line item, new facility construction, included the construction of seventeen new African hospitals: 12 would have 30 beds each and cost £2,050; four would have 50 beds each and cost £2,800; and one (in Zomba) would have 100 beds and cost £7,194. He also proposed a new European Hospital in Lilongwe, with 6 beds and a cost of £1,085. He recommended adding 36 new dispensaries—costing £300 each—to the existing stock of 83. In addition, Shircore recommended five new maternity and child welfare clinics, each with 12 beds, an operation room, a dispensary and an outpatient room, to be staffed by a European Health Visitor and four female African Maternity Assistants (£700 each).⁷¹ Medical and surgical supplies and equipment, including X-ray machines, were to be purchased for the major hospitals.

⁶⁹ “Annual Medical Report on the Health and Sanitary Condition of the Nyasaland Protectorate for the Year Ending the 31st, December, 1930” (Zomba, Nyasaland: Government Printer, 1931), Box 15, No. 24, Society of Malawi Archive.

⁷⁰ Shircore, “Report on the Nyasaland Medical Service with Special Reference to a Grant Under the Colonial Development Fund.” Page 5

⁷¹ Ibid.

Shircore also recommended more than doubling recurrent expenditure on personnel. This would allow for an increase in the number of medical officers from 11 to 18. Such an increase would, Shircore argued, greatly increase productivity, as it would reduce the share of time medical officers spent traveling long distances (often up to 150 miles) to see a single European patient. The number of sub-assistant surgeons was to be increased from 8 to 20 using recruits from Bombay. This class of providers completed the same curriculum as medical graduates in Great Britain, but they could be employed at far lower cost.⁷² A Bacteriologist was to be hired, and a properly equipped laboratory constructed. The Sanitation Branch was to be expanded to two European health officers and 80 African sanitary inspectors.

Shircore's most expansive increase in staff would come in the cadre of African Hospital Assistants. In the short term, he recommended an immediate increase in the number of African Hospital Assistants from eight to 18. Then, over the following ten years, he planned to have Hospital Assistants replace the existing dispensers. "The majority of the dispensers," he claimed, "possess no knowledge of drugs and merely dole out stock mixtures."⁷³ Instead of barely trained dispensers he sought a hospital assistant at every

⁷² Ibid. Shircore noted that his staff in Tanganyika included 58 sub-assistant surgeons, more than 8 times greater than the number in Nyasaland for an African population less than four times its size. The starting salary in 1929 for sub-assistant surgeons in Tanganyika was £240 per year. The starting salary in 1930 for medical officers in Nyasaland was £600 per year. See William H Mercer, AJ Harding, and GEJ Gent, "The Dominions Office and Colonial Office List for 1930: Comprising Historical and Statistical Information, Respecting the Oversea Dominions and Colonial Dependencies of Great Britain" (London: Waterlow & Sons Ltd, 1930).

⁷³ Shircore, "Report on the Nyasaland Medical Service with Special Reference to a Grant Under the Colonial Development Fund." Page 4

health facility in the country, and at least one health facility for every 20,000 people. Even assuming zero growth in Malawi's population, this ratio required the cadre of African Hospital Assistants to grow from eight to 70. To reach this figure, Shircore sought to emulate his work in Tanganyika by establishing a Medical Training School at Zomba. This school would replace an arrangement that the government maintained with the University's Mission for Central Africa (UMCA) hospital in Blantyre, where African Hospital Assistants were trained in a four-year curriculum before being placed in the government's employ. Shircore thought a government training school preferable to the subvention of a mission school, where the "atmosphere" and "methods" might differ from the government service and the ability to study at a large central hospital was not available to trainees.

c) Aftermath of the report: plans, realized and unrealized

Shircore's report was not a radical document. His total request for development expenditure was slightly more than £110,000, only exceeding Whitehead's original request to the CDAC by £30,000.⁷⁴ And though Shircore called for improved facilities and staffing at African hospitals, he recommended nothing approaching equality in medical provision for Europeans and Africans in Nyasaland. For instance, the new six-bed European hospital in Lilongwe would cost £1,085—more than half the cost of a 30-bed African hospital—and was to be staffed by a Medical Officer, Nursing Sister, Sanitary Superintendent and Sub-Assistant Surgeon. Indeed as a 1931 Medical

⁷⁴ Ibid. and "Annual Medical Report on the Health and Sanitary Condition of the Nyasaland Protectorate for the Year Ending the 31st December, 1931" (Zomba, Nyasaland: Government Printer, 1932), UMMC. Page 4.

Department report would find, the cost per patient per day was more than two times higher in European Hospitals than in Native Hospitals.⁷⁵

Blackett's CDAC was enthusiastic about Shircore's proposal, and did not accept the notion that there Nyasaland should finance the development of its medical services. The CDAC approved most of the funds requested, allotting a total of £101,410 to Nyasaland's Medical Department.⁷⁶ But the relative optimism did not last for long. During the depths of the Great Depression, the UK scaled back outlays from the CDF.⁷⁷ As the Depression dried up government coffers throughout the empire, calls for ambitious schemes had turned to calls for economies. The Imperial Treasury eventually approved expenditures of only £78,284 for Nyasaland's Medical Department. This amount was less than Nyasaland than Shircore had proposed, and even less than Whitehead requested of the CDAC in January 1930.

Total disbursements from the Colonial Development Fund between its inception in 1929 and October 1940 (when it was supplanted by the Colonial Development and Welfare

⁷⁵ "Annual Medical Report on the Health and Sanitary Condition of the Nyasaland Protectorate for the Year Ending the 31st December, 1931." While European officials and "natives" were not made to pay at the point of care, European non-officials were charged fees. Luke Messac, "Moral Hazards and Moral Economies: The Combustible Politics of Healthcare User Fees in Malawian History," *South African Historical Journal* 66, no. 2 (April 3, 2014): 371–89.

⁷⁶ "Table A: Recommended and Approved Grants to Be Met from the Fund for the Five-Year Period Ending 31 December 1935, in Provision of Medical Facilities," n.d., CO 525/177/1/18, Colonial Office Records, UKNA. Page 74.

⁷⁷ Morgan notes that "official policy swung from the enthusiasm of 1929-1930 to ultra-caution in 1931." In May 1930 a Committee on Public Expenditure recommended cutting the annual limit of funding approved by the CDF from £1 million to £750,000. This figure was eventually cut to £700,000. Morgan, *The Origins of British Aid Policy, 1924-1945*. Pages 51, 59.

Fund) were £6,523,193.⁷⁸ Nyasaland, a colony with three percent of the population of the British Empire in 1930, received 11.1 percent of total funding.⁷⁹ Between 1930 and 1938, Nyasaland received £726,534 in grants from the CDF. The majority of these funds, £500,000, went towards the TZR loan guarantee (to allow for an increase in the standard revenue). Funding for the medical department represented less than 10 percent of Nyasaland's total CDF funding.⁸⁰ Still, the CDF assistance was more infrastructure funding than Nyasaland's medical department had ever received before. Nyasaland was, then, a disproportionate beneficiary of the CDF, which in other colonies was far less significant contributor to public coffers.

By 1938, 12 new hospitals (with a total of 510 beds), 36 rural dispensaries, and 3 maternity and child welfare clinics had been constructed in Nyasaland with CDF monies.⁸¹ A newly constructed Zomba African Hospital was staffed by two medical officers, two nursing sisters, and a pathologist, and equipped with a new laboratory and

⁷⁸ The CDAC recommended assistance totaling £8,875,000, but a sizable portion was never released by the Treasury. Of approved funding, 30 percent went to internal transport and communications, 16 percent went to public health, 10 percent went to water supplies and water power. Morgan, *The Official History of Colonial Development*. Pages 46-47.

⁷⁹ Morgan, *The Origins of British Aid Policy, 1924-1945*. Page 58. Ann Beck concludes that "the Fund's impact on development did not live up to expectations except in those colonies whose administrators were enterprising enough to exploit the funds for special projects." This history has demonstrated why both Nyasaland Governor Shenton Thomas and John Owen Shircore both had a reputation, with good reason, as enterprising administrators. See Beck, *Medicine, Tradition, and Development in Kenya and Tanzania. 1920-1970*. Page 4.

⁸⁰ Bell, "Report of the Commission Appointed to Enquire into the Financial Position and Further Development of Nyasaland."

⁸¹ *Ibid.* Pages 114-115. Shircore had proposed even more hospital construction, calling for 17 new or renovated hospitals and 5 new maternity clinics, in addition to the 36 new rural dispensaries.

X-ray machine.⁸² But while Shircore had called in 1930 for X-ray machines in African hospitals throughout the country, as late as 1945 Zomba remained the only African hospital equipped with one.⁸³

Staffing remained the largest problem in the years following the Shircore report. The number of medical officers rose from 11 in 1930 to 14 in 1933, but it would not exceed 15 until after World War II. Sub-assistant surgeons on government payroll rose from 8 in 1930 to 10 in 1933, but rose no further during the decade. Nyasaland would never rely to the same extent upon sub-assistant surgeons as Tanganyika.

The new development funding and increased recurrent spending, both made possible by the CDF, changed the quantity and quality of medical care at government hospitals in Nyasaland.⁸⁴ In the early 1930s, medical officer Walter Gopsill was deployed to Cholo, an area in the south known for its tea estates. Heretofore the station had only a small outpatient dispensary for a district of 53,000 people. Shircore had called for the construction of a 50-bed hospital, as well as the appointment of a Medical Officer and

⁸² Mkandawire, *Living My Destiny*. Page 87. Also see ADJB Williams, "Annual Medical & Sanitary Report for the Year Ending 31st December, 1934" (Zomba, Nyasaland: Government Printer, April 25, 1935), Box 15, No 20, SoMA.

⁸³ ADJ Bedward Williams, "Post-War Development of Medical Services," 1944.

⁸⁴ Medical officers were still overwhelmed by the scale of the work with which they had been tasked. Speaking of his responsibilities as the sole medical officer in Mlanje in 1941, Gopsill explained: "As well as being in charge of a Hospital containing one hundred beds one was responsible for the control of Epidemic diseases in the area, the medical care of the European population, eight District dispensaries dotted about the district, inspections and care of factory staffs and the general public health of the district, also the inspection of the numerous Indian Stores and of course the Market. In addition one was called out to treat European planters and their families. The African population was well over 100,000." Gopsill, "A Few Notes on My Life in Zanzibar and Nyasaland from 1926 to 1945." Page 34.

African Hospital Assistant.⁸⁵ The funding was ultimately used to erect a 100-bed hospital. Gopsill was also heartened that “the native staff at the hospital had considerably increased and improved.” He worked alongside “well trained dressers, and dispensers, nurses,” and “one boy who showed promise I taught to do blood films and all microscope work, which was of tremendous assistance to me.”⁸⁶ But some aspects of care remained poor. Funding to feed hospital patients was so paltry that Gopsill required inpatients with venereal diseases to supply their own “bags of mealie meal.”⁸⁷ The only time the Medical Stores supplied his hospitals with sufficient bed sheets was just before an official visit by Nyasaland’s Governor.⁸⁸

VI. Conclusion: medicine as byproduct of colonial and postcolonial politics

If Innocent had lived near a vascular surgeon, he might have left the hospital with both legs. The process of training, employing and equipping surgeons is no mystery. But it takes money, and money—as this chapter has shown—is something Malawi’s health sector has long been denied. Innocent’s avoidable amputation was the product of a thousand decisions and omissions that left Malawi without the equipped and trained medical practitioners needed to salvage his leg. Many these causes (such as the exclusion

⁸⁵ Shircore, “Report on the Nyasaland Medical Service with Special Reference to a Grant Under the Colonial Development Fund.” Page 6.

⁸⁶ Gopsill, “A Few Notes on My Life in Zanzibar and Nyasaland from 1926 to 1945.” Page 21.

⁸⁷ Ibid. Page 20. Gopsill did not explain why he singled out VD patients to bear these costs, though it was not uncommon for medical officers to consider such patients responsible for their illnesses. See Berry, *Before the Wind of Change*.

⁸⁸ Gopsill, “A Few Notes on My Life in Zanzibar and Nyasaland from 1926 to 1945.” Page 22. When in 1937, Gopsill was transferred to Karonga, he arrived to another 100-bed hospital built with funding from the CDF in 1932. Shircore had called for a new hospital at Karonga in 1930. Upon his visit to Nyasaland, he had found a medical officer working out of a mud bricked hospital with a thatched roof. See Ibid. Pages 26, 31.

of education from the 1929 CDA) are quite distal, and only come to light with an analysis that is both geographically broad and historically deep.

The focus on health budgets, political economy, and the moral commitments or greed of individual actors might seem a tad retrograde. Since the postmodern turn, Africanists have written about scarcity in medicine, but they have been especially curious about the innovations, improvisations, appropriations, and hybridizations wrought by health providers and patients. This vein of inquiry has inspired rich literatures in both the history of medicine and medical anthropology.⁸⁹

Yet there are pitfalls to this focus, especially when it moves into the realms of policy and practice. Of late, the notions of “reverse and “frugal” innovation (terms imported from business management) have become infatuations in global public health.⁹⁰ The term “reverse innovation” assumes that the flow of innovation has historically flowed from

⁸⁹ Projit Bihari Mukharji, *Nationalizing the Body: The Medical Market, Print and Daktari Medicine* (London; New York: Anthem Press, 2011); Julie Livingston, *Improvising Medicine : An African Oncology Ward in an Emerging Cancer Epidemic* (Durham: Duke University Press, 2012); Hunt, *A Colonial Lexicon of Birth Ritual, Medicalization, and Mobility in the Congo*; Claire L. Wendland, *A Heart for the Work : Journeys through an African Medical School* (London: The University of Chicago Press, 2010); Stacey A. Langwick, “Articulate(d) Bodies: Traditional Medicine in a Tanzanian Hospital,” *American Ethnologist* 35, no. 3 (August 1, 2008): 428–39.

⁹⁰ Shamsuzzoha B. Syed, Viva Dadwal, and Greg Martin, “Reverse Innovation in Global Health Systems: Towards Global Innovation Flow,” *Globalization and Health* 9, no. 1 (August 30, 2013): 36. Syed, Dadwal and Martin are quick to point out that the “West” has, and never has had, a monopoly on innovation, they still embrace the term “reverse innovation.” The term itself was coined by Vijay Govindarajan. See Jeffrey R. Immelt, Vijay Govindarajan, and Chris Trimble, “How GE Is Disrupting Itself,” *Harvard Business Review*, accessed September 17, 2015, <https://hbr.org/2009/10/how-ge-is-disrupting-itself>. Also see Nigel Crisp, Mutual learning and reverse innovation—where next? *Globalization and Health* 10 (2014); 14, and Thomas J Bollyky, “New cheap and improved: assessing the promise of reverse and frugal innovation to address noncommunicable diseases,” Discussion Paper, Council on Foreign Relation, June 2015.

“West” to “non-West.” This is, of course, obscurantist, continuing a long-standing and widespread ignorance about the history of innovations stemming from the “non-West.”⁹¹ In this way, the politics of reverse innovation” are entirely inapposite to postmodern Africanist literatures, even if both share a concern with “innovation.” The politics of the term “frugal innovation” are subtler, but can have insidious side-effects. Extolling “necessity as the mother of invention” runs the risk of downplaying the fact that, now as in the past, the absence of strong health systems leads most often to suffering and death, not the spark of creativity.

Reexamining the history of health spending—or lack thereof—in British colonial Africa does not necessarily require rehashing the same questions. At stake in much of the earlier literature on this subject was the nature of an imagined unitary soul of colonialism: was it benevolent or malevolent? The battle lines were clear; on one side stood the hagiographers, and on the other the radical critics.⁹² Here, though, I treat the British

⁹¹ Londa Schiebinger, *Plants and Empire: Colonial Bioprospecting in the Atlantic World* (Cambridge, Mass.: Harvard University Press, 2007). Also see Abena Dove Osseo-Asare, *Bitter Roots: The Search for Healing Plants in Africa* (Berkeley: University of California Press, 2014).

⁹² For examples of hagiographic accounts by colonial apologists, see such works as Gelfand, *Proud Record*; Gelfand, *A Service to the Sick: A History of the Health Services for Africans in Southern Rhodesia, 1890-1953*. For a canonical and wholesale of colonialism, see Walter Rodney, *How Europe Underdeveloped Africa* (London: Bogle-L'Ouverture Publications, 1972). Frantz Fanon believed that to admit the good that some colonial medicine did would be to concede too much. It would, he feared, allow colonial apologists (like Gelfand) to claim their entire exploitative regime was essentially good. “When the French authorities show visitors through the Tizi-Ouzou sanitarium or the operating units of the Mustapha hospital in Algiers, this has for the native just one meaning: ‘This is what we have done for the people of this country; this country owes us everything; were it not for us, there would be no country.’ There is a real mental observation on the part of the native; it is difficult for him to be objective, to separate the wheat from the chaff...In certain periods of calm, in certain free confrontations, the colonized individual frankly recognizes what is positive in the dominator’s action. But this good faith is immediately taken advantage of by the occupier and transformed into a justification of the

colonial enterprise as simultaneously exploitative, unfree *and* invested with moral fervor and even heroic works. I turn, instead, to more practical, even prosaic questions: when and why did colonial medicine actually reach African subjects? In what form? And with what consequences? The new resources for health discussed in these chapters were, in the scheme of things, paltry. But, as later chapters will demonstrate, the medical facilities constructed in Nyasaland in the early 1930s would in time become important—and highly valued—to millions of people.

occupation... The colonizer perverts his meaning and translate, 'Don't leave, for what would we do without you?'" Frantz Fanon, *A Dying Colonialism* (New York: Grove Press, 1965).Page 122.

Chapter 4

“We have to wait for riots and disturbances”: Budget cuts in a uniquely quiet Nyasaland, 1935-1945

Abstract

This chapter explores the role of political unrest in colonial medical spending. During the mid- and late-1930s, Nyasaland’s Medical Department annual expenditures barely budgeted, even as revenues continued to rise. This was a product, in part, of the perception in Whitehall that Nyasaland was a placid backwater, and therefore did not need the political palliative of health spending. This perception, and the resulting retrenchment in health spending, continued after the *mchape* anti-witchcraft movement swept across the countryside, and even after the return of the millenarian preacher Elliot Kamwana from forced exile in 1937. Looking elsewhere in the British Empire, though, officials saw far graver threats to economic and political stability. Between 1935 and 1940, waves of riots and strikes roiled the oil fields and ports of the British West Indies, the mines of Northern Rhodesia’s Copperbelt, and the cocoa farms of West Africa. This unrest proved capable of stirring the Colonial Office and even the UK Treasury to call for greater health spending as a demonstration of beneficence. The Colonial Office’s connection between unrest and social services spending was forged deliberately. Malcolm MacDonald, the son of the first Labour Prime Minister, became Colonial Secretary in 1938. He played on British anxieties about the future of the Empire to drum up support for the 1940 Colonial Development and Welfare Act. Most of the Act’s initial funding went to perceived centers of unrest, especially the West Indies. Medical administrators in Nyasaland complained bitterly to their superiors, but to no avail; few development funds went to colonies that did not provoke metropolitan anxieties.

Prelude: When the ‘warm heart of Africa’ turns hot: protests against land alienation in a zone of media indifference

Nicotine was dead. The news spread quickly among the crowd gathered on the dirt road outside the Monkey Bay District Hospital. The normally bustling shop stalls hawking sodas and *mandazis* (fried dough) had been shuttered. Policemen and soldiers stood guard inside the hospital gate. Huddled together in small groups, the adults spoke in hushed tones, their eyes downcast. No one wailed with grief, not yet. Those loud lamentations would come a few days later, at Nicotine’s funeral. Incongruously, a girl skipped around blithely in front of the hospital, her face alight with an unknowing smile. A young man

chided her. “*Simuli ndi chisoni?*” (“Have you no sympathy?”). The girl stopped, looked about, and quickly adopted the somber expression shared by all the other faces.

Nicotine was a nickname, given to the good-natured youth in his early 20s because he always seemed to have a cigarette in his hand. This is unusual in Malawi where, although tobacco is the country’s leading export, few can afford a cigarette habit. Nicotine lived with his grandmother, and had recently received a good score on his terminal secondary school exams. One person in the crowd reported having seen Nicotine being beaten by a policeman, while another said he saw blood coming out of his nose.

Earlier that day, people from the fishing village of Masasa had gathered outside a local government building where they had heard that their local hereditary chiefs and elected



Malawian soldiers in combat gear inside Monkey Bay District Hospital after protests. February 3, 2015.

officials were holding a secret meeting with a representative from Mota Engil, a Portuguese multinational construction corporation. The Malawi Government and Mota Engil, a publicly traded company with over \$2 billion in revenue in 2014, had been in talks for months about plans to build a 5-star resort hotel.¹ It was to be, in the words of one Mota Engil promotional article, a “ranch-style resort, with a beautiful pool, a golf course and an inlet connecting the pool to the lake,” to be operated by “a world-famous brand name hotelier.”² To the surprise of government officials, Masasa residents had

¹ “Mota Engil Earnings Release 2014” (Portugal: Mota Engil Group, n.d.).

² European Times, <http://emagazine.european-times.com/EPT-Malawi/transport-and-public-works-mota-engil-global-leader-transforming-malawis-infrastructure>

obtained a copy of closely-held plans showing the resort would displace their entire lakeshore village.

After months with barely any official response to their vocal complaints and well-reasoned petitions, Masasa residents were angry. Most of them had already been displaced seven years earlier from a verdant plot blessed with fertile farmland in order to make room for company housing. Now, they had built modest thatch-roofed huts on the beach, where most eked out a living as fishermen. They knew from experience not to believe those politicians who painted visions of El Dorado, in which the resort would bring jobs for the many. A \$400-per-night lodge, offering snorkeling and water sports, had for years operated near their village. But this reclusive retreat warned residents not to approach if they did not want to risk being shot, and employed only a handful of locals.

The soon-to-be-displaced had been promised monetary compensation, but the plot where they suspected they would be moved was suitable for neither fishing nor farming. And Mota-Engil already had a reputation among rural Malawians for being untrustworthy. In the months leading up to the Masasa protest, another Mota Engil project had run into similar opposition in the nation's southwest, in Neno District. After the Brazilian mining giant Vale subcontracted to Mota Engil to build a railroad from the Moatize coal mine in Mozambique to the coast, Neno residents accused both companies of renegeing on pledges to compensate the displaced with money, schools and health facilities. Hundreds of protestors in Neno had even gone so far as to block the main road leading to the railway

line.³ Masasa residents protesting Mota Engil's machinations with local officials would soon prove just as determined.

When officials left their meeting with a Mota Engil representative on the afternoon of February 3, they were met by an angry crowd. The assembly had been stoked to a furor by a rumor that their own officials had just signed away their land. What happened next was the subject of much debate among local Malawians and cursory press reports (none of which were written on the basis of first-hand knowledge or detailed research). The account that follows is the consensus view of most of the dozen people I interviewed in Monkey Bay. The Masasa protesters destroyed the car of Traditional Authority Nankumba, a car they had heard had been paid for by Mota Engil. Both Nankumba and the Mota Engil representative were bloodied, but not gravely injured, by protestors. The Monkey Bay police deployed quickly from a nearby station, and after being pelted by rocks opened fire on the crowd using live rounds.

The bullets struck eight people. Two would succumb to their bullet wounds, and an additional six would survive after being treated in nearby hospitals. Some of the victims were not even involved in the protest. Just as the officials emerged from their meeting, a nearby secondary school let out. Among those shot (but not killed) were a 14-year-old male student and a 22-year-old man accompanying his sister on her walk home. The two men killed by the police were not even from Masasa. Nicotine lived in another village in

³ <http://www.nyasatimes.com/2014/09/15/brazilian-vales-railway-project-faces-resistance-in-malawi/>

Monkey Bay. The other victim, who died shortly after being transferred to Mangochi District Hospital, was a fisherman from Cape Maclear.

After the shooting the crowd ran, but they were far from finished expressing their displeasure. A few men ran into town and ransacked a local bar owned by Ward Councillor Bulireni. Bulireni had been a local favorite, having run for office unsuccessfully a few times before winning the people over with displays of generosity such as letting people use his truck to drive to funerals. But he was rumored to have signed away the Masasa residents' land to Mota Engil.

Others ran to the home of Chief Njogo, also rumored to have agreed to the land alienation. While Njogo's wife hid in a neighbor's hut, enraged Masasa residents set fire to his kitchen and his outhouse, ripped the doors off their hinges, tore the screens off of the windows, and smashed his dishes. One man outside the hospital said he heard Masasa residents say they would rather die than move.

Such violence was highly unusual for this sleepy town. Most residents could recall hearing gunshots in town only once before, in 1993. That event had occurred after President Bakili Muluzi had ordered the Malawi Young Pioneers, a paramilitary organization maintained by his predecessor, Hastings Kamuzu Banda, to disband. In response some Young Pioneers had driven through town on pickup trucks, shooting off guns and looking menacing, but people didn't remember anyone being hurt.

This episode included all the outrages and David-and-Goliath drama one would expect to find in a muckraking magazine article. But even in the Malawian press the coverage was sparse and one-sided. A Chichewa-language broadcast on the independent radio station *Zodiak FM* that evening featured an interview with Mangochi's Police Inspector. None of the protestors were interviewed, nor were other witnesses. Local newspapers quoted statements from local politicians following the "fracas," but no reporters interviewed the villagers threatened with displacement or even the victims of the police shootings. For its part, the foreign press did not cover the event.

Not that it would have been easy for reporters to discern what had happened even if they had shown up. There was an imperative to obfuscate on all sides. No one I talked to around Monkey Bay admitted involvement in the protests. And why would they? It would profit them nothing, and risked punishment. Fearing there would be police reprisals during the night after the protests, the men of Masasa found shelter outside their village. Mota Engil disclaimed any interest in building the lakeside resort, explaining to the press that it was more of a favor to the government. They denied that they had even sent a representative to the meeting on the day of the protest. For its part, the Malawi government claimed that a much-criticized letter agreeing to the alienation of the Masasa villagers' land was a forgery created by an opposition politician attempting to smear the ruling party. It seemed as though a great conflagration had erupted, and then disappeared from view. The episode barely registered in the media; as in the 1930s (see Chapter 4), Malawians could be seen by outsiders as an entirely placid people.

Still, the protests had lasting effects. Two months later, *The Nation*, a leading daily, published an op-ed decrying the protestors for throwing up “disincentives to investment” and denying themselves the opportunity for “thousands of jobs.”⁴ There would be no compensation, neither from Mota Engil nor the government, for the families of the two boys who had died, or the six who had been injured. Yet despite the paltry and biased media coverage, and the absence of any official remuneration for the injured, Mota Engil cancelled its planned \$50 million project. Malawian President Peter Mutharika continued to plead with the company to reconsider.⁵ The protestors had proved surprisingly powerful, despite their near-invisibility in the local and international media.

I. Introduction

During the mid- and late-1930s, Nyasaland’s Medical Department budget barely budged, even as revenues continued to rise. This was a product, in part, of the perception in Whitehall that Nyasaland was a placid backwater, and therefore did not need the political palliative of health spending. This perception, and the resulting retrenchment in health spending, continued after the *mchape* anti-witchcraft movement swept across the countryside, and even after the return of the millenarian preacher Elliot Kamwana from forced exile in 1937. Looking elsewhere in the British Empire, though, officials saw far graver threats to economic and political stability. Between 1935 and 1940, waves of riots and strikes roiled the oil fields and ports of the British West Indies, the mines of Northern Rhodesia’s Copperbelt, and cocoa farms in West Africa. This unrest proved capable of

⁴ Aubrey Mbuju, “Disincentives to investment.” April 16, 2015.
<http://mw-nation.com/disincentives-to-investment-2/>

⁵ <http://www.times.mw/peter-mutharika-motor-engil-hold-secret-talks/>

stirring the Colonial Office and even the UK Treasury to favor greater health spending as a demonstration of beneficence. This connection between unrest and social services spending had to be forged deliberately. Malcolm MacDonald, a son of Ramsay MacDonald, the Prime Minister during the passage of the 1929 Colonial Development Act, became Colonial Secretary in 1938. He quickly played on British anxieties about the future of the Empire to drum up support for the 1940 Colonial Development and Welfare Act. Most of the Act's initial funding went to the perceived centers of unrest, especially the West Indies. Medical administrators in Nyasaland complained bitterly to their superiors, but to no avail; few development funds went to colonies that did not provoke metropolitan anxieties.

The political scientist James Scott has argued that “most of the great political reforms of the nineteenth and twentieth century have been accompanied by massive episodes of civil disobedience, riot, law-breaking, the disruption of public order, and, at the limit, civil war. Such tumult not only accompanied dramatic political changes but was often absolutely instrumental in bringing them about.”⁶ This chapter will demonstrate both the veracity of this link between unrest and political change, as well as its logical obverse. That is, in the *absence* of perceived unrest, elites feel little urgency to change methods of governance or levels of social provision.

It might be worthwhile to add a methodological note here. In a 1955 speech, the colonial-affairs expert Lord Malcolm Hailey opened a speech with the following observation:

⁶ Scott, *Two Cheers for Anarchism: Six Easy Pieces on Autonomy, Dignity, and Meaningful Work and Play*. Pages 16-17.

“Everyone must agree that as a source of study, history has one great defect; it is very untidy.”⁷ Indeed, the following three chapters might seem, to some historians devoted to geographic specialization, untidy. But this is, I hope, no defect. These chapters do not focus entirely on Nyasaland, nor on medicine. Instead, they recount labor strikes and riots, intellectual movements, and social and economic policy debates throughout southern Africa, the West Indies, Britain and the United States. These events affected, in indirect but clearly discernible ways, colonial policies and everyday practices in Nyasaland’s dispensaries and hospitals. But Nyasaland was not some passive receptacle of actions taken elsewhere. In later chapters (particularly 8 through 10), events in colonial Nyasaland and postcolonial Malawi will prove to have a profound impact on policies and practices throughout the southern African region and around the globe (see, for instance, the dissolution of Federation in Chapter 8, or the creative use of international crises by Kamuzu Banda in Chapter 10). A robust history of medicine in Nyasaland demands this transgression of political borders and disciplinary bounds.

II. The metropole strikes back: London demands an end to “lavish” care

a) Too much, too fast: Whitehall questions the growth of Nyasaland’s Medical Department, 1935-38

Officials in Nyasaland had yet to spend their last CDF dollars before they began to face a backlash from London. The perception in the Colonial Office and the Treasury was that the medical department had grown dramatically, perhaps even too dramatically. This perception became more prominent in the years after Basil Blackett, the chairman of the CDAC and advocate for new hospitals and health centers throughout the colonies, died in

⁷ Lord Hailey, “Post-War Changes in Africa,” *Journal of the Royal Society of Arts* 103, no. 4955 (July 8, 1955): 579–90.

a car crash in August 1935.⁸ Rumblings of cutbacks had begun even earlier. In May 1935 the Colonial Office sent a letter to the Treasury, suggesting Nyasaland's number of medical officers per unit of land area or per capita compared favorably with other neighboring colonies, and therefore the increases in recurrent expenditure it had experienced in recent years might be stopped.⁹ In a dissent dispatched from Zomba, Nyasaland's Director of Medical Services reminded the Colonial Office that Nyasaland remained an impoverished colony with much lower per-capita recurrent health expenditure than other British colonies in southern and eastern Africa.¹⁰ Nyasaland Governor Harold Kittermaster echoed the Director of Medical Services' argument, stating that on a per capita basis Nyasaland's government spent less on health (7.4 pence per capita) than any other dependency in East Africa. Kittermaster also highlighted a different measure of staffing than the Colonial Office had, demonstrating that Nyasaland had fewer "qualified medical staff" [medical officer *plus* sub-assistant surgeons] than any other dependency in East Africa.¹¹ Statistics could be used to serve different ends; Kittermaster recognized—as had Shircore—that Nyasaland had far fewer sub-assistant surgeons than Tanganyika and other British colonies in East Africa, and he used this fact to demonstrate the paucity of medical staff in his colony. "It would show poor

⁸ Wormell, "Blackett, Sir Basil Phillott (1882-1935), Civil Servant."

⁹ "Precis of Relevant Correspondence with the Colonial Office on Medical and Health Services in Nyasaland," May 3, 1939, S40/1/8/1, Document No 204, MNA.

¹⁰ In a table, the report compares annual per-capita government medical expenditure (European and African) in Uganda (9.5 pence), Tanganyika (9.1 pence), Zanzibar (50 pence), Kenya (15.3 pence), Nyasaland (6.7 pence) and Northern Rhodesia (11 pence). Some of these figures likely reflect higher settler populations, and may not indicate ratios of expenditure on African medical facilities. ADJ Bedward Williams, "Annual Medical & Sanitary Report for the Year Ending 31st December 1935" (Zomba, Nyasaland: Government Printer, April 5, 1936), Box 15, No 19, Society of Malawi Archive., pages 6-7

¹¹ G Howes, "Extract from a Despatch from the Governor's Deputy, No 379 of the 22nd October, 1935," n.d., CO 525/161/4, Pages 36-38, UKNA.

appreciation of the generosity with which the Protectorate was treated by the Colonial Development Fund now to close down or curtail the activities in the hospitals.”¹²

Yet Colonial Office officials persisted in portraying Nyasaland as a colony amply served with medical staff. To do this, they used their own favored statistical ratios. Marcus Greenhill, an 36-year-old official who had worked in the Colonial Office in London since the age of 20, argued that “the medical staff of the Protectorate was large *in relation to the size of the country*...in the southern Province where the population is largely concentrated it seems possible that fewer officers should be able to provide an efficient service with a corresponding reduction in expenditure.”¹³ This was a decided change in Colonial Office policy compared to just five years earlier, when Lord Passfield was Secretary of State for the Colonies under a Labour Government. By late 1935, the UK Government was a coalition of Labour, Conservatives, and Liberals, and this regime proved decidedly less friendly to health spending in Nyasaland. In addition, two downturns in global demand (one in 1929-1933 and another in 1937-38) led to plummeting prices for the mineral and agricultural commodities extracted from southern and eastern Africa. This, in turn, left colonial treasuries even more penurious than usual.

¹² Ibid.

¹³ Marcus A Greenhill, “Minute on Extract from a Despatch from the Governor’s Deputy, No 379 of the 22nd October, 1935,” December 19, 1935, CO 525/161/4, Pages 1-2, UKNA. (Emphasis in original). In 1935, Greenhill worked in the Tanganyika and Somaliland Department (which oversaw Nyasaland). He had started his career in the Colonial Office as an Assistant Clerk in March 1919. See AJ Harding and GEJ Gent, *The Dominions Office and Colonial Office List for 1935* (London: Walterlow & Sons Ltd, 1936). Page xii.

Nyasaland's African population found less of the waged work that helped them to pay hut taxes, while customs duties decreased.¹⁴

These political and economic shifts drastically changed the appetite for development funding in London. The Colonial Office demanded spending cutbacks, and viewed the elimination of medical staff as the quickest route to such economies. Greenhill complained that government medical provision had expanded far too quickly, to a level beyond Nyasaland's capacity to pay for it. "Nyasaland was provided with the necessary funds by the CDF for the provision of hospitals, clinics and staff quarters, but that seems no reason why all the money should have been spent at once. The result is that Nyasaland has a service far in advance of its present stage of development including a large number of hospitals and clinics, etc. which it cannot use to the fullest extent."¹⁵

b) Another doctor calls for more: the de Boer Report, 1938

Not everyone agreed with this call for spending cuts; once again, the rebuke would come from a veteran member of the colonial medical services. In 1938, Henry Speldewinde de Boer began his tenure as Nyasaland's Director of Medical Services. Born in Ceylon, de Boer had studied medicine at the London Hospital. After serving in the Royal Army Medical Corps during the First World War, he took postgraduate degrees at both

¹⁴ H.S. De Boer, "Proposals by Director of Medical Services, Nyasaland, for Reorganization of Medical and Health Services," June 17, 1939, CO 525/178/1, UKNA.

¹⁵ Greenhill, "Minute on Extract from a Despatch from the Governor's Deputy, No 379 of the 22nd October, 1935." Planned expansions of medical services in other British African colonies were also shelved during these years. Ann Beck describes the frustration of Tanganyika's Medical Department over its Whitehall's refusal to approve a school to train African paramedical staff during the 1930s. See Beck, *Medicine, Tradition, and Development in Kenya and Tanzania. 1920-1970*. Page 11.

Cambridge and the London School of Tropical Medicine and Hygiene. Beginning in 1926, he spent five years as medical officer in Kenya, two as Deputy Director of Sanitary Services in Northern Rhodesia, and another five as Deputy Director of Medical Services in Uganda.¹⁶ In these colonies he was known for his interest in malariology and maternal and child welfare.

Immediately upon his arrival de Boer toured the country and submitted a set of proposals on the Medical Department to the Colonial Office. He opened his report with language even more blunt than Shircore's: "The present services are completely inadequate to touch even the fringe of our medical problem. They have not made true contact with the population as a whole, nor can they claim to have gained the confidence of any but a small section of the people. With our existing hospitals and dispensaries, it is doubtful whether [we] have made any serious reduction in the sickness and mortality rates..."¹⁷ De Boer criticized the paltry number of medical officers, who were "tied largely to the needs of the European population." Sub-assistant surgeons were being asked to function as administrators, and even hospital assistants were being put in charge of entire district hospitals.

De Boer recognized that Africans lacked trust in the efficacy of treatments, particularly those available at rural dispensaries. There were 90 dispensaries throughout the country, but de Boer argued the dispensers were held in so little regard by Africans that "the

¹⁶ "Obituary: H.S. de Boer," *BMJ* 1, no. 5034 (June 29, 1957): 1533–34.

¹⁷ H.S. De Boer, "Proposals by Director of Medical Services, Nyasaland, for Reorganization of Medical and Health Services," June 17, 1939, CO 525/178/1, UKNA.

average number of patients seen at most of our dispensaries does not exceed 15 a day,” and the majority of those patients presented only with minor complaints.¹⁸ Can this be taken as an indication that there are no genuinely sick persons in our African villages? What little we do know goes to prove the contrary!” When Africans did bring gravely ill patients to dispensaries, they had to be transferred to district hospitals by stretcher. Such trips often took more than a day and were sometimes impossible when poor roads were washed out during the rainy season.

The answer to the lack of adequately trained medical providers was not, De Boer argued, to halt the construction of new facilities. Instead he called for a rapid *increase* in the number of hospital beds for Africans, from approximately 700 to 1080. He also called for an increase in dispensary construction and an improvement in the training of the auxiliaries who staffed them.¹⁹ De Boer noted that even after the new Zomba African Hospital was built the only training facility for hospital assistants remained the UMCA mission in Blantyre. A training effort on the scale envisioned by Shircore had never been undertaken. De Boer called for a massive recruiting and training effort, with free tuition,

¹⁸ Many officials in Nyasaland shared this view. A report from the Lilongwe District Commissioner in 1937 explained that the three rural dispensaries in his districts were “totally inadequate to serve a native population of approximately 140,000...of miserably poor construction in two cases, badly equipped, and staffed by very low-grade dispensers.” In March 1938 Governor Harold Baxter Kittermaster made his own brief addendum to this report, adding only: “Poor dispensaries are worse than useless.” Harold Baxter Kittermaster, “Minute on Extract from Report on Lilongwe District 1937, MP. 18/38.C. to Director of Medical Services for Comment,” March 1, 1938, S40/1/3/2, no. 40, MNA.

¹⁹ “Extract from Memorandum by DMS on Medical Policy, MP 49/35,” 1938, S40/1/3/2, no. 44, MNA. De Boer’s predecessor as DMS, TA Austin, had campaigned to speed the pace of new dispensary construction. He was particularly opposed to the requirement (designed to limit government expenditure) that Native Authorities cover most of the costs of construction themselves. TA Austin, “Letter from TA Austin, Acting Director of Medical Services, to Chief Secretary, Zomba, Re: ‘Rural Dispensaries: Applications for Native Authorities,’” April 30, 1938, S40/1/3/2, no. 42, MNA.

room and board at both the mission training school and at a government school. Between 1940 and 1947, De Boer requested increases in medical personnel including medical officers (from 14 to 20), European nursing sisters (from 12 to 30) and, most notably, in hospital assistants (from 15 to 116). In total, his proposal called for additional capital expenditure of £122,766 (over eight years) and a considerable increase in recurrent expenditure, more than doubling from its 1938 level of £52,839 to more than £110,000 by 1947.

Realizing that questions about funding such a proposal would follow his report, De Boer proposed fiscal policies with which to fund his program. These proposals reflected De Boer's understanding of Nyasaland's role as a labor reserve for southern Africa, and demanded that industries benefiting from this migration take on additional responsibilities for the health of Africans remaining in or returning to Nyasaland. "It is believed that every batch of returning natives includes one or more individuals bringing back, if not new diseases, fresh strains of old diseases that may flare up and affect adversely the balance of nature that has existed. Our Africans are generally admitted to be our country's only important asset. Can we say that it is not a wasting asset?"²⁰ At the time, Southern Rhodesia remitted 6 of the 20 shillings it collected in taxes from Nyasaland's migrants to the Nyasaland government; de Boer suggested that the entire amount (20 shillings) be sent back to Nyasaland. He also proposed that the Union of South Africa should levy a tax on Nyasaland natives living within its borders, to be remitted to Nyasaland. The Witwatersrand Native Labour Association (WENELA), a

²⁰ De Boer, "Proposals by Director of Medical Services, Nyasaland, for Reorganization of Medical and Health Services."

recruiting organization that drew recruits from Nyasaland for South Africa's mines, would be "asked to contribute £2 per head of labour recruited in Nyasaland."

De Boer knew that most past proposals had not amounted to much. "The files of my department make for very sad reading," he lamented. Past Directors of Medical Services had "little time to think on big lines," and when they did "recommendations and demands have either been neglected completely or in approval so pared down and attenuated, that little progress eventuated."²¹ Indeed, after an initial increase in recurrent expenditure on health in Nyasaland during the early 1930s (rising from £33,191 in 1928 to £49,138 in 1934), the budget for health barely had budged for the rest of the decade (increasing only to £52,343 in 1939). Public sector health spending also came to occupy a smaller portion of overall public expenditures in Nyasaland. The medical department claimed more than 10.1 percent of the Protectorate's total recurrent budget in 1930, but this had dropped to 6.5 percent by 1939.²² De Boer took over Nyasaland's Medical Department at a moment far less ripe with promise and support from London than when Shircore had written his report in 1930.

c) An "excessive" service: reception of the de Boer report in London

The response to De Boer's report clearly demonstrated the conflict between Zomba and London over the quality of medical services due Nyasaland's African population. In a note accompanying De Boer's report in May 1939, Nyasaland Governor Donald

²¹ Ibid.

²² "Annual Medical Report on the Health and Sanitary Condition of the Nyasaland Protectorate for the Year Ending the 31st, December, 1930"; "Annual Medical & Sanitary Report for the Year Ending 31st December 1939" (Zomba, Nyasaland: Government Printer, 1940), Box 15, No 19, SoMA.

Mackenzie-Kennedy—having arrived only two months prior from Northern Rhodesia—expressed his support for the plan, saying its enactment would “avoid a continuance of what can only be described as a sham and a pretense—hospitals and dispensaries, inadequately staffed and insufficiently supervised.”²³ Officials at the Colonial Office did not agree. Edmund Boyd, the Principal Private Secretary to the Colonial Secretary, praised de Boer’s “superabundant energy and enthusiasm,” but dismissed his proposals as the unreasonable wishes of an administrator “coming fresh from Uganda, where medical and public health standards have reached a pretty high standard.”²⁴ Dr. Arthur O’Brien, a member of the Colonial Advisory Medical Committee who had joined de Boer for part of his inaugural tour of Nyasaland, opined that de Boer’s proposals for funding recurrent costs through charges on the governments of Southern Rhodesia and South Africa were not “practical.” The only proposal in the report for which O’Brien’s offered wholehearted support was the call for improving housing and hospital accommodation for white settlers. The existing “European hospitals” were, O’Brien noted, “disgraceful” and had to be improved immediately; the expansion of African medical services could be “more gradual and spread over a longer period.”²⁵

²³ “Memo from Governor DM Kennedy to Chief Secretary, Zomba, Re: Dispatch to Be Sent to Colonial Office Concerning De Boer Report.” Three years earlier in 1936, Director of Medical Services Williams had described medical treatment for “non-native” Europeans as follows: “Government does not accept responsibility for providing hospital accommodation and medical attention for the non-official European community, yet in fact it does provide considerable facilities. Two European hospitals exist and accommodate both officials and non-officials. The fees charged to non-officials being much less than the cost of treatment and of the medical and nursing attention provided.” Williams, “Memorandum A: A Memorandum on the Health Policy in Nyasaland, From the Director of Medical Services to the Governor, the Colonial Office, and the Colonial Advisory Medical Committee.”

²⁴ “Minute by Boyd Re: De Boer Report,” August 14, 1939, CO525/178/1, UKNA.

²⁵ “Minute by Arthur John Rushton O’Brien Re: De Boer Report,” August 2, 1939, CO525/178/1, UKNA.

Gerard Clauson, a Sanskrit philologist and a rising star at the Colonial Office then serving as head of the recently established Social Services Department, was more blunt.²⁶ He dismissed de Boer's proposals as "prohibitively expensive" before expanding on his view that Nyasaland's medical services for Africans were actually too lavish:

I admit that 1080 beds for 1,620,000 inhabitants, i.e. 1 per 1500, is not excessive, but *the quality of the service is. It seems to me fantastic to take a native who all his life has probably never slept anywhere except on the ground or a few boards and, if he stayed sick at home, would continue to live in that way, and directly he gets into the hospital to put him into a bed with blankets, sheets and other appurtenances and wait on him hand and foot.* The solution seems to be to imitate the French who provide much humbler accommodation at their hospitals, comparable to the proposed patients' huts at the Dispensaries, into which *the patient can be moved with his family and be nursed principally by them, the Government providing treatment but not attendance and food.*²⁷

So while Nyasaland's Director of Medical Services saw medical provision as

"completely inadequate, and the Governor thought it a "sham," Clauson argued African patients were being pampered. Bedding and food and professional attendance were, to his mind, much more than any African patient in Nyasaland might expect from a government medical facility. The answer was not more spending and more care for the sick, but rather less of both. De Boer thought African hospitals had empty beds because accommodation and equipment remained dreadful; Clauson said that it was evidence only that a large increase in the number of facilities was unnecessary.

Particularly on the arguments regarding hospital feeding, doctors working in Nyasaland did not share Clauson's opinion. Reporting on medical services in 1939, when the

²⁶ For a brief discussion of the creation of the Colonial Office's Social Services department in 1939, see Frederick Cooper, *Decolonization and African Society: The Labor Question in French and British Africa* (New York: Cambridge University Press, 1996). Page 69.

²⁷ "Minute by Gerard Clauson Re: De Boer Report." Emphasis added

recurrent health budget decreased from his first year, de Boer complained it was “becoming more difficult to provide patients admitted with a satisfactory diet. In a country where the average inhabitant suffers from defective nutrition, good feeding is an important part of curative medicine.”²⁸ Medical officers saw patients’ kin nursing and feeding the sick in their hospitals each day. Though grateful for such care-giving, the medical officers considered this a complement, rather than a substitute, for trained nursing and hospital feeding. In his memoirs WTC Berry, who worked in Nyasaland from 1936 to 1943, recalled the deficiencies in accommodation at rural district hospitals (“outstations”) and the reliance of harried staff on family caregivers:

[The hospitals] were single-story buildings, built of brick with corrugated Iron roofs and cement floors, laid out round a quadrangle of grass or hard-packed earth. The space beneath the roofs was often, especially in out-stations, occupied by bats and sometimes by fierce, wild bees... On out-stations the crowd was more countrified and included more women, children, and babies... A problem in every hospital before the days of DDT, which only arrived in Nyasaland during the last years of the war and was, even then, in very short supply, were the bedbugs. They infested the clothing and bedclothes of the patients and lived in the cracks of the hospital walls... The patients’ relations came into the hospital too, sleeping in their own blankets between the beds and on the verandah. They brought their own food in with them (and, sometimes, their bedbugs) and their food helped to vary the patients’ diet; to that extent, and for some of the nursing, we depended on them. The patients’ diet consisted of maize meal, beans and, where available, fish. Leaf vegetables were cooked as side dishes... The hospital would have been a worse place without the relations and less used as a result.²⁹

Clauson penned his critical response to the De Boer report on August 8, 1939. Less than a month later, on September 1, Nazi Germany invaded Poland. In response, the UK and

²⁸ “Annual Medical & Sanitary Report for the Year Ending 31st December 1939.” Page 25

²⁹ Berry, *Before the Wind of Change*. Page 4. Food has long been a significant line item on hospital budgets. In 1962 a prospective estimate of expenses of Nyasaland’s district hospitals by PR Stephens, the territory’s last Federation-era Director of Medical Services, found that at some native hospitals the per diem, per capita cost of feeding African inpatients would rival—and a few cases, exceed—the cost of drugs. PR Stephens, “Allocation of Expenditure, 1962/63” (Blantyre, Rhodesia & Nyasaland: Ministry of Health Regional Headquarters, June 25, 1962), 4.5.9R, Box 9121, MNA.

France declared war on Germany. It had been difficult to secure finances for expanding medical services just before the war began; it was impossible during the war. As one official remembered, the war brought with it a new “disease” called “Algef—*Après la guerre est fini* (‘After the war is over’)—a refrain which became the “customary direction on nearly all new proposals.”³⁰ Not until after the war would Nyasaland’s health services become an imperial priority once more.

d) The wages of quietus: cutbacks as a consequence of placidity

To what can we attribute Whitehall’s distaste for health spending in Nyasaland during the mid- to late-1930s? Surely the Great Depression and the advent of the Second World War were significant factors, but as we will see in the next section, health services in other colonies garnered far more attention during this period. Economic and military imperatives were not the sole cause of the UK Government’s turn away from Nyasaland’s Medical Department over the course of the 1930s. Clauson and others rebutted De Boer’s report so readily in part because Nyasaland was seen as politically placid during the 1930s. While (as the next section will show) Northern Rhodesia and British West Africa and the West Indies erupted in labor unrest, Nyasaland’s officials reported no episodes of great concern. In an era when health was used as a political palliative, Nyasaland’s Africans seemed to issue no cry worthy of response.

³⁰ Jones et al., “Colloquium on Nyasaland Finance.” Page 3. This policy of delay was evident in Nyasaland as well. In a letter to Secretary of State for the Colonies Oliver Stanley, Governor Edmund Richards explained the lack of progress on plans to improve the colony’s health services: “A comprehensive long-range scheme was prepared shortly before the outbreak of war by the then Director of Medical Services [HS De Boer]...A less elaborate scheme was prepared in 1940, but consideration of it had to be deferred on account of the war.” Edmund Richards to Oliver Stanley, 23 July 1943, CO 859/66/5, UKNA.

This is not to suggest that Nyasaland's Africans were, in fact, quiet. There was plenty of discontent and political activity during this decade. In 1932, an anti-witchcraft movement spread rapidly across the Protectorate. Young men organized sessions in which people were made to drink a concoction known as *mchape* (a derivation of the word *kuchapa*, which means "to wash"), which they said would harm only practitioners of sorcery. The movement spread like wildfire, in part because it helped young men counter the authority of their elders.³¹ But while officials noted the movement in their reports, they were not overly concerned about it. Though witchcraft was technically illegal, authorities did not bother to imprison many involved in the movement.³² The system of indirect rule continued working decently well, and production on European estates was not much affected. This was not the kind of unrest that would spur increased health spending from colonial officials.

Even in the face of politically subversive rhetoric, colonial officials remained nonplussed. In 1932, George Simeon Mwase sent officials in Zomba a typescript entitled "A Dialogue of Nyasaland Record of Past Events, Environments & the Present Outlook within the Protectorate." The bland, nondescript title belied fiery contents, which included a provocative and heroic biography of the revolutionary preacher John Chilembwe as well as Mwase's own criticism of contemporary race relations and living conditions in Nyasaland. Mwase, who had worked as a government clerk and storekeeper, was already well known to officials for his missives on the depredations of the colonial police and

³¹ JC Chakanza, "Provisional Annotated Chronological List of Witch-Finding Movements in Malawi, 1850-1980," *Journal of Religion in Africa* 15, no. 3 (1985): 227-43.

³² McCracken, *A History of Malawi*. Page 210.

other matters, which he had written on behalf of the Central Province Universal Native Association since the late 1920s.³³ But, as historian Richard Rotberg has noted, Mwase “had long been regarded by many white administrators as an excessively opinionated, ‘harmless,’ compulsive writer of memoranda and tracts...the Government of Nyasaland had always replied to his missives in the noncommittal, routine manner it reserved for cranks and other meddling Africans.”³⁴ Officials in Zomba filed away Mwase’s work in the archives, where it remained until Rotberg and his wife rediscovered and published it in 1967.

Nyasaland officials were so unconcerned with unrest during the 1930s that they repatriated Elliot Kamwana, a millenarian preacher exiled on pain of death decades earlier for the anticolonial overtones of his ministry (see Chapter 1). Though the Nyasaland authorities of the era before the First World War had treated Kamwana as a dangerous revolutionary, the authorities of 1937 considered him harmless.³⁵ When he returned from the Seychelles to his home village, Kamwana was even allowed to set up an independent church. The church rejected European medicine—perhaps, historian

³³ John McCracken, “Coercion and Control in Nyasaland: Aspects of the History of a Colonial Police Force,” *The Journal of African History* 27, no. 1 (1986): 127–47.

³⁴ Richard Rotberg, “Editor’s Introduction,” in *Strike a Blow and Die: A Narrative of Race Relations in Colonial Africa*, by George Simeon Mwase (Harvard University Press, 1967).

³⁵ Evidence that officials in Zomba were no longer terribly concerned about religious and political movements in the countryside emerged in 1933. That year, the Nyasaland High Court ruled that Willie Kabvala, a headman in Ncheu who had refused to give the District Administration the names of members of the Watch Tower sect in his village, should not be convicted of any offense. While the Court acknowledged that Watch Tower had “caused considerable disorders in Northern Rhodesia,” and was prohibited in that territory, there was “not a tittle of evidence...in this case that the Watch Tower sect has any unlawful or improper object or that its meetings lead to disorder.” J. Haythorne Reed, “Rex v. Willie Kabvala, Case No.3 of 1933 (Criminal) in Revision,” in *Law Reports Containing Cases Determined by the High Court of Nyasaland, Vol III, 1927-1933* (Zomba: Government Printer, 1934).

Henry Donati suggests, because a European doctor had once failed to heal Kamwana's dying wife, or because of bad experiences as a hospital assistant in South Africa early in life. But officials showed little concern for his preaching, and allowed him to work undisturbed until his death in 1956.³⁶

For their part, officials in Zomba were so confident about political security that they used medical technologies not to quell discontent, but to enforce hated taxation policies. In 1939 the Commissioner of Police reported that the most frequent assignment his men performed was collection of the hut tax.³⁷ The courts, too, spent much of their time on taxation cases; of the 5517 cases tried in subordinate courts in 1936, 1812 were for "breaches of hut tax laws."³⁸

The major concern of Nyasaland officials during mid- to late-1930s was collecting tax revenues. They saw little need to placate the masses of African subjects. During these years, political dissenters, millenarian preachers and anti-witchcraft movements did not much concern them. European estate owners, the major economic interests in the Protectorate, were able to pursue profits unimpeded by unrest. Political legitimacy in Nyasaland appeared secure—or, more precisely, secure enough to them to move ahead

³⁶ Henry Donati, "'A Very Antagonistic Spirit': Elliot Kamwana: Christianity and the World in Nyasaland," *The Society of Malawi Journal* 64, no. 1 (2011): 13–33. Also see Karen Elise Fields, *Revival and Rebellion in Colonial Central Africa* (Princeton, N.J.: Princeton University Press, 1985).

³⁷ McCracken, "Coercion and Control in Nyasland: Aspects of the History of a Colonial Police Force."

³⁸ Bell, "Report of the Commission Appointed to Enquire into the Financial Position and Further Development of Nyasaland." Pages 71-72.

with the overriding imperatives of revenue collection and budgetary retrenchment. For its part the Colonial Office called for economy, not new spending.

III. Imperial disquiet as impetus for the 1940 Colonial Development and Welfare Act, 1935-1940

a) Copperbelt strikes in Northern Rhodesia and health as a political palliative, 1935-1938

Officials elsewhere in the British Empire did not feel this same sense of security. On the morning of May 29, 1935, the Commissioner of Northern Rhodesia's Central Province called the colony's Acting Chief Secretary to report a crisis. A thousand Bemba natives living in a town compound adjacent to the Roan Antelope copper mine in Luanshya District had marched to the compound offices. Troops from the Northern Rhodesia Regiment had already been flown to other mines from the colonial capital in Lusaka by the Royal Air Force two days prior, in response to other strikes. The Provincial Commissioner begged the Chief Secretary to expedite the transport of troops to Luanshya, but by the time they arrived blood had already spilled. The police—Africans led by white officers—were either taking refuge in the compound offices or trying to disperse the gathering by charging at the crowd outside. Some in the crowd hurled stones. The investigators heard conflicting reports of how the firing started, but they believed that the Police Superintendent's attempt to frighten the crowd by firing shots into the air had spurred other police to open fire. They shot randomly into the assemblage of miners, domestic servants, and neighbors who had shown up in support of the strikers. Fold and

other European officials said they tried to stop the firing as soon as they heard it, but by the time the guns fell silent they had killed six people, and wounded 22 others.³⁹

Within days, the mineworkers were back to work across the Copperbelt, including Luanshya, but the brief wave of strikes—where there were not yet even any labor unions—shook the Colonial Office in London. Northern Rhodesia Governor Hubert Young commissioned a report on the “disturbances” led by Sir William Alison Russell, the former Chief Justice of Tanganyika. The investigators concluded that a major proximate cause of the strikes was the news of a tax increase in the mining areas.⁴⁰ Though Russell’s Commission found fault less with the tax increase itself than with the abrupt way in which the policy was announced to the workers, the incident stirred reformers to question what Africans in Northern Rhodesia saw in return for their tax payments.

Colonial Office adviser Sir Alan Pim made Northern Rhodesia the focus of the last in a series of reports on financial administration in British Africa. The Colonial Office had tasked Pim with finding ways to reduce public expenditure and increase revenue in

³⁹ “Report of the Commission Appointed to Enquire into the Disturbances in the Copperbelt, Northern Rhodesia, Presented by the Secretary of State for The Colonies to Parliament by Command of His Majesty” (London: His Majesty’s Stationary Office, October 1935); “Annual Report on the Social and Economic Progress of the People of Northern Rhodesia, 1935” (London: His Majesty’s Stationary Office, 1936); Ian Henderson, “East African Leadership: The Copperbelt Disturbances of 1935 and 1940,” *Journal of Southern African Studies* 2, no. 1 (1975): 83–97.

⁴⁰ Historian Ian Henderson documents how news of this tax increase was spread between mines by a network of clerks who hailed from Nyasaland. Henderson, “East African Leadership: The Copperbelt Disturbances of 1935 and 1940.”

Northern Rhodesia.⁴¹ But his report, published in 1938, criticized the extraction of Northern Rhodesia's resource revenues to public and private coffers in Britain, and called for additional expenditures on health, education, and infrastructure in Northern Rhodesia.⁴² On the state of the medical services, he wrote, "There are large concentrations of natives outside the reach of any doctor...Of the 12 Government hospitals for Natives. Only two...are good." The report lamented that a comprehensive development scheme for improvement of medical and public health services, submitted to the CDAC (where Pim was a member) in 1936, had been awarded only £20,000.⁴³

⁴¹ The Terms of Reference for Pim's Commission, as provided by the Secretary of States for the Colonies, were as follows: "(i) To enquire into and report on the general financial position of the Territory with special reference to the practicability of: (a) reducing the cost of administration, whether directly or by reorganization, and; (b) developing and supplementing the existing sources of revenue, and (ii) to make recommendations generally." Alan W. Pim and S Milligan, "Report of the Commission to Enquire into the Financial and Economic Position of Northern Rhodesia" (London: His Majesty's Stationary Office, 1938). Page 1. Also see Andrew Roberts, "A History of Zambia" (London: Heinemann, 1976). Page 193.

⁴² Pim and Milligan, "Report of the Commission to Enquire into the Financial and Economic Position of Northern Rhodesia." See Page 290: "Taking the territory as a whole the present medical provision for a native population of 1,366,000 spread over a country a quarter as large again as France is entirely inadequate. Including every Government medical post and every missionary medical post aided by Government, no matter how small, how primitive and how ill-trained its staff, a total is reached of some 70 posts where Government makes provision for medical aid to natives. On the generous assumption that each of these covers an area of 25 miles radius, or about 2000 square miles, more than half the territory remains unprovided for." And see Pages 294-295: "The public health service is very inadequate and practically no maternity work or child welfare work has been done...The existing position cannot be regarded as in any way satisfactory and ought not to be allowed to continue."

⁴³ Ibid. Pages 291-293. Hinden, *Plan for Africa: A Report Prepared for the Colonial Bureau of the Fabian Society*. Page 103. Compare this figure to the revenues garnered by the UK Government from taxation of Copperbelt mining companies. Between 1930 and 1940 the UK government kept £2.4 million in such revenues, while Northern Rhodesia received from UK only £136,000 in grants for development during that period. Roberts, "A History of Zambia." Page 193. The CDAC had considered the North Rhodesian health scheme at a meeting held just over a year after former chairman Basil Blackett's death. The meeting was chaired by Sir Alan Rae Smith, and evaluated the scheme in language much less enthusiastic than similar schemes had been received under Blackett. "The Committee felt that if the sums required by this and other territories to meet expenditure of this character were to be met out of the Colonial Development Fund there was no saying to what extent demands might be made on the Fund with the result that the Fund might well be used up in the provision of health services." The CDAC approved only

Recurrent expenditure on health had risen in absolute terms in the years since the protests, but only enough to keep pace with the rise in total recurrent expenditure.⁴⁴ Health was not yet a significant part of the response to burgeoning colonial unrest.

b) Labor strikes in the British West Indies and health as a political rallying cry, 1937-1939

The role of health in colonial politics would soon change. As Pim and others pondered the factors leading to riots in Northern Rhodesia, labor unrest in British holdings in the Caribbean stoked even more concern about the direction of imperial policy. In June 1937, workers in the oil fields of Trinidad began a sit-down strike, demanding an end to racial discrimination in the workplace, unemployment insurance, workmen's compensation, trade union recognition, and an end to an employment passbook system used to depress wages. Strikes proliferated throughout the island, growing to include dockworkers, laborers on sugar, cocoa and coconut plantations, domestic servants, and some government employees.⁴⁵ In July, inspired in part by a labor organizer named Clement Payne who had arrived earlier that year from Trinidad, workers in Barbados rioted in Bridgetown and burned sugarcane fields in the countryside.⁴⁶ Fourteen people were shot dead by police. In October, thousands of cocoa growers in the Gold Coast announced a

one-half of the £40,000 requested. See 94th meeting of CDAC, 27 January 1937, CO 970/2, UKNA.

⁴⁴ Medical Department recurrent expenditure in Northern Rhodesia increased from £60,429 in 1935 (representing 7.9 percent of total recurrent expenditure) to £74,132 in 1938 (representing 8.0 percent of total recurrent expenditure). See Pim and Milligan, "Report of the Commission to Enquire into the Financial and Economic Position of Northern Rhodesia." Appendix X.

⁴⁵ W. Richard Jacobs, "The Politics of Protest in Trinidad: The Strikes and Disturbances of 1937," *Caribbean Studies* 17, no. 1/2 (1977): 5–54.

⁴⁶ Jeremy Seekings, "'Pa's Pension': the Origins of Non-Contributory Old-Age Pensions in Late Colonial Barbados," *Journal of Imperial and Commonwealth History* 35, no. 4 (2007): 529–47.

boycott of “non-essential” European goods and a hold-up of sales to buyers (including the British-based confectionary Cadbury) who had colluded to lower producer prices.⁴⁷ By the close of April 1938 the disquiet reached Jamaica. Sugarcane workers on an estate of the West Indian Sugar Company went on strike during the harvest, protesting low and irregular pay and dismal lodging. Within two days four protesters were dead and another 13 were injured. In the next few weeks, dockworkers and the unemployed in Kingston set fire to buildings, while firefighters threatened to strike unless their wages were increased.⁴⁸ The Peoples’ National Party, established by Jamaican attorney and protest leader Norman Manley in September 1938, promised free secondary education and healthcare for all Jamaicans.⁴⁹

c) Colonial labor unrest as a justification for colonial development, 1938-1940

Manley was not the only person in a position of influence who thought that health and education might be of interest to newly restive colonial publics. Social services were foremost in the mind of Malcolm MacDonald, a 36-year-old M.P. appointed to serve as Secretary of the State for the Colonies in Neville Chamberlain’s Conservative government while Jamaica erupted in May 1938. MacDonald, son of the recently deceased former Prime Minister Ramsay MacDonald, had been a Labour Party member

⁴⁷ Cooper, *Decolonization and African Society*. Pages 58-65. Cooper highlights the communication between protest leaders in the West Indies and those in British Africa. For more on the causes of the cocoa hold-ups in the Gold Coast, see Rod Alence, “The 1937-1938 Gold Coast Cocoa Crisis: The Political Economy of Commercial Stalemate,” *African Economic History*, no. 19 (1990-1991): 77–104.

⁴⁸ O.W. Phelps, “Rise of the Labour Movement in Jamaica,” *Social and Economic Studies* 9, no. 4 (1960): 417–68.

⁴⁹ KWJ Post, “The Politics of Protest in Jamaica, 1938: Some Problems of Analysis and Conceptualization,” *Social and Economic Studies* 18, no. 4 (December 1969): 374–90; DH Figueredo and Frank Argote-Freyre, *A Brief History of the Caribbean* (Infobase Publishing, 2008). Page 201.

until both he and his father were evicted from the party when the latter formed a “National” Government with Conservative Ministers. But the younger MacDonald retained his longstanding interest in colonial development policy, and agreed with the Labour MPs who were calling for a Royal Commission to investigate the “disturbances” in the West Indies. In a memo calling for the appointment of a Royal Commission, MacDonald argued one necessary response to the unrest was an improvement in social services supported by an expanded system of imperial grants.⁵⁰ Labour MP Arthur Creech Jones also made this link explicit in a speech before the House of Commons:

The truth is that until riots and disturbances occurred and we had unrest beginning to sweep from one end of our Colonial Empire to the other, very little was really being done [in social services]. This burst of activity is largely due to the fact that at last the workers are demanding that something should be done. It is a sad commentary on our method of government when we have to wait for riots and disturbances to force us to do what is...right.⁵¹

Such rhetoric had already proved successful. By the time Creech Jones made this speech, MacDonald had only just announced that both the Prime Minister and the Treasury had acceded to his call for the appointment of a Royal Commission.⁵² The Commission’s Terms of Reference—“to investigate the social and economic conditions [in the British West Indies], and matters connected therewith, and to make recommendations”—was rather broad and vague, but the members knew that they had been tasked with finding an antidote to the unrest.⁵³

⁵⁰ Constantine, *The Making of British Colonial Development Policy, 1914-1940*. Page 204.

⁵¹ Arthur Creech Jones, *Colonial Office Debate, Volume 337, cc79-189*, 1938, http://hansard.millbanksystems.com/commons/1938/jun/14/colonial-office#S5CV0337P0_19380614_HOC_431.

⁵² Constantine, *The Making of British Colonial Development Policy, 1914-1940*. Page 205.

⁵³ “West India Royal Commission Report, Presented by the Secretary of State for the Colonies to Parliament by Command of His Majesty” (London: His Majesty’s Stationary Office, June 1945). Page xiii.

Over the next eighteen months, as the Commission did its work, MacDonald prepared to use its findings to announce a fundamental overhaul of the Colonial Development Act. He and others in the Colonial Office believed that imperial grants should be vastly increased, from the existing £1 million per year to £10 million per year. Significantly, in contrast to the grants given under the existing Colonial Development Act, such funding should be allowed to cover recurrent expenses for health and education.⁵⁴

By 1939, as the specter of war loomed ever larger in government plans, MacDonald stressed the impact that such financial support could have on Britain's standing in the world and, more practically, its defense. MacDonald had been a labor organizer, and knew how to foster a sense of crisis. He used these skills within the Cabinet to argue for colonial development. As MacDonald added in a minute to a Colonial Office meeting from 9 December 1938, "It was an essential part of [Britain's] defense policy that her reputation as a Colonial power should be unassailable."⁵⁵ His efforts to drum up concern about colonial stability were aided by recent events. Over the summer, dockworkers had halted trade with strikes in the significant African port cities of Port Sudan (April-May 1939), Dar es Salaam (July 1939) and Mombasa (July-August 1939).⁵⁶ Few of the

⁵⁴ Constantine, *The Making of British Colonial Development Policy, 1914-1940*. Page 207.

⁵⁵ Ibid. Pages 208-209. As MacDonald added in a minute to a Colonial Office meeting from 9 December 1938, "It was an essential part of [Britain's] defense policy that her reputation as a Colonial power should be unassailable."

⁵⁶ Gareth Curless, "The Sudan Is 'not yet Ready for Trade Unions': the Railway Strikes of 1947-48," *Journal of Imperial and Commonwealth History* 41, no. 5 (2013): 804-22; John Iliffe, "A History of the Dockworkers of Dar Es Salaam," *Tanzania Notes and Records* 71 (1970): 119-48; Frederick Cooper, *On the African Waterfront: Urban Disorder and Transformation of Work in Colonial Mombasa* (New Haven, [Conn.]: Yale University Press, 1987). Pages 48-50.

striking workers and rioting subjects throughout the Empire had uttered slogans calling for health and education, but MacDonald and others portrayed social services as an effective and economical palliative for political unrest.

Within two weeks after Britain declared war in September 1939, a Treasury official chastised the CDAC for planning to continue to meet to consider colonial development proposals: “We are not unmindful of the importance which your Secretary of State attaches to social services and economic development in the Colonies...but first things must come first...Here, as in other services at home, we shall have to resign ourselves to stand still now.”⁵⁷ MacDonald, for his part, argued a reformed approach to colonial development would avert costly unrest during the war. Even more importantly, it would improve British standing abroad, particularly in the United States, thereby helping to ensure the UK to retained its empire in a postwar settlement.⁵⁸

Treasury officials continued to object to the use of imperial funds for recurrent social service expenditures, which they believed would put “the Colonies on the dole from henceforth and forever.” But MacDonald would not give in, replying that it was “essential to get away from the old principle that Colonies can only have what they themselves can pay for: they must have what a first-class Colonial power may reasonably be expected to provide.” Pressing upon political arguments about Britain’s reputation in wartime, MacDonald eventually succeeded. Treasury yielded, agreeing in principle to the funding of both capital and recurrent expenditures so long as funding for both came from

⁵⁷ Constantine, *The Making of British Colonial Development Policy, 1914-1940*. Page 214

⁵⁸ *Ibid.* Page 213

a single source.⁵⁹ The Colonial Office agreed that this single source of funding, voted annually by Parliament, should be capped at £5 million, rather than their original proposal of £10 million. Treasury, for its part, had agreed to forgive £11 million of the £15 million in debt owed by the colonies to the Imperial Exchequer.⁶⁰ In a 1939 review Treasury officials had already deemed the hope of repayment of much of this debt “an obvious unreality,” and lauding increased aid to impoverished colonies while continuing to insist upon such debt payments seemed, even to them, “not reasonable.”⁶¹

MacDonald had secured the necessary concessions from the usually-parsimonious Treasury, but his plans to publicly release his proposals alongside the Royal Commission’s report were not to be realized. In a decision that would anger Labour MPs including Clement Attlee and Arthur Creech-Jones, the Prime Minister’s Cabinet had decided that the document was so critical of British policy as to provide fodder for Axis propaganda.⁶²

The Report itself was no radical document. It attributed some of the problems in the West Indies to the “moral standard” of the “negro population.” But the authors did highlight

⁵⁹ Ibid. Page 218-219

⁶⁰ *Colonial Development: A Factual Survey of the Origins and History of British Aid to Developing Territories*, British Aid 5 (London: The Overseas Development Institute Ltd, 1964). Page 24.

⁶¹ Constantine, *The Making of British Colonial Development Policy, 1914-1940*. Page 221.

⁶² In a House of Commons debate on April 20, Creech-Jones and Attlee demanded MacDonald explain why they were withholding the full report. MacDonald’s response was pure evasion: “The government intend to go right ahead with action arising out of the report.” The Report of the West India Royal Commission, also known as the Moyne Report, was not published in full until after the war’s end in 1945. See House of Commons Debate February 1940, Vol 357, cc.1164-61164. <http://hansard.millbanksystems.com/commons/1940/feb/20/west-indies-royal-commissions-report>.

the many grievances presented by members of the “negro” and “coloured” populations, including the problems of “colour discrimination,” the lack of support for peasant agriculture, and restrictions on strike actions. The Commission even declared “a “right to strike,” and considered “any restriction of this liberty of action... tantamount to industrial servitude.” In line with MacDonald’s campaign for social service provision, the report devoted many pages to the woefully inadequate provision of health and education. The report’s authors noted that spending on health (as a percentage of overall government expenditure) and government medical officers (relative to population) were both higher in most West Indies colonies than in any British African holding. But still, the report called for expanded medical auxiliary training, more rural clinics and hospitals, and far greater spending on preventive medicine throughout the West Indies. Increased spending on health services was, according to the report’s authors, an integral part of the imperial response to recent unrest on the islands.⁶³

Though Prime Minister Neville Chamberlain’s cabinet refused to publish the report, they did permit MacDonald to publish the Royal Commission’s summary recommendations alongside the Government’s new *Statement of Policy on Colonial Development and Welfare*. Both were released on February 20, 1940. That day, a publicity campaign coordinated by Colonial Office staff included a speech by MacDonald to the House of Commons and an address by Lord Moyne, Chairman of the Royal Commission; the latter was broadcast on radio in Jamaica.⁶⁴ The *Statement of Policy* touted by MacDonald was

⁶³ “West India Royal Commission Report, Presented by the Secretary of State for the Colonies to Parliament by Command of His Majesty.”

⁶⁴ “Lord Moyne Tells of Findings of Royal Commission,” *The Daily Gleaner*, February 21, 1940.

only six pages of text, but its drafting had occupied the Colonial Office and Treasury in heated debate for months. The final text highlighted His Majesty's Government's agreement with the Royal Commission's recommendation that £1 million per year should be spent on education, health services, housing, slum clearance, and land settlement in the British West Indies. The statement continued to explain that while the Commission conducted its investigation, the UK Government had "been examining the position in the Colonial Empire generally."⁶⁵ It announced a new colonial development policy, in which "assistance will be available not only for schemes involving capital expenditure necessary for Colonial development in the widest sense but also for helping to meet recurrent expenditure in the Colonies on certain services such as agriculture, education, health and housing."⁶⁶

The simultaneous release of the Statement of Policy and the Royal Commission recommendations had the political effects that MacDonald had desired. The Colonial Development and Welfare bill moved, uneventfully, to passage. Though MacDonald was transferred to a new position as Minister of Health after Churchill replaced Chamberlain as Prime Minister in May, the bill's progress through the legislative process continued, and the act received the Royal Assent on July 17, 1940.⁶⁷

⁶⁵ "Statement of Policy on Colonial Development and Welfare Presented by the Secretary of State for the Colonies to Parliament by Command of His Majesty" (London: His Majesty's Stationary Office, February 1940), House of Commons Parliamentary Papers Online. Page 3.

⁶⁶ Ibid. Page 6

⁶⁷ Constantine, *The Making of British Colonial Development Policy, 1914-1940*. Page 222.

The Colonial Development and Welfare Act of 1940 was, then, a dividend of disquiet. Both the labor unrest of the mid- and late-1930s and the outbreak of war furnished MacDonald with powerful political arguments capable of overcoming the longstanding objections of the Treasury.⁶⁸ Colonial Office reports and speeches by Labour MPs had stressed the need for a focus on social welfare in the colonies even before the “disturbances” in the West Indies, but the threat to imperial legitimacy helped soften the objections of Treasury officials and other skeptics. The 1940 Act was, according to historian Stephen Constantine, “devised as a method of removing legitimate grievances in the colonies, stabilizing the empire and defusing criticism of British colonial rule. The emphasis on colonial development and welfare was, then, essentially a defensive operation, to provide a new justification which would legitimize the perpetuation of colonial rule.”

d) Explaining the 1940 Colonial Development and Welfare Act: imperial legitimation or altruism?

But one question remains unanswered in MacDonald’s arguments for—and Constantine’s analysis of—the Colonial Development and Welfare Act: why did health and education spending seem a logical response to labor unrest? After all, investigations of the protests in Northern Rhodesia, Trinidad, Barbados and Jamaica pointed to taxes, low pay and poor working conditions as the causes of unrest, not the level of social service

⁶⁸ Paul Kelemen, “Planning for Africa: The British Labour Party’s Colonial Development Policy, 1920-1964,” *Journal of Agrarian Change* 7, no. 1 (2007): 76–98. Pages 79-80.

provision.⁶⁹ Constantine seems to indicate that the answer lies in a spirit of imperial altruism (he closes his analysis with quotes from other historians lionizing the generosity of Empire), but there was a much more self-interested reason for the focus on public sector social services at the start of the Second World War. For officials in the Colonial Office, it was much more politically palatable to propose increased health and education spending than to contemplate more fundamental changes to the extractive economic systems. The sites of protest, such as the Luanshya mine and the West Indies Sugar Company plantation, were owned by companies registered in Britain that reaped tremendous profits from the mineral wealth and cheap labor made available in the colonies. Investors in such companies were—for the most part—British voters, and among the most invested were a wealthy British MPs and Lords. It was more palatable to such investors to use tax dollars on more nurses and teachers than to lessen their own company profits in order to increase wages.⁷⁰ Such investors were also a target of MacDonald's arguments about the reputation of Empire, for alongside the danger that Britain might lose her territorial possessions came the risk of investment losses through nationalization or expropriation by some other colonial power. Spending on social

⁶⁹ “West India Royal Commission Report, Presented by the Secretary of State for the Colonies to Parliament by Command of His Majesty”; Pim and Milligan, “Report of the Commission to Enquire into the Financial and Economic Position of Northern Rhodesia”; “Report of the Commission Appointed to Enquire into the Disturbances in the Copperbelt, Northern Rhodesia, Presented by the Secretary of State for the Colonies to Parliament by Command of His Majesty.”

⁷⁰ In the late 1930s the Labour Party and the Trade Union Congress in Britain did seek to promote unions in the colonies (unions had been involved in the protests in Barbados, Trinidad, and Jamaica) but they said they would discourage them from “spontaneous action at the grass roots.” See Cooper, *Decolonization and African Society*. Pages 58, 64.

services, then, was an attempt to “palliate” colonized publics and international criticism without more fundamental changes to the imperial economic system.⁷¹

The fate of Nyasaland provides further support for this argument. Far less significant in economic terms, and seen to be relatively unaffected by labor unrest, Nyasaland garnered a fairly small share of the debt relief and new funding made available by the passage of the 1940 Colonial Development and Welfare (CDW) Act. The Act decreased Nyasaland’s outstanding debt for the Trans-Zambesi Railroad loan guarantee from £550,000 to £300,000. Nyasaland’s share of debt relief (less than half) was far less than the overall share of colonial debt forgiven by the Imperial Exchequer (more than two-thirds).⁷² The squeaky wheels, it seemed, got the grease.

IV. Nyasaland, the still-quiet backwater: wartime neglect and the postwar dawn

a) A medical service gutted by war, 1939-1942

At the start of a new global war in 1939, Nyasaland’s public sector medical services became even more threadbare. Unlike the First World War, Nyasaland would not forcibly recruit hundreds of thousands of Africans for carrier duty, but its already paltry medical services would be drained once more. Three African medical officers were seconded for

⁷¹ For arguments that health spending is a form of political palliation, see Stephen Constantine, *The Making of British Colonial Development Policy, 1914-1940* (Totowa, N.J.: F. Cass, 1984). Page 189.

⁷² This despite the fact that, in a speech before the House of Lords during the debate over the 1940 CDW Act, former Conservative MP Charles Bathurst (recently given a peerage as the 1st Viscount Bledisloe, who had chaired a 1937 commission on the amalgamation of Nyasaland with Northern Rhodesia) had called for the elimination of all of Nyasaland’s debt. It created, he said, a “crippling condition.” Charles Bathurst, *Colonial Development and Welfare Bill, House of Lords Debate, Volume 116, cc723-48*, 1940, <http://hansard.millbanksystems.com/lords/1940/jul/02/colonial-development-and-welfare-bill>.

military service abroad in 1939, along with two African hospital assistants, 16 dressers, 20 stretcher-bearers, and seven wagon orderlies.⁷³ The Medical Department was prohibited from spending the resulting savings. Some of Nyasaland's medical stores were also shipped away to aid the war effort.

Initially De Boer reported that despite the staff withdrawals, only three dispensaries had closed.⁷⁴ But in 1940, when Italy joined the Axis powers, another five government medical officers and one of the missionary doctors at the Church of Scotland Mission were released for military service in North Africa. Within two years, the number of medical officers had fallen from 18 to 10.⁷⁵ The remaining doctors took on even more responsibilities than usual. Between 1940 and 1943, in addition to managing pilot Nutrition Units (see Chapter 1), Berry was the only government doctor in Kota Kota and Dowa districts; the two hospitals serving these districts were 90 miles apart.⁷⁶ Medical officers were still overwhelmed by the scale of the work with which they had been tasked. Speaking of his responsibilities as the sole medical officer in Mlanje in 1941, Walter Gopsill explained: "As well as being in charge of a Hospital containing one

⁷³ McCracken explains that military laborers were obtained by less obvious forms of compulsion than during the First World War. "With the entry of Italy into the war in 1940, priority was given to the 'enlistment of as many fit men as possible in the KAR'...Provincial and district officers threatened Native Authorities and Headmen with the loss of privileges if they failed to provide sufficient numbers of recruits." By such means, a total of 27,000 soldiers from Nyasaland were enlisted by 1945. They served in Ethiopia, Somaliland, Madagascar, Ceylon, India and Burma. See McCracken, *A History of Malawi*, 239.

⁷⁴ "Annual Medical & Sanitary Report for the Year Ending 31st December 1939." Pages 4-5

⁷⁵ "Annual Medical and Sanitary Report for the Year Ending 31st December 1940" (Zomba, Nyasaland: Government Printer, 1941), Box 15, No 16, SoMA. Page 1

⁷⁶ "Annual Medical and Sanitary Report for the Year Ending 31st December 1940" (Zomba, Nyasaland: Government Printer, 1941), Box 15, No 16, SoMA. the only other doctor in the area worked in Dowa for the Witwatersrand Native Labour Association to screen labor recruits for South Africa's mines, and according to Berry he sometimes provided care for emergency cases when Berry was far away.

hundred beds one was responsible for the control of Epidemic diseases in the area, the medical care of the European population, eight District dispensaries dotted about the district, inspections and care of factory staffs and the general public health of the district, also the inspection of the numerous Indian Stores and of course the Market. In addition, one was called out to treat European planters and their families. The African population was well over 100,000.”⁷⁷ Obviously, very little of this work was done extensively. Many districts had no medical officer at all during the war. African hospital assistants were put in charge of daily operations at district hospitals in Chiradzulu, Chikwawa, Upper Shire, Ntcheu, Dedza, Dowa, Kasungu and Nkhata Bay.⁷⁸ When the council of chiefs in Lilongwe District requested additional rural dispensaries in 1942, Governor ECS Richards informed them many of the freshly trained African auxiliaries were unavailable to staff new dispensaries because they had been recruited to the military.⁷⁹

b) The politics of scarcity: maintaining a placid populace

De Boer may have been concerned about these conditions, but neither he nor other officials in Nyasaland wanted to see political protests erupt over the sorry state of social services. After years of riots in the West Indies and Africa, officials were alive once more to the dangers of disquiet. By the early 1940s, with all resources directed at the war

⁷⁷ Gopsill, “A Few Notes on My Life in Zanzibar and Nyasaland from 1926 to 1945.” Page 34. Gopsill and other medical officers relied on their wives to help fulfill their duties. Gopsill explained: “My own wife gave unstinted aid in so many ways, from giving chloroform, and assisting at operations, acting matron, clerk, and store keeper, and when needed acting as midwife, sewing maid, and secretary, all unpaid of course.” Ibid. Page 37.

⁷⁸ Michael King and Elspeth King, *The Story of Medicine and Disease in Malawi: The 150 Years Since Livingstone* (Malawi: Arco Books, 1992). Page 137.

⁷⁹ “Provision of Rural Dispensaries in the Lilongwe District, by Chief Secretary, Zomba,” November 18, 1942, S40/1/3/2, MNA.

effort, they sought to mitigate the dangers in Nyasaland not through health spending, but by preventing African medical workers from organizing. After all, African medical workers were among the most educated colonial subjects in a time when education was considered as a risk factor for disquiet. In June 1941, Henry J. Banda and PJ Godfrey Mhango, two African medical assistants at the Zomba African Hospital, wrote de Boer to ask for his comments on their proposed constitution for a “Nyasaland African Medical Association.”⁸⁰ De Boer and the Chief Secretary agreed to recognize the organization, but advised Mhango and Banda to “concentrate on the educational side.”⁸¹ The implication was that they should steer clear of other, more overtly political purposes. Their proposed constitution had suggested that the group would work to “attempt to overcome the difficulties and to examine the complaints of members of the Association.”⁸² For colonial officials, such hints at labor organizing were not welcome.

The colonial administrators were successful at maintaining political calm in Nyasaland during the war. At the same time medical services did not fare well. During the Second World War, with both mission and government personnel depleted and growing patient censuses, the administration attempted to coordinate government and mission healthcare.⁸³ In some cases the absence of adequate medical provision spurred such

⁸⁰ Henry J. Banda and PJ Godfrey Mhango, “Letter to Director of Medical Services H.S. de Boer,” June 1941, S40/1/1/1, National Archives of Malawi.

⁸¹ H.S. de Boer, “Letter to Chief Secretary,” June 6, 1941, S40/1/1/1, National Archives of Malawi.

⁸² Banda and Mhango, “Letter to Director of Medical Services H.S. de Boer.”

⁸³ DM Kennedy, “Letter from Governor DM Kennedy to Right Reverend Bishop of Nyasaland Re: ‘Nursing Sisters,’” July 9, 1941, S40/1/5/4, MNA. These were not entirely successful. In a discussion of Kota Kota in 1941, Governor Kennedy argued it was “absurd that Government and mission should be running similar institutions, each with half a staff within a mile or two of the

frustration that remaining medical officers resorted to uncommon measures. In 1942 John Owen Shircore returned to Nyasaland, where he had begun his career in the colonial service over thirty years earlier. As a veteran medical officer on the cusp of retirement, Shircore wrote to the Director of Medical Services to explain there was a “considerable population” in his district (Karonga) “for whom there are no immediate medical facilities.” Sick Africans in an area called Mlale faced an “arduous journey” to reach his hospital in Karonga. Patients who were carried all the way to the hospital were often so ill they died en route or shortly after arrival. Shircore suggested renovating a building in Mlale owned by the estate of a European farmer; the building could, he explained, be used as a government dispensary.⁸⁴ The prevailing government policy at the time was to deny requests for new dispensaries unless construction was financed out of the budgets of Native Authorities (who kept a small share of hut tax revenues). In this case, Mlale’s Native Authority, Chief Kyungu, wanted to see the new dispensary built but said he lacked the funds to pay for it. Shircore offered Chief Kyungu £100 out of his own savings to pay for the building.⁸⁵ He did not wish to be repaid. Both Kyungu and the Governor gratefully accepted this offer. The next chapter will further explore the unwillingness of

other.” In January 1942 Bishop of the UMCA Mission and Dr. Wigan agreed to the “amalgamation” of medical work in Kota Kota, whereby in return for a £100 “donation” from government to the mission, a mission nurse would work at the Government hospital most mornings, while spending afternoons at the Maternity Centre at her Mission. But the arrangement did not last. By October 1943, the nurse complained her maternity responsibilities at the mission were far too demanding for her to work in both facilities; she explained that laboring women had awoken her for “twelve nights in succession.” The UMCA terminated the arrangement with the government and the staff continued their work separately. See TA Austin, “Letter to Chief Secretary, Zomba, Re: Mission Cooperation at Kota Kota Hospital,” October 14, 1943, S40/1/5/4, MNA.

⁸⁴ JO Shircore, “Letter to Director of Medical Services, Zomba,” September 28, 1942, S40/1/3/2, File 51a, MNA.

⁸⁵ JM Ellis, “Letter to Director of Medical Services, Zomba, from Provincial Commissioner, Northern Province,” June 4, 1943, S40/1/3/2, File 67a, MNA. Also see Juxon Barton, “Letter to JO Shircore from Chief Secretary, Zomba,” November 15, 1943, S40/1/3/2, MNA.

medical officers to accept what they considered to be unprofessionally low standards of medical provision. It will show that neither Shircore's frustration nor his determination were unique, but might be understood as manifestations of a professional imperative in an environment of heavy morbidity and forced scarcity.

c) Miracle drugs in small quantities: Nyasaland's first antibiotics

Even as staff left for military service and the recurrent budget flat-lined, admissions at government hospitals climbed rapidly during the early 1940s. After an increase (from 3,958 in 1930 to 10,052 in 1935) that coincided with the construction of new hospitals with CDF funding, inpatient admissions remained fairly steady through the start of the war, rising only to 11,102 in 1939. But then patients came quickly; inpatient admissions rose to 20,008 in 1941, then to 23,369 by 1945. For the first time since the construction of a dozen district hospitals in the early 1930s, many government facilities were overcrowded. In August 1941, DMS de Boer noted that during a recent visit to Kota Kota he found 114 patients in a hospital with only 70 beds. "There were patients lying on the ground between beds and in the passage-way down the middle of the wards."⁸⁶

Some of this increase can be attributed to the entry of sulphonamide antibiotics, which brought even dramatic changes to patient care even as its use was strictly controlled. The first sulphonamide, Prontosil, was marketed in the United States and Europe beginning in 1935, and won acclaim after it was used to cure U.S. President Franklin Delano

⁸⁶ Memo by DMS H. De Boer to Chief Secretary, 21 August 1941, S40/1/5/4, MNA.

Roosevelt's son of a septic strep throat infection in 1936.⁸⁷ WTC Berry used sulfanilamide (known by its trade name, "M&B 693"), another sulfa drug, in either 1937 or 1938 (he does not specify the exact date) at Mlanje District Hospital for the treatment of gonorrhoea. At Berry's hospital this drug was so limited that he prescribed it only to inpatients. Berry also made sure to witness each administration of the medicine with his own eyes. "The dressers could not be trusted not to change the amount of the prescribed dose, or to substitute some similar but less potent tablet, retaining the surplus M&B for 'private practice,' or for their sale on the black market."⁸⁸

Doctors were excited by the arrival of the new sulfa drugs. Gopsill recalled how before the first sulfa drugs reached Nyasaland a fellow medical officer had died of septicaemia after a postmortem exam. Gopsill also remembered an epidemic of cerebrospinal meningitis in Mlanje that killed "thousands." Once the new drugs arrived such outbreaks became less common and less devastating, as "one was able to protect contacts and carriers were in large degree eradicated."⁸⁹ In 1941, the DMS included in his report his hope that "the more regular use of M&B 693 in the treatment of [gonorrhoea] at

⁸⁷ JM Ellis, "Letter to Director of Medical Services, Zomba, from Provincial Commissioner, Northern Province," June 4, 1943, S40/1/3/2, File 67a, MNA. Page 68.

⁸⁸ Berry, *Before the Wind of Change*. Pages 14-15. During this era, illegal sales of sulphanilamide were also common in British Nigeria. The black market value of *Amabee* ("M and B") rose to sixpence per tablet. Medical officials responded by shifting from tablet to suspension forms of the drug. Schram, *A History of the Nigerian Health Services*. Page 328.

⁸⁹ Gopsill, "A Few Notes on My Life in Zanzibar and Nyasaland from 1926 to 1945." Page 34-35. David Clyde notes that sulphonamides helped halt an outbreak of meningitis in Tanganyika 1939, but a recrudescence of the disease in 1941-42 could not be controlled even by prophylactic use of the drugs. See David F. Clyde, *History of the Medical Services of Tanganyika* (Govt. Press, 1962). Page 151. Broughton Waddy, a medical officer in northwest Gold Coast (Ghana), remembered using sulphonamides to stem an epidemic of cerebrospinal meningitis in 1945. It was, he said, "probably the most exciting and gratifying work I ever did, not least because no village in which cerebrospinal meningitis was treated ever forgot the doctor who did it." Bernard Broughton Waddy, "Life and Death in the African Bush" n.d., MSS.Afr.s.1856, BLOU. Page 108

government hospitals may in time bring infected persons in bigger numbers to those institutions.”⁹⁰

Chapter 7 will discuss the impact of antibiotics on popularizing government medicine in Nyasaland. For now, suffice it to note that the number of patients presenting for gonorrhoea treatment in government hospitals and clinics did indeed increase following the introduction of sulfa drugs, rising from 1061 in 1935, to 2089 in 1945, to 3715 in 1951. Patients seemed to have growing confidence that treatment for this condition was effective; in 1944 medical officers reported to the DMS that patients were becoming less apt to abscond from the hospital before the end of a treatment course.⁹¹

Still, during the Second World War medical officers lamented that many sick patients still did not present to government facilities, or that when they did they often sought inappropriate treatments. Berry complained that for every ailment, from serious illnesses to mild aches, patients demanded injections. He ascribed this to the memories of yaws injections, which brought dramatic cures.⁹² Not all injections were equally popular. Medical officers lamented that they could convince few patients to submit to antimony tartrate injections for schistosomiasis. This was a fairly indolent infection; it could result in blood in the urine or, eventually, bladder cancer, but was not as disfiguring as yaws,

⁹⁰ “Annual Medical and Sanitary Report for the Year Ending 31st December 1941” (Zomba, Nyasaland: Government Printer, 1942), Box 15 No 15, SoMA. Page 8

⁹¹ “Annual Report of the Medical Department for the Year Ended 31st December 1944” (Zomba, Nyasaland: Government Printer, n.d.), Box 15 No 12, SoMA.

⁹² Berry, *Before the Wind of Change*. Page 9

and the injection itself could precipitate serious malaria infections or abscesses.⁹³ Megan Vaughan has described how African patients in Nyasaland knew the difference between the more expensive arsenical drugs (intravenous injections available at some hospitals) and cheaper mercurial compounds (intramuscular injections available at rural dispensaries). Seeking the former, they favored hospitals over rural dispensaries for syphilis treatment. African patients were, in Vaughan's words, "discriminating" in their approach to drug therapy, and medical officers knew it.⁹⁴

While by the late 1940s government health facilities were becoming steadily more popular and more amply funded, hospitals and dispensaries were still not a meaningful part of experience of being governed for most Africans in Nyasaland. Outpatient attendance at government facilities rose steadily, though never dramatically, beginning with the construction of the first dispensaries in the early 1920 to the beginning of Federation in the mid-1950s (see Figure 4.1). Inpatient admissions rose steadily after the

⁹³ H De Boer, "Annual Medical & Sanitary Report for the Year Ending 31st December 1938" (Zomba, Nyasaland: Government Printer, 1939), Box 15 No 18, SoMA. Page 27. Abscesses were often secondary to the inadvertent injection of potassium antimony tartrate (an intravascular injection) to extravascular tissues. Gopsill wrote in 1931 that this often had the effect of "frightening away a primitive or nervous patient." See WL Gopsill, "Schistosomiasis in Nyasaland and Its Treatment by Means of Fouadin," *Journal of the Medical Association of South Africa* 5, no. 7 (April 11, 1931): 222–23.

⁹⁴ Vaughan, "Health and Hegemony: Representation of Disease and the Creation of the Colonial Subject in Nyasaland." Page 191.

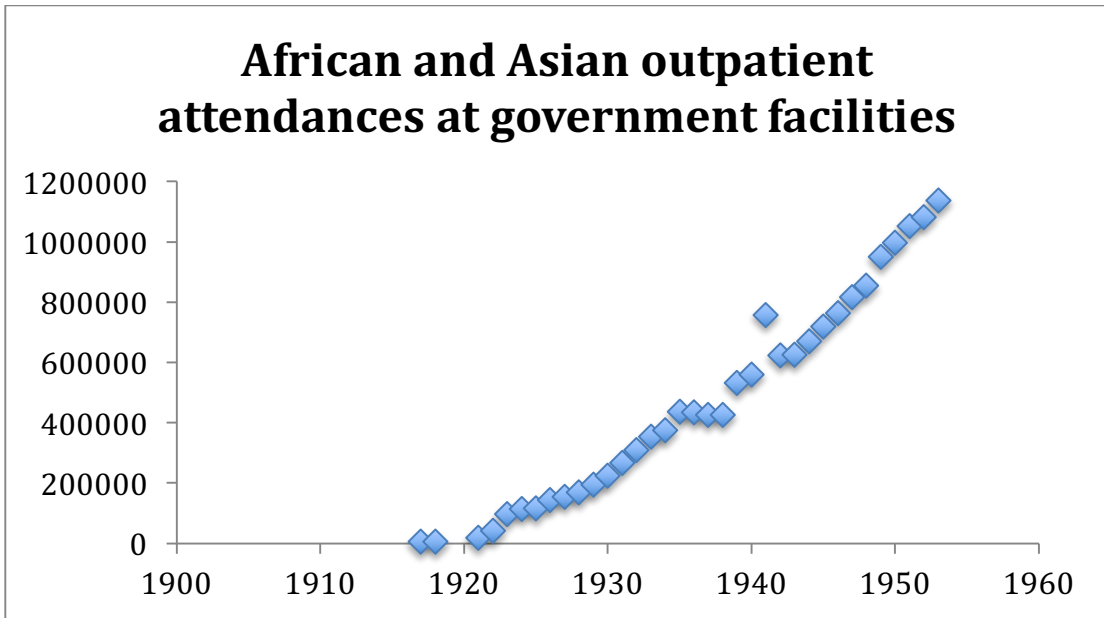


Figure 4.1: African and Asian outpatient attendances at Nyasaland government facilities, 1914-1953. Source: Nyasaland annual Medical Department reports, 1914-1953.

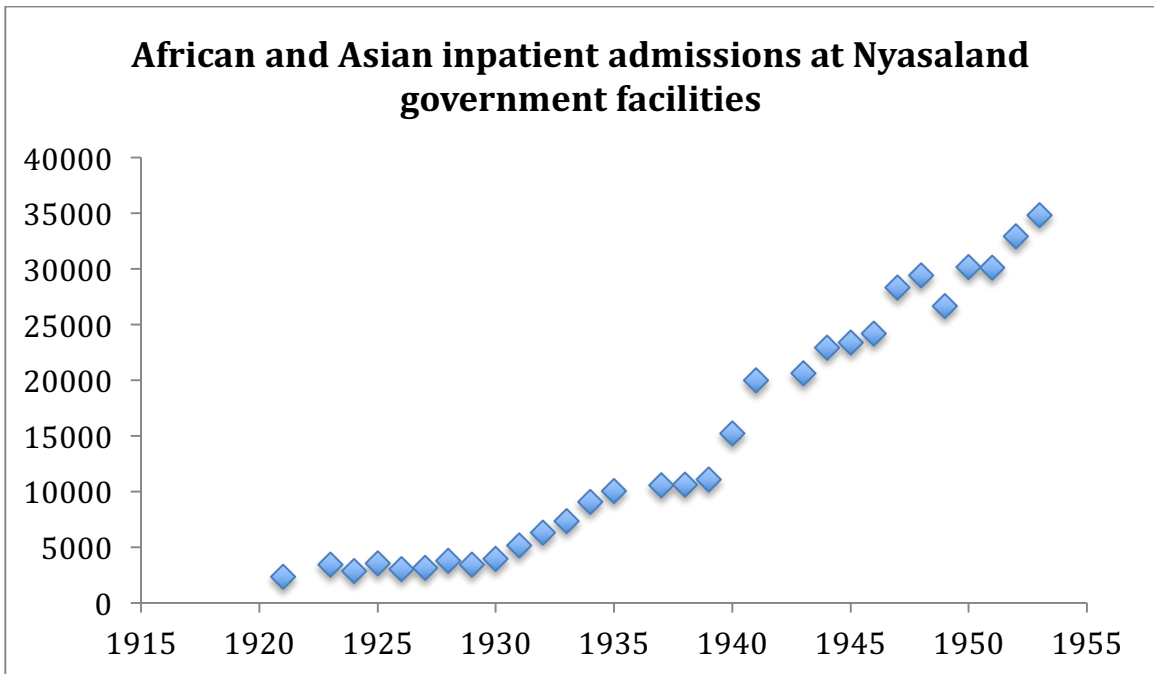


Figure 4.2: African and Asian inpatient admissions at Nyasaland government facilities, 1914-1953. Source: Nyasaland annual Medical Department reports, 1914-1953.

CDF-funded construction of hospitals in the early 1930s, then more dramatically in the early 1940s following the introduction of sulphonamide antibiotics (see Figure 4.2). But as late as 1946, the Director of Medical Services worried that “no more than a beginning has been made in inducing the African population to take advantage of the medical facilities provided.”⁹⁵

V. Conclusion

As Chapter 3 demonstrated, the Colonial Office used unemployment in the UK to garner funds for colonial development in the late 1920s. In the late 1930s, the Colonial Office secured additional funds through the deft use of metropolitan fears about colonial labor unrest. Yet while Nyasaland’s Medical Department benefited from the 1929 Colonial Development Act almost immediately, colonial medicine was far from a priority a decade later.

In both periods, leading colonial medical officers authored reports on the sorry state of Nyasaland’s medical services. But they were received quite differently. Whereas Shircore had been invited to write such a report in 1930, and submitted his work to the sympathetic Basil Blackett at the CDAC, de Boer had no such license. Officials in Whitehall were unmoved by his (apparently unsolicited) report. Whereas the promised materiel orders from the construction of the Zambesi Bridge and the especial attention of a few key MPs rendered Nyasaland a place of imperial concern in 1929, a decade later the Protectorate was known only for its relative political quietus and economic

⁹⁵ PS Bell, “Report of the Medical Department for the Year 1946” (Zomba, Nyasaland: Government Printer, 1947), UMMC. Page 5.

insignificance. While other parts of the empire erupted in deadly riots and costly strikes, Nyasaland seemed to offer little evidence of unrest. Nyasaland was not entirely quiet, but the anti-witchcraft and millenarian movements of the 1930s did not arouse much official concern. Ironically enough, health services would suffer for this seeming placidity.

This chapter, and the last, also demonstrates something else. The scathing tone of both the Shircore and de Boer reports provides further evidence of an emerging historiographical understanding of the differences between colonial doctors and other colonial administrators. Members of the UK Colonial Service have long been stereotyped as Oxbridge-educated white males born into at least some wealth, endowed with a penchant for sports, practical minds and adventurous spirits. In general, historians believed them to have shared a “world-view that was politically conservative, any more radical elements within it being silenced for the sake of preserving the status quo.”⁹⁶

Yet Anna Crozier has demonstrated (through prosopographical analysis of members of the Colonial Medical Service in Uganda, Tanganyika and Kenya) that medical officers hailed from a “more diverse social group” and trained at more varied institutions.⁹⁷ These differences in biography between doctors and other colonial officers could help explain why Shircore, de Boer, and a number of medical officers in Nyasaland during the Federation years (Chapter 8) were so critical of the quality of medical services available to Africans. Both had trained at leading medical schools in the UK (de Boer in London,

⁹⁶ Anna Crozier, “The Colonial Medical Officer and Colonial Identity: Kenya, Uganda and Tanzania before World War Two” (PhD Dissertation, University College London, 2005). Pages 214-215.

⁹⁷ Ibid. Page 217.

and Shircore in Edinburgh). Both had connections to South Asia; de Boer was born into a burgher family in Ceylon (Sri Lanka) and Shircore's father was in the Indian Medical Service.⁹⁸ The Indian Medical Service included famous researchers and enjoyed greater resources, and held much greater prestige than the East African Medical Service.⁹⁹ And both de Boer and Shircore had practiced in other East African colonies, all of which spent more per capita on health for Africans than Nyasaland. Neither man was by any means a radical, but their backgrounds left them dissatisfied with the state in which they found Nyasaland's medical services. Each wrote scathing reports that called for far greater spending on health.

These reports were a necessary, though (as this chapter has shown) not sufficient element in expanding Nyasaland's health services. They reveal contests over budgets and resources between colonial medical officers and the Colonial Office. These debates rarely appear on the physicians' memoirs, which as Crozier notes, tended to "sensationalize Africa" while avoiding quotidian bureaucratic realities.¹⁰⁰ Yet, as the next chapter will demonstrate, sometimes the most bureaucratic prose that creates the greatest sensations. In the midst of the Second World War, an Indian-born British economist named William Beveridge would author his own report, one that would radically shift discourse on medical policy throughout Britain and her Empire.

⁹⁸ DV Altdorff, "Genealogy of the Speldewinde Family of Ceylon," *The Journal of the Dutch Burgher Union* 33, no. 3 (1944): 76; Crozier, "The Colonial Medical Officer and Colonial Identity: Kenya, Uganda and Tanzania before World War Two."

⁹⁹ Crozier, "The Colonial Medical Officer and Colonial Identity: Kenya, Uganda and Tanzania before World War Two." Page 62.

¹⁰⁰ Anna Crozier, "Sensationalising Africa: British Medical Impressions of Sub-Saharan Africa 1890-1939," *Journal of Imperial and Commonwealth History* 35, no. 3 (2007): 393-415.

Chapter 5

Beveridge beyond the British Isles: health in wartime development and postwar visions of social protection, 1939-1945

Abstract

This chapter examines wartime and early postwar debates over social and economic rights in Britain's colonies in southern Africa. During the Second World War Churchill's Coalition Government sought to defend the British Empire not only against Axis troops, but also against critics in the United States. For its part, the Labour Party sought to define its colonial policy. Within the party, the members of the Fabian Colonial Society discussed the relationship between their political commitments to democratic socialism and the practice of colonial rule.

The UK Government responded to its critics by touting spending on colonial development in the midst of war, while the Labour Party called for additional spending on colonial social welfare. At the same time, social policy became a focal point of Britain's domestic politics. William Beveridge's wildly popular *Report on Social Insurance and Allied Services*, published in November 1942, called for rationalizing and expanding programs of social protection including unemployment insurance, health care, and subsistence payments for the elderly and infirm.

For some commentators, including Beveridge and prominent members of the Labour Party, the social and economic rights embodied in the report seemed applicable not only to Britain, but also to its colonies. Immediately after the war Beveridge planned a trip to India, where he hoped to write a report on social protection that included programs for subsistence farmers as well as industrial laborers. Though they had their own pre-existing politics of social protection and social medicine, the Beveridge Report also provided an additional political weapon to advocates in South Africa and Southern Rhodesia. This chapter provides an account of a contingent moment, when various sorts of social welfare were debated in southern Africa.

Prelude: "I have taken them into my hands": kinship and state social protection in 2015

Walking down the main dirt road of the Neno *boma* (district capital) one morning in mid-January of 2015, I saw a stream of men and women using bicycles or wheelbarrows to carry large bags. On closer inspection, I discovered the bags were filled with 50 kilograms each of urea fertilizer. I asked a young man where he had obtained his bag. He pointed to a primary school about 100 meters up the road. I asked him if he had

purchased the fertilizer: “*Munagula feteleyza?*” He answered no, he had *received* it: “*Ayi, ndinalandira feteleyza.*” The distinction was an important one, as the price of imported fertilizer had skyrocketed with the devaluation of the kwacha against the US dollar and the euro.

I walked to the primary school, past young men (and even women) straining to carry the bags on their backs. Parked in front of the school was a large blue lorry with an empty bed, with a few stragglers standing by their bags. The driver of the lorry explained that he had driven from Blantyre that morning with 270 bags of fertilizer, which had been distributed that morning. This distribution, he explained, was not a part of the main government-sponsored fertilizer subvention program (popularly known as the “coupon”); that fertilizer had been sold a month ago. This was a public works program, wherein heads of those households identified as vulnerable by village headmen were employed in fixing roads. In return for their labor, each household received a 50-kilogram bag of fertilizer and 10 pounds of maize seed.

Safety-net programs such as this work-for-farm-input program are, in the words of one World Bank assessment, “core instruments for reducing poverty and managing risk.”¹ In 2015 Malawian social policy included such anti-poverty interventions as targeted cash transfers, cash-for-work programs, subvention of farm inputs and free healthcare and primary education. Each of these programs has come under criticism, from within and

¹ Victoria Monchuk, *Reducing Poverty and Investing in People: The New Role of Safety Nets in Africa* (The World Bank, 2013), <http://elibrary.worldbank.org/doi/book/10.1596/978-1-4648-0094-8>.

from outside Malawi. For instance, the World Bank has long contended that chiefs and politicians distribute fertilizer coupons not to Malawi's poorest people, but to friends and

Figure 5.1: Private and public forms of social support in Malawi

Forms of kinship/village social support

- Child fosterage (permanent or temporary)
- Caring for the sick, accompaniment to hospitals (*woyanganira wodwala*)
- Sharing food
- Working fields of the sick
- Paying school fees of family members
- Piecework labor (*ganyu*) in fields of wealthier relatives and neighbors
- Community donations for marriages, funerals and health care costs

Forms of Government social protection

- Free public sector health care
 - Free primary education
 - Public works programs during hungry season
 - Targeted fertilizer subsidies
 - Targeted cash transfer programs
-

influential supporters.² Newspapers in Malawi often run editorials decrying the cost of providing healthcare and primary education without fees. And the targeted cash transfers remain little more than pilots, and have not reached many of the most destitute in Malawi.

For most Malawians social support is crucial for survival, yet relatively little of it comes in the form of government programs (see Figure 5.1). One particularly common form of kinship-based social support is child fosterage, wherein young children live for in the homes of relatives other than their birthparents. This is especially important for families

² Ibid. Page 101.

with many young children; for parents in this particularly stressful time of the life-cycle of a family, there were many mouths to feed and few hands to help in the field and around the home.³ A year ago, Francis sent his daughter Lucia to visit (*kucheza*) her maternal grandmother in Lilongwe for three months. For weeks while living with Francis I thought Monica was also his daughter; they would call her “my child” (*mwana wanga*). But, while inquiring about his extended family, I finally discovered that Monica was, in fact, the daughter of Edith’s brother, David. Edith and Francis were helping to care for Monica for a time, while David and his wife—who had less material wealth than Francis and Edith—cared for their newborn baby.

In other households in Mbeya village, grandparents cared for grandchildren. In some cases, the parents had died early, while in others they were away working in Lilongwe or South Africa. In a number of these households the grandparents were barely able to provide for the children. An old woman with a marked limp said she had given birth to seven children, but only two survived. Two of her late daughters had each given birth to five children. Seven of those children now lived with her. The grandmother said she received some support from her other three grandchildren, who were older. One worked at the Pumulani Lodge nearby, another worked in in Blantyre, and the third lived in a nearby village. But she placed the most hope in one of her grandsons, currently in his penultimate year of secondary school. She showed me his report card, which listed him as third in his class. His teacher complimented his “seriousness.” Beaming with pride, the

³ This period in the life-cycle of the peasant family has long been known to bring special vulnerability, particularly since the painstaking demographic work of Aleksandre Chaianov in tsarist Russia. See Aleksandre Chaianov (trans. RD Irwin), *The Theory of the Peasant Economy* (American Economic Association, 1966).

grandmother described her great expectations for the boy: “He will take care of me” (*adzasamalira ine*). The care could not come a moment too soon. Only a few days ago, while trying to transport a bag of fertilizer to her field, the grandmother had slipped and dropped the heavy bag on her own foot. It was quite swollen, but she did not think she had broken any bones. She did not think it would do any good to go to the clinic.

Many adults in Mbeya had to provide not only for young children, but also for their elderly parents. For the last two years, Francis’s mother, Anna, has found it difficult to complete her daily chores. She suffers from osteoarthritis that so advanced that she can walk only slowly, and with a grimace on her face. Her husband, Chisomo, Francis’s stepfather (Francis’s father died twenty-five years ago) is even more disabled. Though the medical assistants who see him in rushed visits at the nearby Monkey Bay hospital have diagnosed him with nothing more than benign prostatic hyperplasia (BPH), a common condition among older men the world over, he lives in such chronic pain that he rarely ever rises from his banana-leaf mat (For more on Chisomo’s medical history, see the prelude to Chapter 7). The couple could do little to support themselves. Neither Anna nor Chisomo could complete the walk to the maize fields to help with planting or weeding, though they maintain a tiny garden behind their home. Once every morning Anna hobbled down to the shore of the lake with a pail to gather water to wash her dishes. One morning, I even saw her chopping at a felled tree with a heavy axe in an attempt to gather firewood.

It has fallen to Francis to do much of the work in caring for his ailing mother and stepfather. He gives them a portion of each year's harvest. Edith often cooks extra food to bring to them; often Anna joins them in their home dinner (while Chisomo finds the short walk too painful on most days). "I have taken them into my hands," Francis explains, "so now it is as if I have two houses."

Even within his immediate family Francis must cope with expensive social needs. For the past two years Lucia has complained of intermittent dull pain in her chest and in the left lower quadrant of her abdomen. This often keeps her home from school, and her teachers have complained that she lags in some subjects. When Lucia first complained of this pain Francis had taken her to the private clinic twelve kilometers away in Cape Maclear—a fee-charging clinic but one that is widely thought to give more thorough exams than the public hospital in Monkey Bay. The doctor there could find nothing to explain the symptoms, and transferred her to Mangochi District Hospital, where she remained as an inpatient for two weeks. After those physicians failed to explain her condition, Lucia and Francis went to Zomba Central Hospital. She received an X-ray there, but no diagnosis. Her sojourn continued to Kamuzu Central Hospital in Lilongwe, where she stayed for four days but without any answers or relief. Today she still complains about this pain, which reduces her to tears for hours at a time. Whenever Lucia's pain is mentioned, the expressions on her parents' normally cheery faces quickly change to chagrin.

Francis does not complain much about these familial responsibilities. But he does say that they have prevented him from building up much in the way of savings. Even though most of Lucia's care was at public clinics, weeks of food and long trips to hospitals proved expensive. In addition to providing food for his parents and a home for Monica and Samuel, he also spent four years paying secondary school fees for his late sister's son, William. The problem with meeting these obligations—beyond the pain and suffering that has engendered them—is that it has wiped out his “capital” (here Francis uses the English word). Francis and Edith rarely produce a harvest greater than their household's own consumption in the coming year, so they make very little money from crop sales.

To make cash, Francis prefers to buy *usipa* in bulk from fishermen in his village, then travel on the back of a lorry to larger towns away from the lake (such as Limbe or Dedza or Lilongwe) where he can sell them the fish by the pail at a decent markup in outdoor markets. But in order to make the initial bulk purchase he needs to amass cash. With all of the obligations to pay school fees and find transport to hospitals and provide food for kin he rarely has this cash for long. He feels like he rarely has any savings to guard against a bad harvest or another family emergency, let alone save for a business investment.⁴ With his limited collateral he is unlikely to qualify for a small business loan

⁴ See Chapter 7 for modernization theory's solution for this problem. Modernizers recognized this problem of savings being wiped out by extended family obligations. Their solution was to try to overcome the “obstacle” of extended family obligation by a kind of psychic retraining, a modern mentality with a smaller sphere of mutuality. But, as anthropologists have shown again and again, people are not going to just let relatives die if they can help it, though sometimes the obligations become so overwhelming that they cannot meet them all. Furthermore these obligations fall into readily discernible categories, such as food, medical care, education, housing, all of which could be met by the state in a robust welfare regime. These are not luxury goods to be delayed until the “age of mass consumption” (as modernizers thought) but (as Francis demonstrates) the very

from the bank in Monkey Bay. Even if he did, the annual interest rate charged for such a loan is nearly 30 percent.

So systems of social support exist, even if imperfectly and at great personal cost. While newspaper columnists constantly denounce the “culture of dependency,” rural Malawians often say it is the government that is overly demanding.⁵ As Francis explained in a discussion of taxation, “The government finds ways to get money from the poor.” In the colonial era this took the form of the annual hut tax; the consequences of non-payment were described in Chapter 1. Under Hastings Kamuzu Banda, who ruled from 1964 to 1993, every man, woman *and child* had to buy a Malawi Congress Party card every year; the consequences of non-payment will be described in Chapter 9. In the “multi-party” era, since 1993, consumption taxes increase the prices of basic goods. People expect benefits from their government because they have been made to pay for them.⁶

I. Introduction

In contrast to the 1930s—when plans authored by Shircore and De Boer were frustrated by complacency in London about the legitimacy and staying power of British Empire—by the mid-1940s colonial labor unrest and global conflagration engendered sufficient

preconditions for saving and capital formation. See Hansjorg Dilger. “‘My relatives are running away from me!’ Kinship and care in the wake of structural adjustment, privatization and HIV/AIDS in Tanzania,” in *Morality, hope and grief: anthropologies of AIDS in Africa* (New York: Bergahn Books, 2010), 102-126. Also see Nils Gilman, *Mandarins of the Future : Modernization Theory in Cold War America* (Baltimore: Johns Hopkins University Press, 2003). p 183.

⁵ Mpambira Kambewa, “The Malawian extended family, promoting ‘dependency syndrome’?” March 22, 2015. <http://www.pabwalo.com/debate/the-malawian-extended-family-promoting-dependency-syndrome/>

⁶ Consider, Francis explains, a woman who sells mandazi in the market. “When she buys the *ufa* (flour) she is paying extra. The government gets that extra!”

concern to spur increased funding for health programs. The wartime craze over William Beveridge's plans for social security reforms—including a National Health Service—also increased attention to health policy in Britain's colonies. Some of this attention and funding reached Nyasaland, where government health services grew in both resources and popularity in first postwar decade.

In the prelude to this chapter, I began to explore present-day understandings of obligations that Malawians articulate, obligations between family members and between state and citizen. In this chapter, and the next, I will explore the history of contesting notions of obligation in late colonial British Nyasaland. One set of obligations formed the moral basis for the postwar British welfare state. These ideas circulated widely in the British Empire, forcing the Colonial Office to lay out just how much of the welfare state could and should be enacted outside the British Isles. Another set of obligations circulating during this period concerned social protection in the African village. Discussed by anthropologists, these notions of “traditional” safety nets were repeated often by colonial officials seeking to justify the absence of robust welfare provision in the colonial state. These two sets of assumptions about the relationship between the state and the people would inform a debate, in Nyasaland and elsewhere, about the responsibilities of colonial British administrations to subject African peoples.

Nyasaland's first rural dispensaries grew from the ashes of the First World War (Chapter 1), and the first district hospitals were built after a brief efflorescence of enthusiasm for development spending in 1929 (Chapter 3). This chapter focuses on the years

surrounding the calamitous Second World War, when uncertainty about the future of its imperial possessions once again overcame the consistent chorus of claims about scarce resources long used to protect the UK Treasury from demands for spending on health in the colonies.

II. British colonial development discourse during the Second World War

a) “The Bantu are willing to give everything for victory”: extraction in British Africa during the Second World War, 1939-1942

The historian Stephen Constantine ends his history of the politics of British colonial development in 1940, but debates over aid to the colonies for health and other social services did not abate with the outbreak of war. To be sure, the escalating war effort did dampen imperial expenditures on social services and other development projects in the colonies. In February of 1940 the *Statement of Policy* had acknowledged that spending on the Colonial Development and Welfare fund was not likely to reach the legislated maximum of £5 million per year “at any time during the war.”⁷ MacDonald’s successor as Secretary of State for the Colonies, Lord Lloyd, added his own note of pessimism after the law’s enactment: “Much that we had hoped to do under this Bill when it became law must wait for happier times.”⁸ Though the law allowed for £5 million in annual spending, in the first year (1940-41) the UK government spent only £177,802 on Colonial Development and Welfare fund schemes.⁹

⁷ “Statement of Policy on Colonial Development and Welfare Presented by the Secretary of State for the Colonies to Parliament by Command of His Majesty.” Page 6.

⁸ Constantine, *The Making of British Colonial Development Policy, 1914-1940*. Page 222.

⁹ *Ibid.* Page 222.

Meanwhile, colonial treasuries were impelled to ship away both men and treasure to aid in the war effort. The transfer of financial resources could be substantial. Between 1939 and 1945, the Imperial Exchequer received monetary “gifts” made by colonial governments, native rulers, and private groups and individuals in the colonies. Such gifts emanating from public and private sources in Nyasaland during the war years totaled £164,214.¹⁰ This amount represented nearly three times Nyasaland’s recurrent budget for health in 1939. In 1940 alone the South African protectorate of Basutoland so tightened its belt that revenues exceeded expenditures by £100,000; the entire surplus was transferred to the Imperial Exchequer for the purchase of Spitfire fighter aircraft. “The Bantu,” declared the London-based Royal African Society in 1941, “are willing to give everything for victory.”¹¹

And give they did. The supply of men drawn from the colonies was even more impressive. By the end of the war, 473,000 soldiers in Britain’s army hailed from the Colonies. These soldiers made up a particularly large share of troops in battles against the Italians in East Africa and, later, against the Japanese in Burma. An estimated 7,000 died in combat, and an additional 7,000 were wounded. A government report after the war claimed that the “majority” of the troops from the colonies had volunteered, though some

¹⁰ “Report on the Colonial Empire (1939-1947), Presented by the Secretary of State for the Colonies to Parliament by Command of His Majesty” (London: His Majesty’s Stationary Office, July 1947), House of Commons Parliamentary Papers Online. Appendix II. Other African colonies handed over even more wealth: Northern Rhodesia gave £409,942, while Tanganyika gave £420,988.

¹¹ “Editorial Notes: The South African Protectorates,” *Journal of the Royal African Society*, October 1941, 293–94.

had been conscripted.¹² Labor had also been conscripted in some colonies (including Nigeria, Kenya, Tanganyika, and Northern Rhodesia) during the war to increase production of agricultural and industrial products for the war effort.¹³

b) Wartime development spending as a response to fear of losing the empire, 1942-1945

While the colonies gave blood and treasure from the outbreak of war, they only began to receive substantial quantities of Colonial Development and Welfare funding after the war cabinet grew concerned about critics within Britain and in the United States. In 1942, Labour MPs in Parliament and some quarters of the press pointed to the discrepancy between CDW spending to date and the originally publicized figure of £5 million per annum.¹⁴ In April of that same year, UK Prime Minister Winston Churchill and US President Franklin Roosevelt had “their first serious political argument” over the future of the British Empire, particularly India. Indian nationalists had threatened to withhold support for the Allied war effort, so Roosevelt asked Churchill to make a firm commitment to grant Indians greater self-government. Churchill rebuffed his request, then and repeatedly during the war.¹⁵

¹² “Report on the Colonial Empire (1939-1947), Presented by the Secretary of State for the Colonies to Parliament by Command of His Majesty.” Page 9. British East African military forces rose from 11,000 on Sept 1, 1939 to 228,000 on May 1, 1945; British West African military forces rose from 8,000 on Sept 1, 1939 to 146,000 on May 1, 1945 See Appendix III, page 116.

¹³ Ibid. Page 10.

¹⁴ *Colonial Development: A Factual Survey of the Origins and History of British Aid to Developing Territories*.

¹⁵ William Manchester and Paul Reid, *The Last Lion: Winston Spencer Churchill: Defender of the Realm, 1940-1965* (Little, Brown, 2012). Page 506. *Colonial Development: A Factual Survey of the Origins and History of British Aid to Developing Territories*. Page 26. James P. Hubbard, *The*

Anti-imperial sentiment in the United States, a concern of the Colonial Office in the 1930s, was proving an even greater danger to Britain as it became clear that the United States would have the preeminent role in the postwar world. In May 1942, US Under-Secretary of State Sumner Welles announced that an Allied victory “must bring in its train the liberation of all people.”¹⁶ United States Vice President Henry Wallace urged the Roosevelt Administration to advocate for immediate independence for colonized peoples.¹⁷ In a May 1942 speech, Wallace predicted a “Century of the Common Man” that would commence after the war. The advent of this Century would bring a rapid end to European empires:

No nation will have the God-given right to exploit other nations. Older nations will have the privilege to help younger nations get started on the path to industrialization, but there must be neither military nor economic imperialism. The methods of the nineteenth century will not work in the people’s century, which is now about to begin.¹⁸

Colonial development spending was, to apologists of British imperialism, a demonstration of beneficence directed not only at colonized subjects, but also at Roosevelt and other American architects of the coming postwar world. Colonial

United States and the End of British Colonial Rule in Africa, 1941-1968 (McFarland, 2010). Page 23.

¹⁶ Hubbard, *The United States and the End of British Colonial Rule in Africa, 1941-1968*. Page 11. Welles’ views of colonial rule proved more complicated than this speech suggested. He thought African colonies might have to remain in British hands for some time. Their political progress, he believed, was too slow for immediate independence; after all, he contended, “Negroes are in the lowest rank of human beings.” See Christopher D. O’Sullivan, *Sumner Welles, Postwar Planning, and the Quest for a New World Order, 1937-1943*, 1st Edition (New York: Columbia University Press, 2008). Page 6.

¹⁷ Ruth B. Russell and Jeannette E. Muther, *A History of the United Nations Charter: The Role of the United States, 1940-1945* (Washington, DC: Brookings Institution, 1958). Page 76.

¹⁸ Hubbard, *The United States and the End of British Colonial Rule in Africa, 1941-1968*. Pages 11-12.

development was a version of Wallace's vision of a global New Deal, but without his call for an immediate end to colonial rule.

Amidst these pressures, the UK Government accelerated its approval of new Colonial Development and Welfare Fund schemes. Up until October 31, 1942, after two years in operation, the Secretary of State for the Colonies had approved only 167 schemes involving a total financial liability of just over £2 million. Most of these plans were for possessions in the Caribbean, where memories of unrest were freshest and American attention greatest. But the next two and one-half years (November 1, 1942 to March 31, 1945), the Secretary of State approved an additional 381 schemes involving liability of almost £14 million.¹⁹ CDW schemes classified under the heading "medical, public health and sanitation" also increased after 1942. During the first two years 35 such schemes with an aggregate cost of £330,000 were approved. During the next two and a half-years 65 such schemes were approved, involving costs of more than £2.6 million.²⁰

c) Seeking a colonial policy for the Left: the Labour Party before the Second World War, 1900-1939

International pressures were not the only influence on UK policy on colonial development. During the War, the most prominent site in Britain for discussion and debate over how the government should improve living standards for the colonized was the Fabian Society. Given the Society's history, this was an unlikely forum for such

¹⁹ "Report on the Colonial Empire (1939-1947), Presented by the Secretary of State for the Colonies to Parliament by Command of His Majesty." Page 11.

²⁰ Ibid. Page 13.

discourse. The Fabian Society had been established in 1884 to engage, according to the historian Mark Minion, in “a long and gradualist fight against the evils of late-nineteenth-century capitalism.” The Fabian Society was also established in opposition to those Marxists and trade unionists who called for social transformation by way of revolution. Instead, the Fabians sought to achieve socialism in Britain through peaceful politics—their members founded the Labour Party—as well as dissemination of information and democratic discourse.²¹ Toward that end, the Fabians published essays, books, and pamphlets, primarily on domestic economic issues.

Disagreements within the Society had caused its membership to steer clear of discussions of imperial policy, particularly after 1900. During that year, in the midst of the Boer War, the Society published an essay by Irish playwright George Bernard Shaw entitled “Fabianism and Empire: a Manifesto.” Shaw argued that since imperialism was a *fait accompli*, the Fabians should support the British Government and help develop the empire into a “great socialist Commonwealth.” But a large portion of the Society sympathized with the Boers against what they saw as British imperial aggression. Thirteen members, including future Prime Minister Ramsay MacDonald, resigned in protest. Thereafter, until the end of the Great War, the Society published few tracts on international affairs.²²

²¹ Mark Minion, “The Fabian Colonial Society and Europe during the 1940s: The Search for a Socialist Foreign Policy,” *European History Quarterly* 30, no. 2 (2000): 237–70. Pages 237–238.

²² *Ibid.* Also see Michael Cowen and Robert Shenton, “The Origin and Course of Fabian Colonialism in Africa,” *Journal of Historical Sociology* 4, no. 2 (June 1991): 143–74.

Fabians became more vocal on colonial policy when Lord Passfield (Sidney Webb), a leading Fabian, became Secretary of State for the Colonies in 1929, but the Society's reticence on imperial issues finally ended in 1940, when Rita Hinden, a 31-year-old economist raised in South Africa and Palestine, suggested the establishment of a Fabian Colonial Bureau, a new section of the Society devoted to the problems of the Empire.²³ Her own doctoral dissertation at the London School of Economics had focused on Palestine as a case study in colonial economic development.²⁴ At the first meeting of the bureau, on October 26, Hinden was elected secretary.

To chair the bureau, the founding members chose Arthur Creech Jones, a Labour MP who had served over two years in prison as a conscientious objector during the First World War. Creech Jones had been interested in colonial issues since 1926 when, as a leader of the Transport and General Workers' Union, he had provided advice to Clements Kadalie, the Nyasaland-born General Secretary of the South African Industrial and Commercial Workers' Union. During the interwar years, Creech Jones served on the Labour Party's Advisory Committee on Imperial Questions and helped found the Trade Union Congress' colonial affairs committee.²⁵ By the outbreak of the Second World War, he had become the *de facto* spokesman for the Labour Party (and Britain's political left more broadly) on colonial issues. To Creech Jones, the mission of the Bureau was to serve as "a clearing-house of information on current colonial problems, and for the

²³ Minion, "The Fabian Colonial Society and Europe during the 1940s: The Search for a Socialist Foreign Policy." Page 246.

²⁴ Patricia Hugh, "Hinden, Rita (1909-1971): Journalist and Campaigner on Colonial Issues," *Oxford Dictionary of National Biography* (Oxford University Press, 2004).

²⁵ Patricia Hugh, "Jones, Arthur Creech (1891-1964), Politician," *Oxford Dictionary of National Biography* (Oxford University Press, 2004).

formation of a group of liberally-minded persons, expert in colonial matters, who would sponsor research an inquiry into subjects concerned with the welfare and development of the colonial peoples.”²⁶

The bureau was not a band of anti-colonial activists. This was evident from the (uncritical) title of the group’s bi-monthly journal, *Empire*, begun in May 1941. In general, the sympathies of the group members led them to call for increased spending on social services and welfare programs, policies of racial non-discrimination, and increased participation of colonized peoples in political administration. Yet from the outset, many leading policymakers and public voices on colonial affairs viewed the Bureau with skepticism. The Colonial Office subscribed to *Empire*, and copies were circulated throughout the office. But in July 1941 Colonial Office assistant under-secretary JA Calder penned a minute expressing his desire to establish “some guidance as to the propriety of members of this office supporting this Bureau by subscriptions or donations.”²⁷ CJ Jeffries, another assistant under-secretary, opined, “There is no absolute reason why members of the office should not, in their private capacities, support this Bureau with subscriptions and donations. But I think it is better that they should not do so.”²⁸ Jeffries did not offer any reasons for this counsel, but he might have shared the concerns articulated by the editors of the *Journal of the Royal African Society* when they “welcomed” the formation of the Fabian Colonial Bureau in October 1941. “The

²⁶ “Arthur Creech Jones to JL Keith Re: Fabian Colonial Bureau Journal Empire,” June 16, 1941, CO 1015/701, UKNA.

²⁷ “Minute by JA Calder Re Fabian Colonial Bureau Journal Empire,” July 3, 1941, CO 1015/701, UKNA.

²⁸ “Minute by CJ Jeffries Re: Fabian Colonial Bureau Journal Empire,” July 4, 1941, CO 1015/701, UKNA.

usefulness of this new movement,” the editors warned, “will depend upon the degree of accuracy, and of the absence of prejudice due to preformed opinion, to which its work attains. No doubt its workers will be alive to the pitfalls for research inherent in starting from a political background.”²⁹

But even if some in the Colonial Office and intelligentsia were put off by Fabian socialism’s foray into imperial affairs, the members of the Colonial Bureau were an august group. Besides Hinden and Creech Jones, the other founding members were: evolutionary biologist Julian Huxley; Labour MP John Parker; former Labour MP James Francis Horrabin; socialist writer Margaret Cole; development economist W. Arthur Lewis; physician and former Under-Secretary of State for the Colonies Sir Thomas Drummond Shiels; author and long-time secretary for the Labour Party’s Advisory Committee on Imperial Questions Leonard Woolf (better known, in many circles, as the husband of the writer Virginia Woolf); imperial historian Margery Perham; and historian of race relations William M Macmillan. Their contacts with leading publications were so strong that within six months of the Bureau’s first meeting they had published articles in *The Economist*, *The Manchester Guardian*, *the New Statesman*, *Time and Tide*, *Reynolds News*, *the Evening Standard*, and *the Daily Herald*. They had also recruited over a dozen MPs who agreed to pose questions on the Bureau’s behalf in Parliament or directly to the Colonial Office. They had also found volunteers to maintain a press-cutting service that

²⁹ “Editorial Notes: The Fabian Society’s Colonial Bureau and the Journal Empire,” *Journal of the Royal African Society*, October 1941, 297–98.

drew from colonial journals available in London.³⁰ This was no fringe group, but rather a well-resourced operation endowed with immense stores of social capital.

c) A Colonial Charter: social services as the socialist's justification for Empire

Members of the Fabian Colonial Bureau (FCB) produced most of the literature that defined the Labour Party's stance on colonial issues. Early in the war, FCB members tried to ensure that increased spending on colonial development and welfare was a major focus of Labour's rhetoric. In April 1940, the Advisory Committee on Imperial Questions, long led by Leonard Woolf, had issued the Labour Party's Declaration of Policy for Colonial Peoples. This document argued that improving health was a major part of Britain's justification for continued colonial rule. Though the document did not say so explicitly, this promise to improve health seemed to provide a justification sufficient to reconcile (for most Fabians) the contradictions inherent in socialist advocacy for the persistence of imperialism.³¹ In seeking to bring Britain's possessions to eventual independence, improving health was a necessary and urgent step:

Political self-government is not enough. It must be accompanied by economic independence and economic self-government. By economic independence we mean a new orientation of motive in colonial policy, putting first the satisfaction of urgent colonial needs (for instance nutrition and the conquest of the disease) and treating external trade as a secondary and auxiliary object.³²

³⁰ "Report of Activities of Fabian Colonial Bureau for the Half Year, November 1940-April 1941," n.d., CO 1015/701, UKNA.

³¹ The difficulties the Fabians faced in reconciling the adherence to socialism and apologias for empire are obvious to any reader of Vladimir Lenin, who even wrote a tract, published in 1917, titled *Imperialism: the highest stage of capitalism*.

³² "Labour Party's Declaration of Policy for Colonial Peoples, Labour Party International Department, Advisory Committee on Imperial Questions," July 1940, Mss Brit Emp s. 365, Box 46, File 1, BLOU.

In September of 1941 Leonard Woolf sought to lay out, in greater detail, how this commitment to “the satisfaction of urgent colonial needs” would manifest in Labour Party policy should it be handed the reins of Government. In a draft “Memorandum formulating a colonial policy for the Labour Party after the war,” Woolf argued, “Much larger sums will have to be found” for economic development, education, and health “than is now usual in colonial budgets.” But, he continued, the lack of education and the low standard of health amongst the colonized caused the poverty that so limited colonial revenues usually required to fund public services. This “vicious circle” could be broken only with capital from Europe or the United States. Because resulting growth would necessarily be slow, this capital had to be provided on terms more generous than market-rate loans.³³

Woolf’s focus on social services spending found critics on both the left and right even within the Labour Party. On the left, long-time colonial commentator Norman Leys urged deletion of the section of the memorandum calling for “costly education and health services.” He argued that land alienation, direct taxation of the poorest, and legal restrictions on free movement and political organizations were the fundamental causes of colonial poverty. His focus deemphasized the contribution of health and education to endemic diseases, which “can be uprooted only as and when a general advance is made, that need not be slow but must be liberative.”³⁴ To Leys, Labour’s focus should remain

³³ Leonard S. Woolf, “Draft Memorandum Formulating a Colonial Policy for the Labour Party after the War,” Revenue, Expenditure & Public Finance, (September 1941), Mss Brit Emp s. 365, Box 46, File 1, BLOU.

³⁴ “Response by Norman Leys to Woolf’s Draft Memorandum Formulating a Colonial Policy for the Labour Party after the War,” September 1941, Mss.Brit Emp. S. 365, Box 46, File 1, BLOU.

on these causes, rather than on the social services that had so recently been the stated focus of Colonial Office policy under the Conservative PM Neville Chamberlain.³⁵

Farther to the right, Thomas Reid (who would become a Labour MP in 1945) contended it was political suicide to advocate colonial social service spending outlays to a “groaning British taxpayer” besieged by war and want. Colonies had low “taxable capacity,” so such “obviously desirable boons cannot be provided, unless we, or other altruists, finance the needs of about 500 million poverty-stricken people in the midst of our own bankruptcy.” Woolf’s proposed platform, Reid said, was not only “generally impracticable” and “unjust to our own people,” but “electorally disastrous to Labour, and therefore to the public and the world for whom a Labour Government in Britain after the war is a *sine qua non* of success for all.” In any case, since “tropical people do not exercise birth control and breed up to the bare subsistence or below it as a rule,” health and education spending would result in an increase in population rather than an increase in per-capita wealth.³⁶ Labour, then, was not at all united in their visions for colonial development. Fierce critics of extractive economic policies (e.g. Leys) mingled with neo-Malthusian colonial apologists (e.g. Reid), while still others (e.g. Woolf) tried to steer a

³⁵ In his own memo from 1939, Norman Leys’ criticism of the UK’s history of development even included the previous Labour Government (1929-1931), which he claimed “left no mark on Colonial Policy.” As the previous chapter made clear, Lord Passfield’s commitments to the paramountcy of native interests as well the under the 1929 Colonial Development Act both came during this period. So to say that there was “no” mark left on native policy is to discount the value of both rhetoric and development expenditure. Leys’ focus was on more fundamental political strictures and economic expropriation from the colonized. See Norman Leys, “Memorandum on Labour’s Colonial Policy,” Labour Party International Department, (February 1939), Mss.Brit Emp.s.365, Box 46, File 1, BLOU.

³⁶ “T Reid Comments on Woolf Draft Memorandum Formulating a Colonial Policy for the Labour Party after the War,” September 1941, Mss.Brit Emp. S. 365, Box 46, File 1, BLOU.

middle course similar to the prewar policies pursued by the Colonial Office under Malcolm MacDonald.

Even with this dissension within the Labour Party, members of the Fabian Colonial Bureau soon reiterated calls for social services following supportive words from British officialdom's favored colonial expert, Lord Hailey. Hailey, a retired member of the Indian civil service, had become the preeminent public intellectual on colonial issues since the publication of *An African Survey*, a massive interdisciplinary study under his direction, in 1938.³⁷ In a keynote address to the annual meeting of the Anti-Slavery and Aborigines Protection Society on May 28, 1942, Hailey suggested that the increasing expectations of state social protection within Britain should also extend to the colonies. These expectations entailed a "conception of the State not merely as an agency for maintaining justice and equal rights, or for preventing abuse...but as the most active agency for promoting social welfare and improving the general standard of living." Judging the legitimacy of colonial government with the same criteria as domestic governance would "serve to justify our position as a colonial power to the outside world, and to mitigate some of the suspicion which now attaches to it." He called for a statement outlining "our obligations to the colonial peoples...not as those of trustees, but as those incumbent on the modern state in regard to the improvement of the social services and the standards of living in its own domestic backward areas."³⁸

³⁷ Hailey, *An African Survey: A Study of Problems Arising from Problems Arising in Africa South of the Sahara*. Also see Tilley, *Africa as a Living Laboratory*.

³⁸ Lord Malcolm Hailey, "A Colonial Charter: An Address at the Annual Meeting of the Anti-Slavery & Aborigines Protection Society" May 28, 1942, Mss.Brit Emp. S. 365, Box 46, File 4, BLOU.

Hailey said this statement should come in the form of a “Colonial Charter.” The Colonial Charter, he explained, would be a supplement to the Atlantic Charter, a document signed by Churchill and Roosevelt in August 1941 to express shared aims in fighting the war. That document had included a “wish to see sovereign rights and self-government restored to those who have been forcibly deprived of them.” Before the House of Commons on September 9, Churchill said he felt compelled to clarify that the Atlantic Charter applied only to “the states and nations now under Nazi yoke,” and did not address the “separate problem progressive evolution of self-governing institutions in the regions and peoples which owe allegiance to the British Crown.”³⁹

Hinden, who noted the “disappointment” of peoples “in the colonies” to Churchill’s unwillingness to include them in the promises of the Atlantic Charter, quickly took up Hailey’s call for a Colonial Charter.⁴⁰ Within a week of Hailey’s address, she had drafted a memo to members of the Bureau to explain her thoughts on the politics and content of such a charter. In a political stroke reminiscent of MacDonald’s arguments to the Treasury a few years prior, Hinden pointed to a colonial crisis to call for increased social spending. In Hinden’s case, the crisis was the fall of British Malaya to the Japanese in January of 1942. This defeat of British, Indian, Australian and Malayan forces “seemed to indicate an apathy on the part of the colonial peoples to a British victory.” This crisis

³⁹ Hubbard, *The United States and the End of British Colonial Rule in Africa, 1941-1968*. Page 10.

⁴⁰ After the Atlantic Charter was issued, but before Churchill insisted that it did not apply to the colonies, Clement Attlee had spoken before a union of West African students studying in London. He told them that the charter applied to all peoples in the world, including colonial subjects. See *Ibid.* Page 30.

of legitimacy should be addressed with “specific pledges and guarantees as to the future of the Colonial people on the successful outcome of the war.” Hinden argued that one guarantee capable of increasing martial zeal in the colonies was a promise to improve social services.⁴¹

The Bureau had already called for a “charter of colonial social welfare” in a pamphlet published earlier that year.⁴² In his May 28 address, Lord Hailey said that the Charter should promise “the extension to the colonies of the obligations accepted by the modern state to provide a minimum of social services for all its citizens.”⁴³ Hinden went even further, suggesting that a Colonial Charter prepared by the Bureau should include an imperial “responsibility” to “secure a uniform standard of social services.”⁴⁴ Her language showed a stronger commitment to egalitarianism than that produced by the Anti-Slavery and Aborigines Protection Society, which in its own proposed International Colonial Convention, declared, “Measures for improving health and preventing and curing disease shall be expanded.”⁴⁵ There was clearly a movement afoot, at the highest levels of left-leaning intelligentsia on imperial policy, to spur greater spending. As the last section demonstrated, approval of colonial development and welfare schemes (including medical projects) did accelerate by the end of 1942. Much of this discourse did focus on the need to quell imperial unrest and gain support for the war effort in the

⁴¹ Rita Hinden, “A Colonial Charter,” June 4, 1942, Mss Brit Emp s.365, Box 46, File 4, BLOU.

⁴² Fabian Colonial Bureau, *Labour in the Colonies. Report Submitted to the Labour Committee of the Fabian Colonial Bureau.* (London: V. Gollancz, 1942).

⁴³ Hailey, “A Colonial Charter: An Address at the Annual Meeting of the Anti-Slavery & Aborigines Protection Society.”

⁴⁴ Hinden, “A Colonial Charter.”

⁴⁵ “An International Colonial Convention, Prepared by the Anti-Slavery and Aborigines Protection Society” (London, May 1943), Mss.Brit.Emp s.365, Box 46, File 4, BLOU.

colonies. But beginning in late 1942 there would arise another impetus—from within Britain itself—for colonial experts and colonized peoples to advocate for greater state provision of social protection.

III. Beveridge at home, Beveridge abroad: social protection and health in the Empire and Commonwealth, 1942-45

a) Domestic labor unrest in the political response to the Beveridge Report, 1942

Sir William Beveridge made for an unlikely international celebrity. Detractors derided him as a mechanistic bureaucrat. Indeed, the bureaucracy was in his blood; he had been born in Bengal, the son a judge in the Indian civil service. He had spent his entire career either in the civil service (the Board of Trade, the Ministry of Munitions, and the Ministry of Food) or in academia (the London School of Economics and, later, Oxford). Though a recognized expert on social insurance, he had only authored a single book (*Unemployment: a problem of industry*, in 1909) before the Second World War. In appearance he presented a slender frame, a heavy brow and a shock of straight white hair combed over a bald scalp.

He was hardly a firebrand. He favored the Liberal Party—the party of John Maynard Keynes, Lloyd George, and John Stuart Mill—over democratic socialist Labour, but until he himself ran for Parliament in 1945 Beveridge had always maintained that academics should refrain from overt commitments to political parties.⁴⁶ As Director of the London School of Economics—a school founded by the Fabian Socialist Sidney Webb—

⁴⁶ Jose Harris, *William Beveridge: A Biography*, 2 edition (Oxford, England ; New York: Clarendon Press, 1998).

Beveridge recruited faculty of every persuasion, including the Austrian economist and hero of libertarians Friedrich von Hayek. He made for an unlikely father of the “welfare state,” a phrase he detested. He lauded individual initiative, decried sloth, and championed private efforts at charity and social uplift.⁴⁷

But ever since his youthful days working at Toynbee Hall in Britain’s East End, Beveridge had been firmly committed to a “national minimum,” in which “no one is to fall below a certain standard.”⁴⁸ In 1942, Beveridge’s proposals to render this commitment a reality made his a household name in Britain and in many parts of the English-speaking world.

The fame began with the publication of the *Report on Social Insurance and Allied Services* in November 1942. The report was the product of an interdepartmental commission tasked with providing recommendations on means to improve the coordination of social insurance programs. Beveridge noted that Churchill’s Government had created the commission in June 1941 in response to a demand by the Trades Union Congress.⁴⁹ But according to the historian Daniel Rodgers, this was not supposed to be an influential commission, and Beveridge himself did not really want to lead it. Beveridge saw himself as an expert on efficient use of manpower. He had declined offers to sit on official committees investigating old-age and health insurance, claiming they were not within his field of expertise. The assignment Beveridge most wanted was to

⁴⁷ Ibid. Beveridge even authored a book in 1948 entitled *Voluntary Action*.

⁴⁸ *Sir William Beveridge Talks to Pathe Gazette*, Newsreel, 1942, https://www.youtube.com/watch?v=l2DhvTCuK_s.

⁴⁹ William Beveridge, *Power and Influence* (New York: The Beechurst Press, 1955). Page 296

direct the allocation of wartime labor, but he lacked the connections within the Ministry of Labour necessary to secure the post.⁵⁰ Recognizing that his “welcome had run out” in the main war coordination effort and consigned to a task deliberately designed to be obscure and out of the way, Beveridge set to work on the social insurance report.⁵¹ Though many other prominent officials had been named to the commission, Churchill’s government would not endorse the document, so Beveridge called the rest of these members “advisers” and made himself the report’s sole signatory.

In 299 pages of text and tables, Beveridge’s report painstakingly detailed a plan to expand and rationalize Britain’s programs of social protection, including unemployment insurance, subsistence payments for the elderly and infirm, children’s allowances. He also proposed a government-run health care system to be financed entirely by general taxation and provided free at the point of care.⁵² Despite the report’s dry prose and seemingly interminable tables, it was a sensation. Within two weeks of its release, nine in ten Britons were telling pollsters they approved of it. Within a year, 600,000 copies of the report had been sold.⁵³ In 1945 the London correspondent of the *New York Herald*

⁵⁰ Daniel T. Rodgers, *Atlantic Crossings: Social Politics in a Progressive Age* (Harvard University Press, 1998). Page 489.

⁵¹ Beveridge, *Power and Influence*. Page 297.

⁵² On health, Beveridge proposed: “A comprehensive national health service will ensure that for every citizen there is available whatever medical treatment he requires, in whatever form he requires, domiciliary or institutional, general, specialist or consultant.” Part of the funding for the national health service was to be derived from the social insurance contributions paid by individual Britons. But “the service,” he explained, was to be “provided where needed without contribution conditions in any individual case.” Beveridge did not detail precisely how the national health service would be structured. He only outlined a few financing issues. Still, he referred to the national health service as one of the three main pillars of his plan. See William Beveridge, “Social Insurance and Allied Services,” Inter-departmental Committee on Social Insurance and Allied Services (London: His Majesty’s Stationary office, 1942). Pages 158-159.

⁵³ Hodge, *Triumph of the Expert*. Page 198.

Tribune reported, “Beveridge has become almost a common noun in the English language. It stands for hope.”⁵⁴

Churchill had worked with Beveridge decades earlier on the National Insurance Act of 1911, but was initially skeptical of the proposals. The Prime Minister told his War Cabinet that he did not wish to encourage “false hopes and airy visions of Utopia and El Dorado.” Harold Nicolson, Churchill’s Minister of Information, opined in his diary that Beveridge was a “vain man,” and predicted Conservatives would “welcome the Report in principle, and then whittle it away with criticism.”⁵⁵

But to many Britons, the Beveridge Plan was neither a dry technical exercise nor a utopian dream. It was, to them, a practical promise for a better society after the guns fell silent. A number of historians and sociologists of wartime and postwar Britain have written of a popular consensus on the need for “fairness,” a product of both generalized Depression-era want and shared wartime sacrifice. In this milieu, political opposition to welfare spending and social protection programs was, for a time, muted.⁵⁶ The Labour Party, led by Clement Attlee, quickly lent its support for the Beveridge Plan as a key part of its postwar domestic platform.⁵⁷ Throughout 1943 Beveridge addressed large crowds

⁵⁴ Rodgers, *Atlantic Crossings: Social Politics in a Progressive Age*. Page 492.

⁵⁵ William Manchester and Paul Reid, *The Last Lion: Winston Spencer Churchill, Vol. 3: Defender of the Realm, 1940-65* (Little, Brown, 2012).

⁵⁶ See Tony Judt, *Postwar: A History of Europe Since 1945*, Reprint edition (Penguin Books, 2006); R. M. Titmuss, *Problems of Social Policy. History of the Second World War*, 1st edition (His Majesty’s Stationary Office, 1950).

⁵⁷ Manchester and Reid, *The Last Lion*. Pages 619-620.

across the country to drum up support for his proposals. He even starred in a newsreel that summarized his proposals to cinemagoers across the nation.⁵⁸

As in the 1920s and 1930s (see chapters 3 and 4), labor unrest proved a crucial impetus for a change in government policy. Some British workers in key industries were clearly growing tired of forbearance on questions of material security. Following years of relative quietus in the late 1920s and 1930s, labor stoppages became more common during the war. In the midst of a legal ban on strikes and lockouts, labor stoppages increased in the UK. Nationwide, strikes escalated from 922 in 1940 to a new record peak of 2194 in 1944.⁵⁹ Neither mass arrests by government nor calls for patience from union leaders proved effective deterrents to workers striking for higher wages and other protections, particularly in the economically crucial coalfields.⁶⁰ In the face of rising unrest, Churchill finally decided to issue some promises on postwar social protection. On the evening of March 20, 1943, in a radio broadcast carried nationwide, Churchill called himself a “strong partisan of national compulsory insurance, for all classes, for all purposes, from cradle to grave.” He added: “We must establish on broad and solid foundations a national health service.”⁶¹ Most of Beveridge’s proposals would be implemented after the war, under Attlee’s Labour Government. The health care proposal, a key pillar of the Beveridge Report, was made manifest in the 1948 inauguration of the

⁵⁸ *Sir William Beveridge Talks to Pathe Gazette.*

⁵⁹ David Morgan and Mary Evans, *The Battle for Britain: Citizenship and Ideology in the Second World War* (Psychology Press, 1993). Pages 35-36.

⁶⁰ Wigham, *Strikes and the Government, 1893-1981*. Pages 90-93.

⁶¹ Manchester and Reid, *The Last Lion*. Pages 652-653.

National Health Service, a single-payer health care system provided free at the point of care to all British citizens.⁶²

b) Social protection in South Africa: African pensions but not health care, 1942-1943

For many, Beveridge's aims of "freedom from want" and universal healthcare seemed possible and urgent not only in Britain, but also in the Colonies and Commonwealth. As his Report became a bestseller in Britain, visions of social protection abounded around the globe. These visions were not always welcome. As one official in the UK actuary office lamented in a November 1943 letter, "It is unfortunate that the ideas in the Beveridge Report have stimulated a vague but strong desire for 'social security' in so many parts of the world where they are manifestly inappropriate without severe limitation."⁶³ Yet political officials could not afford to entirely ignore calls for social security. In the British Empire and Commonwealth, reports on social security commissioned by political leaders invariably included mentions of health, and often were followed by fuller investigations of national health services.

In early 1943, as MPs in the Union of South Africa's Parliament called for comprehensive welfare schemes, Prime Minister Jan Christiaan Smuts made the worried observation in a letter to a friend in London that "it is here very much as with you, where people talk Beveridge instead of war and Hitler." Though Smuts privately lamented the "preoccupation with the postwar paradise on earth," he would lead his United Party to

⁶² Judt, *Postwar*.

⁶³ Epps to George Gater, 5 November 1943, ACT 1/717, UKNA.

victory in June 1943 by coopting the Labour Party's rhetoric. Smuts persistently promised a society in which "there will be no forgotten men."⁶⁴ African political leaders in South Africa also made use of this Beveridge moment to advance their claims. In December 1943 the African National Congress unanimously adopted a report written by Dr. Alfred Xuma, the Congress' President-General. The document has been called "The Atlantic Charter from the Africans Point of View," or the "Bill of Rights," or "Africans' claims in South Africa." Dr. Xuma combined Beveridge's proposals with the rights articulated by Atlantic Charter, and insisted that both should be applied to Africans. Though Xuma's document was focused foremost on rights of political representation and an end to economic exploitation, it also demanded "equality of treatment...in the State social services, and inclusion on an equal basis with Europeans in any scheme of Social Security." In a section devoted to health services, Xuma, a medical doctor educated at Northwestern University in Chicago, urged "the establishment of free medical and health services for all sections of the population."⁶⁵

Responding to demands to follow in Beveridge's footsteps from many sections of South Africa's population, Parliament appointed a Committee on Social Security and a National Health Services Commission (NHSC) to investigate and issue proposals in their respective remits. In 1944, following a report from the Committee on Social Security, Parliament passed the Pension Laws Amendment Act, establishing war pensions and

⁶⁴ Jeremy Seekings, "Visions, Hopes & Views about the Future: The Radical Moment of South African Welfare Reform, Eds. Saul Dubow and Alan Jeeves," in *South Africa's 1940s: Worlds of Possibilities* (Cape Town: Double Storey Books, 2005), 44–63.

⁶⁵ Alfred Xuma, "Africans' Claims in South Africa, or the Bill of Rights and the Atlantic Charter from the African's Point of View" (South Africa: African National Congress, December 14, 1943), <http://www.anc.org.za/show.php?id=4474>.

extending non-contributory old-age pensions and disability grants to African men and women. The maximum benefit payable to Africans was less than one-third the maximum for white pensioners, but the inclusion of Africans in this massive new social security program was a significant departure from earlier policies.⁶⁶

The NHSC also reported its findings in 1944. Drawing upon the community-based health centers of Sidney and Emily Kark in Natal, the report recommended a network of 400 such centers, which were to be accessible to all races, free at the point of care and funded by a common “health tax.” Though inspired in part by Beveridge, the report’s recommendations were far from a facsimile of his report. As historian Shula Marks has observed, “The break with the hospital system, the centrality of the health centers, and the focus on health education all put the commission’s report ahead of the contemporary Beveridge Report.”⁶⁷ Enthusiasm for Beveridge might have helped spur Smuts to promise schemes for social protection, but South Africa had its own extant politics of social medicine that shaped the reports commissioned by his government.

Yet the NHSC’s plan would not come to fruition. Smuts, who had opposed efforts to strengthen public sector health care for decades, dismissed the report as “utopian” and,

⁶⁶ Seekings, “Visions, Hopes & Views about the Future: The Radical Moment of South African Welfare Reform, Eds. Saul Dubow and Alan Jeeves.” The 1944 act also extended disability grants to “Indian” and “coloured” people for the first time.

⁶⁷ Marks mentions the Wits School of Medicine, where the Karks and Henry Gluckman lectured, as a center for social medicine in South Africa. Shula Marks, “Public Health Then and Now: South Africa’s Early Experiment in Social Medicine: its Pioneers and Politics,” *American Journal of Public Health* 87 (1997): 452-459.

save for a few clinics, the commission's vision was never realized.⁶⁸ Perhaps the most influential result of this work was that it caught the attention of the physician John Grant, a consultant for the Rockefeller Foundation's International Health Division, who in 1947 drew upon the report of the NHSC to call upon every nation in the world to enact family allowances, maternity benefits, home help, housing and food assistance, and universal access to medical care.⁶⁹ In addition, the wartime South African politics of social medicine also made its way to the World Health Organization, where Sidney Kark, deputy chief health officer Harry Gear, and George Gale all later worked.⁷⁰

c) Social protection in Southern Rhodesia: African health care but not pensions, 1943-1945

Southern Rhodesian officials were similarly compelled by the Beveridge Report to investigate reforms to systems of social protection, though their conclusions differed from those in South Africa. In a radio broadcast on March 6, 1943, Prime Minister Godfrey Huggins (a physician who had once practiced in London) announced that the government social security officer, Frank Thomas Russell (a former schoolmaster), had

⁶⁸ Shula Marks, "Reflections on the 1944 National Health Services Commission: A Response to Bill Freund and Anne Digby on the Gluckman Commission," *South African Historical Journal* 66, no. 1 (January 2, 2014): 169–87; Bill Freund, "The South African Developmental State and the First Attempt to Create a National Health System: Another Look at the Gluckman Commission of 1942–1944," *South African Historical Journal* 64, no. 2 (June 1, 2012): 170–86; Anne Digby, "Evidence, Encounters and Effects of South Africa's Reforming Gluckman National Health Services Commission, 1942–1944," *South African Historical Journal* 64, no. 2 (June 1, 2012): 187–205.

⁶⁹ Farley, *Bilharzia*.

⁷⁰ Shula Marks, "Public Health Then and Now: South Africa's Early Experiment in Social Medicine: its Pioneers and Politics," *American Journal of Public Health* 87 (1997): 452-459.

been tasked with an investigation of possible reforms of existing social security programs.

In the first part of his report, issued in 1945, Russell focused on public pensions. Here he recommended expanded protections for European settlers, but he explicitly excluded Africans. Russell argued that even though Africans had been included in South Africa's unemployment and disability insurance and old-age pensions, in Southern Rhodesia Africans should continue to be excluded because "the Natives [in Southern Rhodesia] are less urbanized, less dependent on wages and to a large extent self-supporting in less crowded and better reserves." The most appropriate tools for improving African welfare, Russell argued, were not "civilized" social security protections but national economic policies that increased aggregate production.⁷¹

In the second part of the report, however, Russell turned his focus to social services, and in particular to health services. Though animated mostly by the quest to find an arrangement by which poor whites could have some private practitioners' fees covered by general tax revenues, Russell also investigated the medical care for Africans. He called for greater spending for preventive and curative health services, especially for "natives." Russell believed that for both natives and non-natives, the government should undertake nationwide surveys of nutrition and urban housing, and the compilation of vital statistics. He called for free school meals and milk for schoolchildren (immediately for non-natives

⁷¹ Seekings, "Visions, Hopes & Views about the Future: The Radical Moment of South African Welfare Reform, Eds. Saul Dubow and Alan Jeeves"; Frank Thomas Russell, "Social Security in Southern Rhodesia: A Summary of Part I of the Social Security Report," 1945.

and “as soon as possible” for native school children) and food subsidies for natives in reserves.⁷² He called for increased personnel and spending on preventive activities including sanitation, health propaganda, and TB sanatoria. For curative services, he contended that while the segregated facilities and personnel devoted to the care of the European community were, on the whole, sufficient, those devoted to the care of natives were woefully inadequate. Russell estimated that his proposals required an increase in the share of government expenditure devoted to health (defined in the broad sense encompassed by his proposals) from its 1942 level of 8 percent to 10 percent.⁷³ In monetary terms, this represented an increase in spending from general revenue of £100,000 on preventive services (for natives and non-natives) and of £150,000 on curative services for natives. Russell believed that Africans should continue to receive medical attention free at the point of care in government facilities, and proposed various schemes to lessen the financial burden on Europeans, who at that time usually paid private practitioners for outpatient services while paying fees at government hospitals for inpatient care.”⁷⁴

After Russell completed his report in 1945, Huggins appointed a Commission to investigate a National Health Service. The chair of this commission (which included Russell) was Dr. Charles Frederic Morris Saint, Professor of Surgery at the University of Cape Town. This report concurred with Russell’s. “There must be thousands of patients who never see a doctor...No doctor could possibly attend to 100,000 patients, or even

⁷² Frank Thomas Russell, “Social Security in Southern Rhodesia: A Summary of Part II of the Social Security Report,” 1945. Page 20.

⁷³ Ibid. Page 58. This figure does not factor in war expenditure.

⁷⁴ Ibid.

50,000, as is the case in several districts of the Colony.”⁷⁵ It argued for increased medical training for Africans (which would, in turn, demand expanded secondary education), and the construction of hospitals and clinics in more remote regions around the country. The commissioners argued against fees for African patients, and said that spending on health services for Africans should not be related to the taxes they paid, “for the poorer the community, the greater is the need for health expenditure upon it.”⁷⁶

Some of the report’s plans were acted upon in the following years, though the expansion in access to care was not dramatic. Training of “African female nurses” had previously been left entirely to the missions, but in 1945 a new government-run training program was begun at the Memorial Hospital in Bulawayo.⁷⁷ Care remained free at the point of care for Africans. The number of government rural clinics increased from 76 in 1946 to 88 in 1952, and additional wards were added existing clinics.⁷⁸

But the muted expansion was entirely inadequate to keep up with burgeoning demand. At Gwelo’s African Hospital, for instance, the number of beds rose from 62 to 72 between 1945 and 1950, but the number of inpatients more than doubled, from 2175 to 4092. Even colonial apologist Michael Gelfand, then a medical officer at Gwelo Hospital, remembered how patients covered all the floors and blocked the hallways. He also recounted that the European Hospital in Gwelo received a new X-ray machine after the

⁷⁵ Charles Frederick Morris Saint, “Report of the National Health Services Inquiry, 1945” (Salisbury, Southern Rhodesia: Government Stationary Office, 1946). Pages 11-12.

⁷⁶ Ibid. Page 128.

⁷⁷ Gelfand, *A Service to the Sick: A History of the Health Services for Africans in Southern Rhodesia, 1890-1953*. Page 98.

⁷⁸ Ibid.

war, while the African hospital remained without any until 1954. Huggins' administration in Salisbury rebuffed requests additional staff, facilities, and equipment, citing "financial constraints."⁷⁹

d) Beveridge's aborted mission to advise on "freedom from want" in India, 1945

At the end of the war, Beveridge had an opportunity to apply the lessons of his Report to India, where he had been born in 1879. In July 1945 the Labor Department of the Government of India invited Beveridge to chair a Planning Committee tasked with designing social security measures for industrial laborers.⁸⁰ Beveridge was eager to accept the invitation, but strongly suggested the committee's scope should be broader, for "an Enquiry limited to the very small part of the population engaged in industrial labour, however valuable in itself, would not justify...such words as 'freedom from want.'" A broader report that examined rural labor and urban non-industrial labor would, Beveridge believed, be "something quite different" from his report on social insurance in Britain.⁸¹ But India's colonial Labor Department insisted on limiting the terms of reference to industrial labor, and Beveridge eventually turned down the offer. He focused his efforts instead on an upcoming tour of the United States.⁸²

⁷⁹ Ibid. Pages 76-81

⁸⁰ "Labour Department, Government of India to David Monteath, Permanent Under-Secretary of State for India and Burma," July 19, 1945, GB 097, Box XI, File 40, London School of Economics and Political Science Library.

⁸¹ "Beveridge to Sir David Monteath," September 9, 1945, GB 097, Box XI, File 40, London School of Economics and Political Science Library.

⁸² "Sir David Monteath to Sir William Beveridge," September 29, 1945, GB 097, Box XI, File 40, London School of Economics and Political Science Library.

Had he returned to India, what programs might Beveridge have proposed? Would social services have played a role in his scheme? Beveridge's papers offer little insight, though there is one hint that he might have had an interest in health in particular. Of the five candidates he considered to serve as his assistant on the India report, the only one stationed in India was Major Geoffrey Stone, a young Brit whose focus in the previous decade had been nutrition research. But Beveridge himself never seems to have authored a plan to achieve freedom from want in any British colony.⁸³

IV. Conclusion

Descriptions of welfare regimes in the political science literature are often based on ideal-types, such as Esping-Anderson's tripartite division into the social democratic, the conservative and the liberal. These, in turn, are abstracted from regimes of social protection in Europe.⁸⁴ In recent years the number of typologies has expanded to include "liberal-informal" welfare states in Latin America and "productivist" welfare states of East Asia.⁸⁵ African states, however, are mostly grouped among regimes of social *insecurity* wherein large swaths of the population can rely on little protection.⁸⁶ But the categories of welfare regimes in this literature tend to elide the long-standing debates

⁸³ "Sir Henry Clay to Sir William Beveridge," September 12, 1945, Box XI, File 40, London School of Economics and Political Science Library.

⁸⁴ Gosta Esping-Andersen, *The Three Worlds of Welfare Capitalism* (Princeton, N.J.: Princeton University Press, 1990).

⁸⁵ Geof Wood and Ian Gough, "A Comparative Welfare Regime Approach to Global Social Policy," *World Development* 34, no. 10 (2006): 1696–1712.

⁸⁶ Joao Biehl, *Vita* (Berkeley: University of California Press, 2013); Philippe Bourgois and Jeffrey Schonberg, *Righteous Dopefiend* (Berkeley: University of California Press, 2009); James Ferguson, *Global Shadows: Africa in the Neoliberal World Order* (Durham [N.C.]: Duke University Press, 2006).

over the proper scope and scale of social protection among impoverished, mostly rural colonial subjects in Africa and South Asia.⁸⁷

This chapter recounted a contingent moment, when various sorts of social welfare were considered in late-colonial southern Africa. This era was a brief one. Though old-age pensions would be retained for black South Africans throughout the apartheid era that began in 1948, the value of such pensions differed sharply along racial lines. And, as the next chapter will make clear using Nyasaland as a case study, the Beveridgean moment did precious little to ensure material subsistence among Africans facing famine and other forms of dire want during the late 1940s.⁸⁸

Still, the early 1940s was a watershed moment, one driven in part by crises and changing expectations of government in Britain and its Empire. From relatively industrialized and independent South Africa to the heavily agricultural British colony of Nyasaland, discussions over welfare state policy during the 1940s fostered ideas about public sector health care, subvention for agricultural inputs, and public pensions that have had lasting consequences for African political discourse and public budgets. As the next chapter will demonstrate, the shift in thinking in Britain about the role of the state in social provision would prove especially influential in debates over the quality and reach of medicine in the colonies. While officials tried to write off other portions of the Beveridge Report as inapplicable to rural Africa, the universality of disease and the growing efficacy of

⁸⁷ James Ferguson, *Give a Man a Fish: Reflections on the New Politics of Distribution* (Durham ; London: Duke University Press Books, 2015).

⁸⁸ John Iliffe, *The African Poor : A History* (New York: Cambridge University Press, 1987).

medical therapeutics made medical spending appear all the more urgent in places like Nyasaland.

Chapter 6

“The old imperialism has come to an end”: Nyasaland as case study of postwar development, 1944-1952

Abstract

Though Beveridge’s plan for social security in the United Kingdom interested a number of colonial commentators and colonial officials, plans to extend such programs throughout the Empire were almost invariably limited to waged labor. Still, increased access to health services was a piece of Beveridge’s vision most officials agreed should apply even in rural Africa. Health services also figured in the colonial plans of the Labour Party, which came to power following a landslide victory in the 1945 UK general election. Arthur Creech Jones, a leading light in the Fabian Colonial Bureau and the new Colonial Secretary under Labour, touted a promised expansion of health services to buttress his claim that “the old imperialism has come to an end.” But, at least initially, the rise of Labour did not seem to usher in any new era in colonial medical services. This new era would follow another wave of unrest, which swept across Empire in the late 1940s. Only then did the Colonial Office begin to increase spending on hospitals, clinics, and training institutions. Between 1944 and 1952 Nyasaland received some aid for venereal disease treatment, and officials in Zomba finally began to improve and expand training of African medical auxiliaries. But, in these years just before the advent of a controversial Federation with Northern and Southern Rhodesia, Nyasaland’s politics remained too quiet to merit any concerted attempt to expand African health care services.

Prelude: No money for diapers: seeking social security in communal and chiefly obligations

Izeki is pressed for cash. Before she departed for the afternoon, his wife told him she needed cloth diapers for their new baby. She expected Izeki to give her money to buy the diapers by the end of the day. On this point, she was very insistent. She warned that she did not want find him still empty-handed upon her return.

At first, Izeki did not know what to do. He simply did not have the money. But all of a sudden, he had an idea! He walked from the porch of his mud-brick hut down the narrow path to the dirt road. There he tore small branches from a short tree. He laid the branches

on the road, in two lines separated by five meters. Between the lines he placed a small plastic bowl. Then he returned to his porch and sat down.

Soon, this exercise had the desired effect. One passerby dismounted his bike when he came to the branches, and walked between the two lines before remounting his bike once he passed them. Then, another passerby—a man walking a goat—stopped to drop a few bills into the bowl. Two women stopped to drop money in the bowl, then walked up the path to talk to Izeki. A few moments later, a man named Jakobo followed suit.

Izeki had made use of a local practice used to collect funds for an impending funeral. The passers-by were under the impression that there had been a recent death in Izeki's home. Those who had come to his home were coming to pay their condolences. When Jakobo reached the porch, he rattled off a string of lamentations. *Nkani basi! Nyimbo basi! Azimayi watopa!* (Enough of this news! Enough of this [funeral] music! The women are tired [of mourning!]).

Izeki, acting downtrodden, thanked Jakobo for coming. “What happened?” asked Jakobo.

“One of my children was hit by a car in town while walking to school,” Izeki explained.

“Where will the funeral be held?” Jakobo asked. “In town? Or in the village?”

Tentatively, sensing he was being a bit too far into the lie, Izeki answered, “Here, in the village.”

“Well, in that case, I will bring the money to the *mfumu*,” Jakobo offered. “He will organize the funeral, of course. That is his job.”

“No!” yelled Jakobo. Composing himself, he explained, “I want to plan it myself.”

Izeki’s wife returned to this scene, and fell into inconsolable sobbing. Seeing the branches and the bowl and the assembled mourners, she naturally assumed that someone had died.

Unable to maintain the lie any longer, Izeki admitted no one had died. “I just didn’t know where to find the money to buy diapers,” he confessed. His wife stopped crying, and joined the rest of the crowd in angry yelling. Jakobo grabbed the money and returned to everyone the donations they had given.

The story of Izeki’s spectacular failure is fiction. It was a Chichewa-language sketch performed by the popular Malawi comedy duo Izeki and Jakobo. A video of this 18-minute sketch, titled *Matewera amwana* (“Children’s diapers”), had over 30,000 views on YouTube in the three years since it was first posted on January 18, 2013. The sketch resonates with its Malawian audience because it makes light of one of the most binding community obligations in present-day Malawian villages, that of helping to pay for and

attending local funerals. Izeki and Jakobo's sketches often draw upon anxieties about trust in impoverished village communities. In a more recent sketch, which garnered over 16,000 views on *YouTube* in its first eighteen months, a crooked preacher is found to be pocketing money donated by his congregation in a collection for the sick.¹

In real life, the village chief must navigate these anxieties about distrust and expectations of protection. He (or sometimes she) serves as a tenuous link between the (limited and patchwork) support provided by the central government and the (strained) networks of support within kinship groups. Even though, as the last chapter detailed, chiefs were lauded as wealthy providers for the needy during the colonial era, now (as then) they have neither the capacity to provide in times of need, nor the social expectation that they should do so.

In Nyanza village, the chief does not appear formidable. Chief Nyanza (the village is always an eponym of the chief) is an elderly man with the kind of face that looks stern even when that is not his intention. He has a prominent brow, sunken, slit-like eyes and hollowed-out cheeks. His body is incredibly slender, though he says he is in good health. At one meeting he sports a bright pink button-down shirt, gray pants that are too short for his legs, and worn black sneakers. Like most chiefs in the Mangochi area, he wears a white *kufi* cap during official meetings. Though the chief is a Catholic, the chiefly garb in the region has been influenced by the Yao Muslims who have held sway in the region since they invaded from the south in the mid-nineteenth century.

¹ *Izeki ndi Jakobo- Kusutsa galu mkukumba* ("Translation?").
<https://www.youtube.com/watch?v=eHZ2of3vyNw>

Writing about fieldwork he had performed in the late 1940s in a village not far away, social anthropologist Clyde Mitchell had concluded, “A village headman may expect little material benefit from his position of authority...the position of headman is no sinecure.”² The same could be said almost three-quarters of a century later. Chief Nyanza lived in a modest home similar to Francis’. It was not the most well-appointed home in the village, though its construction had been paid for by the owners of a resort lodge nearby. The lodge owners had sought to make a display of goodwill to counteract their reputation as a forbidding and miserly neighbor, and the chief had accepted the gift. At meetings the chief almost always looked tired. Sitting in what looks like a beach chair on the porch of his home, he delivers an opening statement, then looks as though he might be sleeping until he opens his eyes at the end of the meeting to deliver a concluding statement.

But he was trusted. He became chief in 2008 following the death of his brother, who had been chief since the late 1960s. He had been born in the village but had spent most of his life in his wife’s village twenty kilometers to the south. He was summoned to return to Nyanza because he was widely reputed to be an honest man and a strong advocate. After one meeting where he had appeared to be sleeping through the entire proceedings, he perked up to deliver a concluding statement. The meeting had mostly consisted of a lecture delivered well-dressed local officials with desk jobs in the Parks Department. They had driven to the meeting in a pickup truck to warn the assembled residents of

² J. Clyde Mitchell, *The Yao Village: A Study in the Social Structure of a Nyasaland Tribe* (Manchester [England]: The Manchester Press, 1956). Page 113.

Nyanza that they would be fined if they were found to be illegally cutting down branches in the surrounding the protected forest that surrounded their village. The Nyanza residents were annoyed by what they heard as condescension and unwillingness to consider their needs. They did not wish to contribute to deforestation, but none could afford gas stoves, and few could by charcoal. Without firewood, how could they cook their food?

When the chief spoke, he seemed to channel their frustrations. “We were here before this land was named a national park, and we will be here long after you have left your jobs,” he told the officials. “The lodge has cordoned off so much of the land where we used to collect firewood,” he continued. “We were not consulted about this, but now we have to go even further to find wood.” He concluded with a barely veiled challenge, “We will do what we must to live.”

Though his subjects appreciated such proud soliloquies, the chief could do little else to improve their lot. In an interview, the chief explained his responsibilities. First, he was a gatekeeper for some forms of public provision. So, for instance, he decided which of the households in his village should be given limited coupons for fertilizer subsidies, or food packages distributed during emergencies. Second, he was charged with allocating land to new entrants to the village. Third, as Izeki and Jakobo’s skit averred, he was responsible for organizing the funeral when anyone in the villages 300 homes died. Fourth, he adjudicated disputes within the village. This last responsibility, he said, was work rife

with difficulties (*ntchito wavuto*) that often involved him getting yelled at by drunken combatants.

Chief Nyanza was not a rich man. He worried about money; like Francis, he had spent much of his income seeking a remedy for a family member in chronic pain. His wife had felt pain in her chest after meals for the past year. The hospital in Monkey Bay had prescribed cimetidine (an H₂-receptor antagonist used to treat heartburn and peptic ulcers), but this treatment provided no relief. She had felt no relief after visits to the fee-charging clinic in at the Catholic mission nearby, or the private hospital in Cape Maclear.

The chief and his wife had even traveled hours to see a famed *sing'anga* (traditional healer). The *sing'anga* had told the chief that his wife was dying because she had been taking on improper responsibilities. She had, he said, been helping to manage the *mfumu*'s relationship with his people, hearing stories that she was not meant to hear. Since that time the chief had tried to shield his wife from his official duties, but there had been little improvement. He hoped to go back to the *sing'anga* for another consultation, but lacked the money for transport and fees. Like Francis he feared that the year's maize harvest would be poor; unlike Francis he had no livestock to sell off in times of need. Like Izeki in the comedic sketch, the chief was trying to find money to meet his wife's needs. While his office held some vestigial authority, it was not a fount of power and wealth. Much as he might wish to be, he was no great provider for his people. He could not even salve his own wife's pain.

1. Introduction

Beveridge's ideas did not prove as influential in the colonies as they would at home. Though his 1942 report on social security in the United Kingdom interested a number of colonial commentators and officials, plans to extend such programs throughout the Empire were almost invariably limited to waged labor. Still, increased access to health services was a piece of Beveridge's vision most officials agreed should apply even in rural Africa. Health services also figured in the colonial plans of the Labour Party, which came to power following a landslide victory in the 1945 UK general election. Arthur Creech Jones, a leading light in the Fabian Colonial Bureau and the new Colonial Secretary under Labour, touted a promised expansion of health services to buttress his claim that "the old imperialism has come to an end." But, at least initially, the rise of Labour did not seem to usher in any new era in colonial medical services. This new era would follow another wave of unrest, which swept across Empire in the late 1940s. Only then did the Colonial Office begin to increase spending on hospitals, clinics, and training institutions. Between 1944 and 1952 Nyasaland received some CDW aid for medicine and public health, and officials in Zomba finally began to improve and expand training of African medical auxiliaries. But, in these years just before the advent of a controversial Federation with Northern and Southern Rhodesia, Nyasaland's politics remained too quiet to merit any concerted attempt to expand African health care services.

II. Social Security in "subsistence economies"

a) Idealizing traditional village systems of social security in Nyasaland, 1944-1949

The India Office's refusal to allow Beveridge to propose social security programs outside of industrialized urban areas reflected a broader prejudice in colonial orthodoxy. During the 1930s and 1940s, the Colonial Office propounded an idealized vision of African villages with their own robust, if primordial, forms of social security. This portrait, buttressed by ethnographic work and repeated in numerous reports, had the useful function of deflecting demands to increase public expenditure on social welfare programs. The argument that villages had their own sufficient social security mechanisms proved of great use for penny-pinching officials in heavily rural colonies—colonies like Nyasaland. In fact, the only participants in the debate who did not seem to believe in the immense capacities of traditional mechanisms of African social protection were Africans themselves, who insisted they should be included in social security programs.

The assumption of “traditional” village African welfare was especially prominent in publications immediately following the fervor surrounding the Beveridge Report, which had increased expectations for colonial social security programs. In May 1943, the London-based Anti-Slavery and Aborigines Protection Society drafted “An International Colonial Convention.” The Convention called for immediate implementation of expanded social insurance programs, but focused most of its attention on waged laborers. It did include more generalized demands, namely that “free education shall be made available to all colonial peoples,” and that “measures for improving health and preventing disease shall be expanded and medical research increased.” But in calling for social insurance to

mitigate “the effects of sickness, unemployment and old age,” the draft convention focused on “persons dependent on the money economy.”³

Assumptions about the robustness of village social protection was more explicit in the writings of Lucy Mair, a former student of Bronislaw Malinowski who had aided Lord Hailey in producing the *African Survey* (she was also Beveridge’s stepdaughter).⁴ In 1944, while working for the UK Ministry of Information, Mair wrote a report titled *Welfare in the British Colonies* that was published by the non-governmental Royal Institute for International Affairs. Mair argued that in “traditional African societies...the aged and sick were cared for by their relatives.”⁵ Moreover, in the more centralized of these societies people were protected by “a king or paramount chief” against disasters that threatened to overwhelm the resources of smaller kinship groups. Political leaders used the wealth garnered from the tributes of their followers to “store up a reserve of food against famine” or “offer hospitality to the many people who visited his fort.”⁶ Mair concluded that African societies offered “a complete system of social security provided for by the obligations of kinship.”⁷

³ “An International Colonial Convention, Prepared by the Anti-Slavery and Aborigines Protection Society.”

⁴ Beveridge married Jessie Mair (née Jessie Janet, widow of David Mair), one month after he released his report in 1942. Lucy Mair’s was Jessie Mair’s daughter (from her previous marriage).

⁵ Mair, *Welfare in the British Colonies*. Page 9.

⁶ Ibid. Page 10.

⁷ Ibid. David Stevenson, a missionary medical officer who worked in Nyasaland in the late 1950s, echoed this belief in his 1964 MD thesis. “While Malawi has many poor people, most individuals have a definite place in the community and obtain food and shelter (if sometimes rather inadequate by our standards) as a natural right. The idea of communal and family responsibility...has great advantages in ensuring a measure of social security for each individual. David J.D. Stevenson, “The Health Services of Malawi” (Thesis presented for consideration for the degree of Doctor of Medicine, University of Glasgow, 1964). Page V.

In April 1945, the Colonial Office echoed these arguments in a report entitled *Social Welfare in the Colonies*. The report claimed that prior to the imposition of colonial rule, the peoples of the British Empire “had worked out their own methods of dealing with social problems according to the resources at their disposal, often with remarkable success.”⁸ In Great Britain public provision of welfare was necessitated by the fact that there had been, until recently, little credence in the idea of a community as “an organic whole whose health and vitality depend upon the well-being of all its constituent members.”⁹ Lacking such a belief, the weak, poor and unconnected were left without support in European societies. By contrast, the report claimed, in African villages notions of communal obligation had been widely accepted since time immemorial. European-style systems of social security were needed, then, only in urban areas, where the social norms of traditional life were threatened by “contact” with “industrial civilization.”¹⁰

The authors of these works could turn to earlier ethnographic work to support their claim that African villages offered their systems of social protection sufficient to obviate the need for social security. But, as John Iliffe has pointed out, anthropologists based their analyses of communal obligations on the testimony of chiefs, who in the 1930s had an

⁸ “Social Welfare in the Colonies” (London: Colonial Office, April 1945), Box 11, No 9, SoMA. Page 2.

⁹ Ibid. Page 2.

¹⁰ Ibid. Pages 2-3. This argument was of a piece with the culture-contact thesis of Bronislaw Malinowski, a social anthropologist then teaching at the London School of Economics. Malinowski had supervised the doctoral dissertation of Lucy Mair. In a posthumously published book, Malinowski decried the “anarchy and disorganization” resulting from “detrification” among the “floating population of the copper belt and in the lowest Black proletariat of Native townships and locations.” Bronislaw Malinowski, *The Dynamics of Culture Change: An Inquiry into Race Relations in Africa* (New Haven: Yale University Press, 1945). p 53.

interest in telling tales of “aristocratic philanthropy.”¹¹ When the anthropologist Margaret Read wrote of the Ngoni—whom she had lived amongst before joining the Nyasaland Nutrition Survey—she recounted social expectations that chiefs would feed the hungry and house the homeless.¹² But Read heard these stories from chiefs themselves, who sought to legitimate their rule by portraying themselves as providers for their material security. Iliffe found contrary reports from missionaries and travelers in the nineteenth and twentieth centuries, of neglected orphans, abandoned epileptics, discarded blind or mentally ill men and women.¹³ But in the early decades of indirect rule, which afforded chiefs wealth and power while allowing colonial administrations to shirk responsibility for social provision, it was convenient for both groups to promote the mythology of a robust system of primordial social security.

Even when chiefs abandoned this mythology, officials holding the purse-strings of the budget held fast. British colonial officials claimed publicly that they were seeking both to modernize agricultural production in rural areas without upsetting the existing systems of social protection. It is unclear whether officials really believed in the existence of primordial systems of social protection, or that they could preserve them while completely transforming the economic base. Nevertheless, repeating this fiction seemed useful in justifying the paucity of government social services and social insurance. Take, for instance, the official response to chiefs in Mlanje District in May 1949, when they asked “whether government through the Native Treasuries would agree to financial

¹¹ Iliffe, “The Poor in the Modern History of Malawi.”

¹² Margaret Read, *The Ngoni of Nyasaland* (Oxford University Press, 1956).

¹³ Iliffe, “The Poor in the Modern History of Malawi.”

assistance being given to orphans.” The Provincial Commissioner replied that he had rarely ever seen an abandoned orphan. The chiefs’ requests grew more urgent in the coming months, as a poor harvest in the previous years made it clear that famine was approaching. Chief Chikumbu argued that aged, disabled and orphaned who were without relatives were the most vulnerable in such times. The African Council of the Southern Province proposed that three-pence from each annual tax should be placed into a fund to aid such cases, but Nyasaland’s Financial Secretary objected: “If any sort of arrangement was set up on the lines contemplated by the PC, the whole thing would snowball and become a crippling financial liability in a very short time.” When, that same year, the Colonial Office Adviser on Social Welfare wrote a report urging the administration in Zomba to pursue social welfare with greater vigor, the Chief Secretary demurred: “The conclusions are to spend more money,” he summarized, “and we have no more to spend.”¹⁴ While Southern Nyasaland hurtled toward a deadly famine—one in which officials would express their shock at widespread social abandonment of the aged, the disabled, the orphaned—the Nyasaland Government ruled that “special funds” for the aid of the vulnerable were counterproductive, as they “would lead to a further breaking down of the system of social security which has in the past been a feature of African rural society.”¹⁵

Both during the war and in the years immediately following it, British administrators in Africa saw the need for government provision of social security as particular to waged labor. Peasant producers of cash crops could be afforded a measure of protection through

¹⁴ Iliffe, *The African Poor*. P 267

¹⁵ Iliffe, “The Poor in the Modern History of Malawi.” Page 266.

agricultural marketing boards, which “provide the peasant proprietor with the maximum safeguards against wide fluctuation in the prices of the produce upon the sale of which his livelihood depends.”¹⁶ But for “subsistence economies,” including most of Nyasaland, the colonial administration did not plan to provide the family allowances, disability insurance and old age pensions then being universalized in the UK. The mythology of robust traditional social security was a useful crutch: as a 1944 Colonial Office report, titled “Social Security in the Colonial Territories,” insisted: “In subsistence economies...the tribe or the family still helps substantially to provide against old age, indigence and, to a more limited extent, sickness,” so “the first consideration should be to support, for the time being at least, the existing social structure which ensures this traditional provision.” The main point of this report was not to plot out progressive steps towards an African welfare state, but to ensure that the reader understood that social security in the Colonies was not a responsibility of the Imperial exchequer. “In all cases the process must be visualized as one of an *internal* redistribution...The importance of avoiding the establishment of a standard of minimum maintenance which may prove beyond the capacity of the community cannot be overemphasized.”¹⁷ Cash payments to individuals would only follow increases in aggregate production within the colonies, and would not be financed from outside.

It was not only stingy colonial officials who argued that social security was unnecessary in Nyasaland. The problem lay also in prevailing conceptions of the function of social

¹⁶ “Social Security in the Colonial Territories,” Papers on Colonial Affairs (Colonial Office, June 1944), Mss Brit Emp s.332, Box 47, File 4, BLOU. Page 4.

¹⁷ Ibid. Pages 4-5

security according to leading reformers. In the United States and Europe, mid-twentieth-century architects of social insurance often saw their goal as the replacement of “traditional” protections that had disintegrated during the proletarianization of labor. In the United States, for instance, New Dealers in the administration of President Franklin Delano Roosevelt looked to the idealized solidarity of villages in Poland for the ethos they were trying to recapture.¹⁸ Because state social security was supposed to function as a photographic negative of residual traditional social supports, it was easy to see it as an unnecessary redundancy in seemingly remote agrarian locales (e.g. much of Nyasaland) where village life appeared intact.

b) Health as an exception to Colonial Office insistence on village social security

And yet there was at least one piece of Beveridge’s vision of “freedom from want” that did figure in Colonial Office plans for non-wage-earning populations. Increasing spending on preventive and curative health care was a major part of the stated intent of the Colonial Development and Welfare Act of 1940, and continued to be included in colonial plans for post-war development. Lucy Mair may have extolled the virtues of “a complete system of social security” in “traditional” African societies, but she also argued that because disease remained widespread in these societies “the importance of [government] medical work is particularly great.”¹⁹ The same Colonial Office reports that insisted that cash payments to the needy could only be financed by funds raised within the colonies also stated that colonial health and education were a metropolitan responsibility. “Even where the traditional organization is fully maintained, it is generally itself quite incapable of providing allied social services, particularly of public health and

¹⁸ Rodgers, *Atlantic Crossings: Social Politics in a Progressive Age*.

¹⁹ Mair, *Welfare in the British Colonies*. Page 72.

education, and the village or tribal social security provision needs to be systematically supplemented by extension of Government public health and education services.”²⁰

Beveridge had called for universal access to health care as a pillar of his plan for “freedom from want.” This was one pillar of the Beveridge Report that would extend to colonial plans for Africans even in rural areas.²¹ While they insisted most colonized Africans would have to make do with traditional social security mechanisms, no prominent contemporaries in the Colonial Office argued these traditional support mechanisms could cure the sick as readily as the recently released antibiotic and antimalarial drugs. These drugs, which had already begun to transform medicine in both rich nations and poor colonies, would figure prominently in postwar plans.

III. The realities of postwar development

a) Nyasaland’s Postwar Development Committee, 1944-1945

Many officials in Nyasaland’s colonial administration hoped that health would be a significant beneficiary of postwar CDW grants. Director of Medical Services Arthur Williams, who had been educated at Cambridge and who had worked in West London Hospital before joining the Colonial Medical Service in 1912, offered a litany of complaints about the state of his department in the introduction to his 1944 proposal for postwar development.²² While the hospitals built in the 1930s were in fair repair, “the

²⁰ “Social Security in the Colonial Territories.”

²¹ In describing how the Government of Nyasaland “managed to avoid specific provision for the poor for more than a decade after the Second World War,” Iliffe does note one exception: a “free if limited health service.” Iliffe, “The Poor in the Modern History of Malawi.” Page 268.

²² “Obituary: ADJB Williams, OBE, MRCS, LRCP,” *BMJ* 1, no. 5084 (June 14, 1958): 1421.

same cannot be said with respect to the standard of nursing, diagnostic facilities and transport services for the seriously sick and injured, and in the development of maternity and child welfare clinics at Government hospitals.” Only a single hospital in the entire country had an X-ray machine, which Williams insisted was “an essential part of the doctor’s diagnostic equipment.” Most of the hospitals lacked electricity. To those who doubted the handicap this posed, he advised ‘the difficulties of doing either surgical or maternity work at night with no illumination other than a hurricane lantern or temperamental pressure lamp have to be experienced to be appreciated.’ The entirety of Nyasaland had two ambulances, and both were intended primarily for the use of Europeans. The personnel of rural dispensaries were equipped with few diagnostic skills or—because few were entrusted with intravenous injections or pills in short supply—medicines capable of effecting cure.²³

Preventive health campaigns fared little better: the existing contingent of 50 African “sanitary assistants,” charged mainly with vaccination efforts in rural areas, lacked the education to understand or explain their work to fellow Africans. Williams criticized those distant officials who lamented Africans’ unwillingness to build cement floors in homes and pit latrines, or to use soap, or wear shoes (all necessary to prevent hookworm and other endemic infections). These critics, he said, propounded the virtues of prevention without helping Africans pay for cement, or soap, or footwear.²⁴

²³ Arthur DJB Williams, “Post-War Development of Medical Services,” 1944.

²⁴ Ibid. TA Austin, one of Williams’ predecessors as Director of Medical Services, had made similar arguments a decade earlier. In a report on a study of a village community on the island of Chilwa, Austin wrote, “Treatment, education and propaganda unless accompanied by financial and technical aid will not accomplish much. Until alternative facilities in the form of uninfected

All of these deficiencies, Williams argued, could be addressed if he was given sufficient funding. Nyasaland's Post-War Development Committee, a body composed of officials and Europeans serving on the Legislative Council, agreed. In 1945, the committee submitted a report requesting a vast increase in the quantity and quality of medical provision. Their ten-year plan even proposed an increase in the number rural medical centers from the current figure of just over 100 to 400. Such an increase would be made possible by of a concomitant increase in primary education and a new Medical Training School in Blantyre to supplement the number of hospital assistants emerging from existing institutions in Zomba and at mission stations. The Committee's ten-year plan foresaw an increase in capital and recurrent health spending over the ten-year period totaling £1.8 million.

Nyasaland's Post-War Development Committee argued that this new funding should come from metropolitan grants and the repayment of money owed by the Imperial exchequer, not from domestic revenue. In sum, the Committee's proposals (for health and all other departments) planned for £7.5 million in capital and new recurrent costs associated with the development schemes it had proposed between 1946 and 1955. The committee requested that £6.5 million of this funding should come from CDWF grants. The remaining £1.0 million, they suggested, should be paid for by "the Protectorate's surplus balances which have been loaned to His Majesty's Government during the war."

bathing places and protected wells are available, contaminated water from Lake Chilwa must be used and schistosomiasis will continue to be a menace to the health of the people." Williams, "Annual Medical & Sanitary Report for the Year Ending 31st December 1935." Page 91.

The Exchequer had called these transfers “gifts” from the colonies, but Nyasaland officials wanted the money back.²⁵

b) Effects on postwar colonial health spending of Labour’s victory in the 1945 UK general election

The prospects for such plans, in Nyasaland and elsewhere, appeared brighter following the July 1945 UK general election. In the nation’s first general election in ten years, Clement Attlee’s Labour won a landslide victory, increasing its seats in the House of Commons (a 640-seat body) from 154 to 393. The Conservatives, led by Winston Churchill, lost nearly half their seats, plummeting from 385 to 197. With a sizable majority of seats in Commons, Labour claimed a mandate to remake British society in the postwar dawn. They set to work implementing Beveridge’s recommendations, including the National Health Service. Transformation seemed certain to reach the colonies, especially after Attlee named Fabian Colonial Bureau chair Arthur Creech Jones his Secretary of State for the Colonies in October 1946. Indeed, just as he assumed this office, Creech Jones spoke before the Anti-Slavery and Aborigines Protection Society, the same group before which Lord Hailey had called for a Colonial Charter in 1942. Creech Jones’ address was full of grand promises:

So far as Britain is concerned, I think we can assume today that the old Imperialism has come to an end... We are determined as a people now to face up to the problems presented to us in the territories which we have to administer. We have to try to convey to the world as well as to the people in the territories for which we are responsible some understanding of our purpose and we have to win their completest confidence... The past has left a legacy of trouble. It has somehow to be dealt with in the progressive work we seek to do today... We have

²⁵ “Report of the Post-War Development Committee,” 1945.

to harness nature to the will of man and to safeguard the life of man and hold in check disease.²⁶

A more prosaic manifestation of this almost millenarian rhetoric could be seen in the revamped Colonial Development and Welfare Act. The renewal of the Act was begun before the election and completed in October 1945, three months after Clement Attlee had moved into 10 Downing Street. The 1945 Act extended the Colonial Development and Welfare Fund's term of existence from 1951 to 1956, and increased funding to a total of £120 million between 1946 and 1956.²⁷ Even before Labour's 1945 victory, the Colonial Office deployed development officers to the colonies to help draft new schemes.²⁸

Yet if these new development officers and Labour's victory seemed to augur a flood of new money, Nyasaland's administration would soon learn—as Shircore and De Boer had before—that recent unrest was a more powerful motivator for development funding than dismal indices of poverty and medical provision. When the Colonial Office announced the CDW allocations to every colony on November 12, 1945, Nyasaland was promised only £2 million, less than one-third of its request.²⁹

²⁶ “An Address by Rt Hon A Creech Jones, Secretary of State for the Colonies, to the Annual Meeting of the Anti-Slavery and Aborigines Protection Society” (London, UK, October 24, 1946), Mss Brit Emp s.332, Box 47, File 4, BLOU.

²⁷ *Colonial Development: A Factual Survey of the Origins and History of British Aid to Developing Territories*. Page 32. This sum included £20 million carried forward in allocations awarded but not yet spent under the 1940 Act.

²⁸ Nyasaland shared its development officer with Northern Rhodesia. “Editorial: Colonial Tasks,” *Times (of London)*, January 10, 1945, The Times Digital Archive.

²⁹ “Nyasaland Development Programme, Revised 1947,” 1947. Also see Colonial Development and Welfare, 12th November 1945, from the Secretary of State for the Colonies to Colonial Governments, Printed by the Secretary of State for the Colonies to Parliament by Command of His Majesty, December 1945, London, HMSO, Cmd.6713, UKNA. Eventually, of the £2 million

Per-capita allocations were much higher for Caribbean colonies that had experienced significant strike action in the 1930s. Nyasaland, a colony with 2 million inhabitants in 1945, was allocated £2 million (£1 per capita). Trinidad, with a population of 547,000 in 1945, received £1 million (£1.83 per capita). And Barbados, a colony with 187,000, received £800,000 (£4.28 per capita). Jamaica, a colony with 1.3 million inhabitants in 1945, was allocated £6.5 million (£5 per capita).³⁰ Between 1940 and 1946, over half of the £10.4 million expended from the Colonial Development and Welfare Fund had gone to the West Indies. It was still seen as a potential locus of unrest, and as America's window to British imperialism.³¹ The post-war allocation announcement indicated development spending would continue to favor the West Indies. Following this announcement, Williams had to curtail his planned expansion of the medical services

that Nyasaland received from the Colonial Development and Welfare Fund between 1946 and 1955, £348,830 (17.4 percent) was spent on the Medical Department. This included £205,000 for hospitals and training schools, £111,770 for health units and dispensaries, £9,440 for ambulances and other equipment, and £22,620 for leprosy settlement). By the early 1950s, though, some of these projects (such as the training schools) had been delayed. See "Colonial Development and Welfare Act 1945, Nyasaland, Public Health Plan, CDWAC No 1077, 17 February 1947, CO 525/210, UKNA.

³⁰ "Return of Schemes Made Under the Colonial Development and Welfare Acts, by the Secretary of State for the Colonies with the Concurrence of the Treasury in the Period from 1st April, 1946 to 31st March 1947" (London: His Majesty's Stationary Office, July 1947), House of Commons Parliamentary Papers Online.

³¹ Constantine, *The Making of British Colonial Development Policy, 1914-1940*. P 201. Criticism from American officials and celebrities was especially concerning to colonial officials. In an October 1946 speech, Secretary of State for the Colonies Creech-Jones lamented, "There has been, only recently, a number of statements by responsible people in American public life in which Britain has been characterized as an imperial power pursuing her own material aims and little actuated by the purpose of winning freedom and building up the social life of the people in the Colonies. It is unfortunate, too, that this view is shared by those of negro descent in the United States... The latest statement I saw came from Paul Robeson himself after his interview with President Truman last month when it is alleged he said: 'The British Empire is one of the greatest enslavers of human beings..'" "An Address by Rt Hon A Creech Jones, Secretary of State for the Colonies, to the Annual Meeting of the Anti-Slavery and Aborigines Protection Society." P 4.

considerably. The post-war development plan written in 1947 had reduced new expenditures over the coming ten years from £1.8 million to £1.0 million.³²

c) Labor unrest, once more: Colonial development following strike waves of 1946-1948

But if stated intentions and welfarist ideology were not enough to significantly increase spending for health, colonial unrest could do wonders. In 1946, another wave of strikes began; this time the focus was not the West Indies, but British Africa. A range of laborers from dockworkers to domestic servants organized general strikes in Mombasa (in Kenya) and Dar es Salaam (in Tanganyika) in 1947, while railway workers and miners struck in the Gold Coast.³³ In 1948 general strikes paralyzed both Zanzibar and the Southern Rhodesian city of Bulawayo.³⁴ Between 1946 and 1948 agricultural tenants, railway workers and hospital orderlies struck to protest price controls, low pay and poor working conditions in Anglo-Egyptian Sudan.³⁵ In 1949-1950, 46 strikes in Nigeria resulted in 577,000 man-days of labor lost.³⁶

Major grievances motivating these actions included shortages of consumer goods, inflation, low wages and poor working conditions, but as in the late 1930s health would figure prominently in the Colonial Office's response. In 1950 the Colonial Development and Welfare Act was revised once more, adding another £20 million to the total fund

³² "Nyasaland Development Programme, Revised 1947."

³³ Iliffe, "A History of the Dockworkers of Dar Es Salaam."

³⁴ Cooper, *Decolonization and African Society*. Page 226.

³⁵ Curless, "The Sudan Is 'not yet Ready for Trade Unions': the Railway Strikes of 1947-48."

³⁶ Cooper, *Decolonization and African Society*. Page 226.

(bringing the maximum to be awarded by March 1956 up to £140 million).³⁷ In the November 1950 House of Commons debate over this increased funding, Members of Parliament once more made the link between unrest and social welfare spending. Stanley Awbery, a former trade union leader and Labour MP from Bristol, was most explicit. He urged his colleagues to spend far more than the planned £140 million. “We have to win the confidence of the people of the Colonies,” he declared. “A little help given two decades ago might have prevented the mountain of trouble we are experiencing today. Our record of omissions in this field of social welfare has proved fruitful soil for both unrest and Communism.”³⁸

The wave of labor strikes in Africa had helped greater rhetorical (and financial) commitments to social services, including health.³⁹ A significant portion of the Colonial Development and Welfare Act would go toward health schemes. Between 1946 and 1955, the Colonial Development and Welfare Act approved £17.0 million in grants and loans for health services schemes. The only category of funding receiving a larger amount was education, which received £19.0 million.⁴⁰

³⁷ Roy Lewis, *10 Years of Colonial Development and Welfare, 1946-1955* (London: Central Office of Information, 1956). Page 16.

³⁸ Stanley Awbery, *Colonial Development and Welfare Bill, Volume 480, cc1135-251, 1950*, http://hansard.millbanksystems.com/commons/1950/nov/09/colonial-development-and-welfare-bill#S5CV0480P0_19501109_HOC_342.

³⁹ Steven Feierman has made a similar argument about the link between health and protest. In a 1985 review article on “the social roots of health and healing in modern Africa,” he explained: “In the colonial situation the ultimate arbiter was in the metropole; employers of labor were well-represented there, but the potential African beneficiaries of improved health care had little influence in the colonial mother-country. What influence they had emerged from the politics of resistance and of nationalism.” See Steven Feierman, “Struggles for Control: The Social Roots of Health and Healing in Modern Africa,” *African Studies Review* 28, no. 2/3 (June 1985):. 123.

⁴⁰ Lewis, *10 Years of Colonial Development and Welfare, 1946-1955*.

In apportioning these additional CDW funds (as well as the reserves from the initial allocation), both African and West Indian colonies were among those receiving new funds. Some of the largest increases were allocated to postwar hotbeds of unrest. Between 1945 and 1960 the Federation of Nigeria (including Cameroons) was allocated £36.4 million and Kenya was allocated £9.7 million, more than any other colonies in the entire British Empire. Nyasaland, though it was not such a hotbed until the Federation period, also saw some benefit to the increased funding. Between 1945 and 1960, Nyasaland was allocated £4.9 million in CDW grant aid.⁴¹

To be sure, the increase in spending is not entirely attributable to colonial unrest. Creech Jones would later point to larger postwar forces that had not allowed for full and immediate implementation of the Act: “The new Government in Britain had to cope with confused international relations, with anarchical economic conditions, with scarcities of supplies and low production, with complicated issues of finance, and with demands for capital and goods at home and in the Commonwealth which could not be satisfied.”⁴² With these pressures abated, Parliament and the Treasury were less opposed to increased CDW expenditure. The CDW Fund expended only £3.5 million in 1946-1947, but this figure rose to £16 million by 1954-55.⁴³

⁴¹ Between 1946 and 1955 Kenya and the Federation of Nigeria (including Cameroons) received more CDW aid than any other British Colonies. Kenya received £9,657,000, while Nigeria received £36,380,000. Ibid. p 19.

⁴² *Colonial Development: A Factual Survey of the Origins and History of British Aid to Developing Territories*. Page 31.

⁴³ Lewis, *10 Years of Colonial Development and Welfare, 1946-1955*.

There was increasing recognition of the benefits of a “stabilized,” productive labor force. After the Second World War, the UK Government sought to bolster its dwindling dollar reserves by expanding exports of African primary products. Part of the strategy to do so was to render labor more productive through “stabilization,” allowing families to live together rather than relying on migrant labor to mines and plantations. In order to allow for this stabilization, companies and colonial administrations built better housing and expanded health and education facilities near these centers of production.⁴⁴ But while this move toward stabilized labor was an important factor in expanding health services in some places, it was less important in Nyasaland. Some workers on Northern Rhodesia’s copper mines enjoyed greater social service provision and higher wages, but the economic logic of labor stabilization affected few among Nyasaland’s overwhelmingly rural smallholder population.⁴⁵

d) Assessing the impact of Labour rule on health services in Nyasaland

In the end, what difference did it make to African patients in Nyasaland that *Labour* held power in Britain? Did the ideals of the Fabian Colonial Bureau actually impact decision-making in Whitehall?

The existing historiography insinuates that the Labour Party’s rhetoric of socialist planning “for the Common Weal” in the colonies masked a basic continuity with imperial policy of the previous half-century. In a discussion of the mostly abortive large-scale agricultural mechanization programs (e.g. the Tanganyika groundnut scheme) pursued

⁴⁴ Feierman, “Struggles for Control.”

⁴⁵ Roberts, “A History of Zambia.” Pages 187-190.

during under Labour, Michael Cowen and Robert Shenton point to “the obvious similarity of Labour’s policies to those enunciated by the ‘archimperialist’ Joseph Chamberlain some four decades earlier.” Chamberlain, who became Colonial Secretary in 1895, had argued that the British were “the landlords of a great estate,” and had favored policies favorable to settler-run plantations.⁴⁶ Historian Paul Kelemen recounts that by the 1951 UK general election, both the Conservatives *and* the Labour left argued that Attlee’s government had exploited the colonies. Noting the increasing sterling balances of the colonies, in 1952 the leftist editorial board of the weekly *Tribune* argued that even considering the CDW aid provided by the Imperial Exchequer, “the colonies...are financing us!” These histories argue that the ideological commitments of the Fabian Colonial Bureau seem to have had little impact on the actual practice of economic policy-making in the 1945-51 Labour Government.⁴⁷

In the realm of health policy, though, the archives reveal that Creech Jones’ subordinates echoed some of his ideological commitments in consequential policy deliberations. In February 1949, the Colonial Office heard from the Crown Agents for the Colonies that UK manufacturers were declining to fill their orders because of instructions from other government ministries “that their output, or a large proportion of it, must be retained for the home market.” The Colonial Office was particularly concerned about export controls on medical supplies, namely “surgical dressings, surgical instruments, and electrical medical machinery.” X-ray machines were a particular concern. This technology had

⁴⁶ Michael Cowen and Robert Shenton, “The Origin and Course of Fabian Colonialism in Africa,” *Journal of Historical Sociology* 4, no. 2 (June 1991): 143–74.

⁴⁷ Kelemen, “Planning for Africa: The British Labour Party’s Colonial Development Policy, 1920-1964.”

become particularly important for tuberculosis diagnosis and monitoring, as new chemotherapeutics (especially streptomycin) began to reach clinics around the world. One manufacturer of X-ray machines had told the Crown Agents in February 1949 that “he was allowed by the Ministry [of Health] a small quota merely to maintain his export connections,” and that the company planned to export only one mobile X-ray machine (which was destined for Nigeria) in the next two years.⁴⁸ “Orders for hospital and medical equipment placed as long ago as 1945 have still often not been executed,” complained Morris in a letter to the Ministry of Health.⁴⁹

Henry Wilkinson, Comptroller of Supplies for the Ministry of Health, confirmed that he had placed some controls on exports, but noted that even though orders of X-ray machines for the NHS were “seriously in arrears,” he had “released” one unit to the Tanganyika groundnut scheme in 1948 in addition to the unit recently promised to Nigeria. Wilkinson explained that, due to acute shortages and arrears in orders of gauze, lint and bandages in the UK, only one-quarter of surgical dressings produced domestically were exported. He noted further that, despite shortages of surgical instruments and streptomycin in NHS facilities, all Crown Agents orders for these items were being met. In all, he concluded, the colonies were “getting a fair share of the available supplies.”⁵⁰

⁴⁸ “Committee on Colonial Development: Export to the Colonies of Items of Equipment Which Are in Short Supply in the United Kingdom, Memorandum by the Colonial Office,” February 7, 1949, MH79/629, UKNA.

⁴⁹ William Alexander Morris, “Letter to Henry Wilkinson, Comptroller of Supplies, Ministry of Health,” February 16, 1949, MH79/629, UKNA.

⁵⁰ Henry Wilkinson, “Export to the Colonies of Items of Equipment Which Are in Short Supply in the United Kingdom, a Note by the Ministry of Health,” February 14, 1949, MH79/629, UKNA.

At a March 28 meeting of the Cabinet Committee on Colonial Development, this issue became the subject of heated dispute. According to the meeting minutes, Wilkinson insisted he was “not willing to contemplate the diversion to export of anything which would endanger the health of this country.” Hilton Poynton, an Under-Secretary of State for the Colonies who had previously served in Sierra Leone, “stressed that this view was not acceptable...as His Majesty’s Government had an equal responsibility for safeguarding health in the Colonies.”⁵¹ Poynton and Wilkinson eventually agreed to a proposal put forward by the Ministry of Agriculture and Fisheries, in which the Colonial Office would provide other ministries “guidance on particular items which were for the time being of concern to the colonies.” Poynton inserted the proviso that “colonial orders for these items should be treated on an equal footing with home orders.”⁵²

Shortly after this agreement was reached, Nyasaland finally received long-sought additional X-ray machines. Nyasaland’s Postwar Development Committee had called, in 1944, for an increase in the Medical Department’s supply of X-ray machines from one to eight. By 1952, this figure had increased only to three, with machines in Lilongwe, Blantyre and Zomba. In 1951 the department was also afforded its first radiologist, who in turn trained three African hospital assistants. The number of X-rays performed had

⁵¹ S.R. Ashton, “Poynton, Sir (Arthur) Hilton (1905-1996), Civil Servant,” *Oxford Dictionary of National Biography* (Oxford University Press, 2009); “Cabinet Committee on Colonial Development” (Cabinet Office, Great George Street, SW, March 28, 1949), MH79/629, UKNA.

⁵² “Cabinet Committee on Colonial Development.” (March 28, 1949) The committee did agree to “some degree” of “home favoritism” for fuel supplies.

risen from 1,570 in 1950 to 2,956 in 1952.⁵³ Still, this expansion paled in comparison to the concurrent increase in X-ray facilities in the home market. Between 1950 and 1952 the National Health Service added 560 X-ray units across the United Kingdom.⁵⁴ Thus, the United Kingdom received more than 280 times more X-ray units than Nyasaland, though the population of the former was only 17 times larger than that of the latter.⁵⁵ “Home favoritism” in the form of budgets if not export controls, was alive and well.

IV. Staff, space, and stuff in the postwar health system

a) The fight against venereal disease: new treatments for the postwar moment, 1944

Shircore was unwilling to await the end of the war to see a new dispensary built in his district. But the war did end, and soon retrenchment of colonial budgets turned to expansion. In 1944 Nyasaland’s government convened a Post-War Development Committee, chaired by a veteran administrator named Juxon Barton who was then serving as Chief Secretary. One of the committee’s reports concerned public health in Nyasaland. This report began with a warning, that the “economic development of Nyasaland...is not likely to be satisfactory because a large proportion of the Native population suffers from the debilitating effects of malaria, hook-worm, bilharzia and other parasites.”⁵⁶ The Colonial Office was also concerned with health in Nyasaland,

⁵³ “Annual Report of the Medical Department for the Year 1950” (Zomba, Nyasaland: Government Printer, 1951), University of Malawi Library; “Annual Report of the Medical Department for the Year 1952” (Zomba, Nyasaland: Government Printer, 1953), Box 15, No 2, SoMA. Page 19.

⁵⁴ “Shortage of X-Ray Films,” *BMJ* 1, no. 94 (January 12, 1952): 94–95.

⁵⁵ In 1950 the estimated population of Nyasaland was 2.8 million, while the population of the United Kingdom was roughly 50 million.

⁵⁶ Post-war development committee 1944, Interim report No 3 –public health [authors are Juxon Barton (chairman), GH Adams, W Tait Bowie, MP Barrow, HG Duncan, AF Barron, JA Lee, J Marshall.

particularly with venereal diseases brought back by African soldiers returning from war (many had served in South Asia, notably Burma).⁵⁷ Given the concern with under-population in the colonies in the 1930s and early 1940s (see Chapter 1), the anticipated spread of gonorrhoea and syphilis, the “great preventer of life” and “great destroyer of life,” respectively, justified spending on medical services.⁵⁸ There was also new funding available for medical provision across the British Empire; the Colonial Development and Welfare Act (CDW), which had first passed Parliament in late 1939, finally secured funds from the Imperial Treasury toward the war’s end.⁵⁹ In May of 1945, the Colonial Office granted Nyasaland its first tranche of CDW funding when it approved an application for a five-year, £42,000 grant to Nyasaland to provide free medical treatment for gonorrhoea and syphilis at government and mission institutions.⁶⁰

b) Buildings and drugs are not enough: a call for better training and equipment, 1944

Arguments that venereal and other diseases would stanch Nyasaland’s postwar growth helped spur a broader reappraisal of the quality of care in government health facilities. As

⁵⁷ W.A.M. to Mr. Boyse and Mr J.B. Williams, April 11, 1945, CO 525/199/5, UKNA. Approximately 27,000 Malawian soldiers enlisted during the Second World War. According to John McCracken, “outright compulsion was largely avoided. Instead, provincial and district officers threatened native authorities and headmen with the loss of privileges if the failed to provide sufficient numbers of recruits. McCracken, *A History of Malawi*. p 239.

⁵⁸ “Post War Development Committee, Draft Interim Report No. 3- Public Health, Nyasaland Secretariat.” Page 3

⁵⁹ The historian Ann Beck notes that the word “welfare” was included in the name of the act to “indicate the new special emphasis to be given social improvement, for it had been found that emphasis on schemes of a capital nature gave too much priority to material development.” Ann Beck, *Medicine, Tradition, and Development in Kenya and Tanzania. 1920-1970*, First Edition (Waltham, Mass: African Studies Assn, 1981). Page 5.

⁶⁰ Edmund Charles Smith Richards, “CDWAC No 527: Nyasaland. Venereal Disease: Purchase of Drugs for Treatment. Application for Free Grant of £42,000,” January 23, 1945, CO 525/199/5, UKNA. Also see Governor’s Despatch No 72 of the 12th July, 1944, on the subject of Venereal Disease, to Colonial Office

of July 1944, treatments for gonorrhoea (sulphapyridine tablets) and syphilis (bismuth and neosalvarsan tablets) were provided at all district hospitals. But of the 91 rural dispensaries, only the four staffed by African hospital assistants (with four years of training) were allowed to administer these drugs. Because of the toxicity of the most important injections, and presumably because of the scarcity of sulphapyridine tablets, African auxiliaries at the rest of the dispensaries were entrusted only with “palliative treatment” such as dressings and bandages for traumatic wounds.⁶¹ A 1944 commission on venereal disease in Nyasaland recognized the inadequacy of training not only as an impediment to venereal disease control, but also to “the diagnosis and treatment of other prevalent and preventable diseases.” Many of the most commonly used drugs in this era could be highly toxic. Injections of quinine (for malaria), antimony tartrate (for schistosomiasis), emetic (for amoebiasis), and bismuth and mercuric compounds (for syphilis and gonorrhoea) were prepared by boiling a tablet on a tablespoon over a spirit lamp, then injecting the dissolved solution. In addition to the toxic effects of the drugs themselves—antimony tartrate, for instance, was known to cause splenic contraction and a subsequent rise in circulating malaria parasites—poor preparation and administration technique could result in abscesses or even death.⁶² Nyasaland’s venereal disease

⁶¹ See 1944 commission on VD. Also see De Boer, “Annual Medical & Sanitary Report for the Year Ending 31st December 1938.” page 27: “Treatment of [schistosomiasis] at dispensaries has not yet been started for few members of the native staff have been trained in giving intravenous injections; an endeavor is to be made to train all staff in this necessary technique.” A medical officer named WI Gopsill said he trained “native dressers” to give intravenous antimony tartrate injections at his hospital in Port Herald in the early 1930s, though it is not clear whether these dressers performed the injection only in his hospital or in outlying dispensaries. WI Gopsill, “A Few notes on my life in Zanzibar and Nyasaland from 1926 to 1945, page 14.

⁶² Mkandawire, *Living My Destiny*, 100 and Gopsill, “A Few Notes on My Life in Zanzibar and Nyasaland from 1926 to 1945.”, 12. In the years prior to the introduction of penicillin, most

commission recommended expanding the availability of treatment through increased training of African hospital assistants (to be posted, contrary to the name, at both hospitals and dispensaries) and laboratory assistants.⁶³

The Postwar Development Committee argued that while Nyasaland's medical buildings were "said to compare favourably with similar institutions in other African territories," the Protectorate lagged in "the standard of nursing, diagnostic facilities, equipment and medical transport services," and "in the development of maternity and child welfare clinics." They requested funds for X-ray machines and electric lighting at eight district hospitals, 11 new ambulances (to be added to the current stock of only two), and the transfer of patients at the Lunatic Asylum (then under the Prison Department) to a new 200-bed Mental Hospital (to be administered by the Medical Department). The committee recommended 18 additional European medical officers and 30 additional European nurses. Most importantly, the training of hospital assistants should be undertaken at a four-year Medical Training School able to accommodate four classes of 15 students each. The committee did not seek a medical school—Nyasaland lacked even a single government secondary school until 1946—but instead recommended sending "those of outstanding ability" to Makerere College in Uganda.⁶⁴

physicians considered neosalvarsan superior to mercury for the treatment of syphilis. Nyasaland's government facilities for Africans continued to use mercury, most likely because it was cheaper.

⁶³ IC Ramsay et al., "Report Submitted by the Committee Appointed to Consider and Make Recommendations on the Problem of Venereal Disease in Nyasaland," January 26, 1944, CO 525/199/5, UKNA.

⁶⁴ Before the 1940s, only two Africans from Nyasaland were known to have completed a medical degree. Both DRS Malikebu (MD, 1926) and Hastings Kamuzu Banda (MD, 1937) studied in the United States, at Meharry Medical School, a black institution in Nashville. Malikebu became a missionary doctor at the Providence Industrial Mission in Chiradzulu, while Banda would not

Finally, the Postwar Development Committee recommended a rapid increase in recurrent expenditure on health. Over the ten years between 1934 and 1943 the Medical Department had averaged £54,100 in annual recurrent expenditure. Between 1941 and 1943 the average was £66,000. The report recommended increasing annual recurrent expenditure to £157,500 by 1949. They also recommended £453,125 in development spending on health facilities and equipment over five years.⁶⁵

c) Postwar growth of medical spending and staffing, 1945-1952

Nyasaland's medical department did enjoy increasing recurrent and capital budgets during this postwar period. By 1949, recurrent expenditure on health in Nyasaland was £163,321; its peak in the years prior to the 1953 advent of the Federation came in 1951, when recurrent health expenditure in Nyasaland reached £185,800. Between 1945 and 1952 recurrent spending in current pounds sterling more than tripled. Capital expenditure in the medical department came a few years later than requested, but between 1948 and

return until 1958, not to practice medicine but to lead the anti-Federation movement (see Chapter 4). Only one African from Nyasaland, Sam V Bhima, was sent to Makerere in the 1940s. He returned in 1952 with a medical diploma, and was posted to the Zomba African Hospital. No other Africans from Nyasaland earned medical degrees until the early 1960s, when Harry Bwanausi, Anne Ascroft and Vida Nwira, returned from studies abroad. See Mkandawire, *Living My Destiny*. Pages 90-91

⁶⁵ "Post War Development Committee, Draft Interim Report No. 3- Public Health, Nyasaland Secretariat."

1953 it totaled over £284,368 (with additional expenditure on health facilities included in the Public Works Vote).⁶⁶

But the postwar expansion of Nyasaland's health sector was not as impressive as these numbers appear to indicate. First, the postwar years were a period of increasing primary commodity prices and intensified tax collection drives. As a result, domestic public revenues (not including grants-in-aid) rose substantially, from £1.2 million in 1946 to £3.9 million in 1952. Yet the postwar Governor, Geoffrey Colby, who held this post between 1948-1956, did not prioritize health. When he requested additional CDW funding from the Colonial Office, it was not for health care but rather for roads, telecommunications, and electricity. During his tenure, even the Protectorate government's applications to the Colonial Development and Welfare Fund claimed the medical system was already quite adequate: "There is at present a reasonably comprehensive curative service in relation to the economic and social development of the Territory."⁶⁷ Colby's only interest in health, as indicated by his requests to the Colonial Office, was in improving clean water.⁶⁸ The share of recurrent expenditure devoted to Nyasaland's medical department fell from 7.2 percent in 1947 (the year before Colby

⁶⁶ "Annual Report of the Medical Department for the Year Ended 31st December, 1945" (Zomba, Nyasaland: Government Printer, 1946), Box 15, No 11, SoMA; "Annual Report of the Medical Department for the Year 1952."

⁶⁷ "Application for a grant from Colonial Development and Welfare Funds: Medical Department," 1950, CO 525/218/11, UKNA.

⁶⁸ Colin Baker, *Development Governor: Sir Geoffrey Colby - A Biography* (IB Tauris & Co Ltd, 1994). Page 91.

arrived) to 4.1 percent in 1951, before beginning to rebound to 5.9 percent in 1952 (the year before the start of Federation).⁶⁹

d) Training African medical providers in postwar Nyasaland, 1945-1952

Auxiliary medical training finally increased after the war, following decades of smaller efforts. These African providers included dressers, dispensers (used interchangeably with “dressers” in Nyasaland), hospital assistants, medical assistants, and varied “classes” of nurses and midwives. Though these cadres had long formed the front line of Nyasaland’s government medical provision, governments in British Africa only began to assume responsibility for training (previously done entirely by missions) in the mid-1930s. There were relatively few educated Africans from whom these training institutions could draw. As detailed in Chapter 3, the Colonial Development Act of 1929 did not include funding for primary or secondary education. Shircore (in 1930) and De Boer (in 1938) had both lamented the limited training and knowledge of dressers put in charge of dispensaries. De Boer claimed that the only improvement in the training of dressers since Shircore had called for an overhaul of dresser training was a two-month course at the Zomba African Hospital.⁷⁰ By the early 1940s dressers had usually completed Standard 4, and were able to read and write, but their lack of fluency in English often frustrated medical officers.⁷¹ A few dressers were trained by medical officers at district hospitals to deliver anesthesia during surgery (sometimes medical officers’ wives also filled this role), but here the

⁶⁹ These figures differ from those quoted in Baker’s *Development Governor*, but he does not cite his source for the figures, whereas mine come from Nyasaland’s annual Medical Department reports.

⁷⁰ De Boer, “Proposals by Director of Medical Services, Nyasaland, for Reorganization of Medical and Health Services.” Page 7.

⁷¹ Berry, *Before the Wind of Change*. Page 16.

“minimal qualification was to be able to render the patient unconscious without killing him!”⁷²

For decades the colony’s few African hospital assistants were trained in courses at the Universities’ Mission for Central Africa (UMCA) hospitals, first in Livingstonia before then in Blantyre after 1928. The Nyasaland government had first accredited the UMCA curriculum in 1909, and the Blantyre mission school received public subsidies.⁷³ Some of the graduates of these programs joined Nyasaland’s medical department.⁷⁴ In the 1910s and 1920s the course of study was three years, including 850 lectures on subjects spanning the basic sciences as well as public health, clinical medicine and surgery, and even medical jurisprudence. This curriculum increased to four years in 1928, lengthening to include additional clinical training in medicine, surgery, pathology, nursing and anesthesia. The prerequisite educational requirements also increased over the years, from completion of Standard 3 in 1911 to completion of Standard 6 by the 1930s.⁷⁵ Hospital assistants’ literacy, numeracy, work ethic, social grace, and medical knowledge often impressed medical officers; Berry remembered a case in the early 1940s when a hospital assistant corrected his own failure to order a blood film to check for malaria in a febrile patient admitted for schistosomiasis treatment.⁷⁶ Berry recalled another, Dan Ngurube, as

⁷² Ibid. Page 15

⁷³ Mkandawire, *Living My Destiny*. Page 83

⁷⁴ In 1925, only three African hospital assistants (Thomas Cheonga, Moses Kaunde and Daniel Gondwe) were employed by Nyasaland’s Medical Department. By comparison, the Department had two senior medical officers, eight medical officers, a matron, seven nursing sisters, and nine sub-assistant surgeons. Whitehead, “Annual Medical Report on the Health and Sanitary Condition of the Nyasaland Protectorate for the Year Ended 31st December, 1925.” Page 16.

⁷⁵ Mkandawire, *Living My Destiny*. Page 82-85

⁷⁶ Berry, *Before the Wind of Change*. Page 5.

the “cleverest of all our hospital assistants.” At times, Berry reminisced, Ngurube “corrected the diagnoses made by (unidentified) white Rhodesian or South African doctors” on patients sent home as invalids from the mines.⁷⁷

Organized training of African hospital assistants in a Nyasaland government facility finally began after the Second World War. The Zomba African Hospital was renovated with CDW funds with new classrooms, male and female student hostels, and a recreation hall, as well as additional exam rooms, a new pharmacy, a bigger pathological laboratory and an antenatal clinic.⁷⁸ The new hospital drew its senior African staff largely from the UMCA mission hospitals or from veterans of the Kings’ African Rifles.⁷⁹ The most educated of the new male matriculants were expected to become Medical Assistants after two years of training; the top performers among them would go on to train as Hospital Assistants. Other male students could become medical aides (below medical assistants), health assistants (a cadre focused on community public health campaigns) and laboratory assistants, while female trainees could become midwives or (after 1951) nurses.⁸⁰

Austin Mkandawire completed Standard 6 in 1948. To his chagrin, he had not been selected to attend Blantyre Secondary School, then the only government secondary school in Nyasaland. Mkandawire applied and was accepted to the Zomba Medical Assistant training course along with fifteen other new students. After two years of

⁷⁷ Ibid. Page 5

⁷⁸ Mkandawire, *Living My Destiny*. Page 89

⁷⁹ For more on the involvement of Nyasaland soldiers in the Second World War, see McCracken, *A History of Malawi*.

⁸⁰ Mkandawire, *Living My Destiny*. Page 97.

training he passed his exams with distinction, and was among the four selected to proceed with the hospital assistant training course. In his memoirs, Mkandawire recalls his pride in this moment:

The hospital assistant course gave one status and therefore was the envy of everyone in the medical field. It was a prestigious position to reach and I felt privileged to have had the honour of being selected. I was thrilled knowing my financial position would also improve substantially so that I could at last pay for my studies. The highest hospital assistant scale was £240 per annum and that of a senior medical assistant was £198 per annum...I reached the highest point of £240 when I was promoted to principal hospital assistant in 1957.⁸¹

Mkandawire admitted, with characteristic forthrightness, that he enjoyed the status afforded hospital assistants. But the “status”—or lack thereof—due African auxiliaries became a point of contention in the micro-politics of Nyasaland’s African hospitals. Among the few Africans to with the financial resources to complete primary school, the students at Zomba were, for the most part, born into relative wealth; Mkandawire, for instance, was the son of a teacher at the Livingstonia Mission. Many former students at Zomba’s African Hospital came to occupy positions of power and privilege *outside* medicine after independence. John Kadzamira, who decided not to work in medicine after completing the medical assistant course without being selected for hospital assistant training, joined the Postal Service and became Postmaster General following independence. Another classmate became Secretary General of the Malawi Congress Party, another became a diplomat, and a third rose to a high rank position in the Malawi Police Force.⁸² Mkandawire himself eventually completed a medical degree in Ireland in 1971.

⁸¹ Ibid. Page 105.

⁸² Ibid.

Despite the status they brought to medical training and the status they earned by dint of that training, in the early 1950s these students were Africans in a segregated colonial society, and were treated accordingly. Mkandawire recalled an Irish surgeon named Roberts who had been posted in Nyasaland since 1942. He was Nyasaland's first surgical specialist, "loved, revered and almost worshipped by the Africans, to whom he was dedicated and with whom he formed a special relationship." Mkandawire remembers himself as Roberts' favorite trainee in his cohort, and he often assisted on cases. But Mkandawire vividly remembered one night while preparing for a surgery, he was "kicked in the ribs" by his mentor because he accidentally placed Roberts' boots on the wrong feet.⁸³

e) Politics of health in Nyasaland on the eve of Federation: protesting nursing care, 1952

While they suffered the condescension—and even physical abuse—of European doctors and nurses, African medical professionals were sometimes seen by African patients as haughty and uncaring. In a January 1953 letter from Rose Chibambo and other members of the Nyasaland African Women's League to the Director of Medical Services, the Women's League leaders complained about the treatment of women by African nurses in Zomba's African Hospital:

It is a sorrowful thing that these criticisms are directed on the African Nurses who should be more aware of their responsibility in caring for their fellow African Women, than anybody else...In most cases those women who are admitted are dangerously ill and are incapable of doing anything on their own, but when the patients seek Nurses' help, it is very surprising that they are very resentful and care very little. Indeed, the men are doing far better than the Nurses in these wards, for they really have their spirit of service to their fellow people. The

⁸³ Ibid. Page 101. Roberts apologized fifteen years later, when Mkandawire reminded him of the incident.

Nurses unlike the men have no sense of responsibility towards their fellow women patients. ... When a patient asks for a bedpan she finds that it takes a considerable time before she can receive help; and when it is too late she cannot help but spoil her beddings. When this happens the nurses become very cross... The result is that the patient loses all the confidence in both medicine and the staff and also discourages many from coming to the hospital... It seems a rule at the hospital to make patients to take water for drinking from the taps by themselves. But in most cases the patients are so ill that they cannot rise and walk to bring water and in this regard it is the duty of the Nurse to bring the water for the patients... In the Labour Ward when the pains are so severe that some of the women cry... the Nurses turn round to mock and frighten the women... Through the medium of the authorities they should learn of their immense responsibility and duty to their people.⁸⁴

While in the late 1930s Colonial Office officials claimed Africans could do without nursing at hospitals, by the early 1950s Africans themselves were demanding better nursing care. Caregiving by strangers was proving a thorny issue. The Women's League invoked their status as "fellow people" to argue that African nurses should render impartially solicitous care.⁸⁵

This episode also demonstrates a markedly different politics of medicine than the one that would begin under Federation the next year. Here, African patients complained to European administrators about the unprofessional behavior of African health care workers. Under Federation rule, African publics (and leaders like Rose Chibambo) would be united in their protests against the Federation regime and its medical system, even as they accessed government health facilities ever more frequently.

⁸⁴ Rose Chibambo and Chalobuko, "Letter from the Nyasaland African Women's League to the Director of Medical Services in Zomba," January 9, 1953, IDCZA 3/4/2, MNA. Also see Joey Power, *Political Culture and Nationalism in Malawi: Building Kwacha* (Rochester, NY: University of Rochester Press, 2010).

⁸⁵ Shula Marks has documented a similar divide between black nurses (who had adopted some of the habitus of white middle-class nurses) and poor black patients in apartheid South Africa. See Shula Marks, *Divided Sisterhood: A History of Nursing in South Africa* (Basingstoke: Macmillan, 1994).

V. Conclusion

Though spending on health in Nyasaland rose in absolute terms between the end of World War II and the start of Federation, it was not a distinct priority of Governor Colby's administration. And Nyasaland, a quiet backwater of the imperial estate, was not afforded anywhere near the level of financial support given to development projects in Jamaica after the 1938 protests, or to schemes in Kenya and Nigeria following their late-1940s bouts of labor unrest. Nyasaland was economically insignificant and politically peaceful. It seemed, to many observers, to be fated to remain a land filled with semi-subsistence farmers and a few European settler plantations. Exports had grown during the postwar boom in commodity prices, but Nyasaland not seem to present any particular prospects for anything other than a handful of tobacco and tea estates, or recruitment for mine labor elsewhere in southern Africa.

In 1953, the imposition of the Federation of Rhodesia and Nyasaland would change all of this. Many Nyasaland Africans had spent time in Southern Rhodesia, and they did not relish the prospect of having their home soil ruled by whites in Salisbury. They did not react with their characteristic calm and good cheer to Whitehall's accession to Southern Rhodesian demands for federated rule. Nyasaland became, in the 1950s, a focal point of organizing, agitating, civil unrest and violent repression. Not coincidentally, the colony also experienced its most rapid expansion in health spending and health services in its history. During the prior decades of quietus, Nyasaland only received metropolitan resources for health after unrest elsewhere. But in the Federation era, Nyasaland itself

became the dramatic lead. For a tumultuous decade, officials would portray popular hospitals and health centers as symbols of beneficence. Nyasaland's health sector would expand far more under the thumb of a regime of avowed white supremacists (in Southern Rhodesia, between 1953 and 1963) than under rule by democratic socialists (in the UK Labour Party, between 1945 and 1951). The politics of health would become especially potent, though, because government medicine had rather suddenly become incredibly popular.

Chapter 7

Patients finally arrive, but may not be welcome: the simultaneous rise in attendances for health services and modernization theory, 1945-1970

Abstract

During the 1950s and 1960s the number of Africans attending government health facilities in Malawi increased rapidly, from 1.3 million in 1954 to 10.2 million in 1967. The rise in attendance at medical facilities was driven primarily by the training of auxiliaries than by the entrance of new chemotherapeutic agents with demonstrated efficacy and fewer adverse effects. At the same time, many prominent development experts of the era believed government spending on curative medicine was fiscally imprudent. University economists from the US and the UK argued for “modernization,” a strategy for rapid industrialization that required focusing public expenditure on infrastructure and industry. To modernization theorists, health was an unproductive welfare state benefit, inapposite to the primary goal of GDP growth. This chapter highlights a conflict between a newly popular government medical service and a disfavor for medical spending among economic experts. The tension between public demand for biomedicine and expert opinion arrayed against it serves as a prelude to the political propaganda and contests over government medicine during the Federation and early post-colonial eras.

Prelude: “Life is capital”

Tsinu lina nditadwala (One day after falling ill)

Ndinapita kuchipatala (I went to the hospital)

Nditafika kumeneko (When I got there)

Ndinapeza odwala ena (I found some patients)

Ataimana pakhomo (Waiting by the door)

Kukanizidwa kulowa (Forbidden to enter)

Ndinafunsa ndichiani (I asked what it was about)

Akuti nthawi sinakwane (They said it was not time yet)

...

Patapita nthawi pang'ono (After a short while)

Atavala suti yache (Some gent arrived)

Alonda ananjemnjemela (Wearing his suit)

Awana inu lowani (The guard shook with deference)

Kukodola mkulu uja (Pointing at the gent)

Tonsefe tinyanganana (We just looked at each other)

Tati dziko lathu lokonedwa (Wondering about our beloved nation)

Kukhala tidzikhala chonchi? (Is this to be our lot?)

Pakuti tilibe maina (Because we are nobodies.)

--Charles Nsaku, *Kuchipatala* (At the Hospital), 1999¹

It was finally clear to me why Chisomo insisted on arriving so early. By the time we dismounted the bicycles and paid the cyclists who took us the 12 kilometers from Chisomo's home to the Monkey Bay hospital, it was already 7:30AM. Entering the outpatient department of this hospital, rebuilt with funds from Iceland's government a decade ago, there were already 30 other people waiting to be seen. They sat along the wall of a long hallway, mostly in silence. Some sat on benches with their heads in their hands. Most of the women were seated on the floor, their legs stuck out ramrod straight, in the manner I had seen many women sit while eating in Mbeya village.

The medical assistant (MA) arrives a half-hour late, 8:30AM. She was a young woman wearing a white coat and a tired, harried expression. As soon as she unlocked the door, there was a mad dash to follow her inside. The queue formed in the hallway was less the agreed order in which the patients were to be seen than the starting line of a race every time the door opened. The visits were incredibly short. Each patient spent two to three minutes in the room before exiting to fight through another crowd to gather the prescribed medicines at the dispensary.

Chisomo eventually cajoled and cornered his way into the room, and invited me to join him. He did not wait for the MA to ask him a question. Instead he handed over a tattered yellow booklet. This was the same booklet that everyone in the country keeps in their

¹ John Lwanda, "Poverty, Prophets and Politics: 'Marxist' Discourses in Malawi Music, 1994-2012," in *Indigenous Language Media, Language Politics and Democracy in Africa*, Eds. Abiodun Salawu and Monica Chabita (London: Palgrave MacMillan, 2016), 211-34.

possession and brings to such visits. (Most Malawians are in the habit of calling it a “passbook,” a relic, perhaps, of the passbooks blacks were made to carry in Southern Rhodesia and apartheid South Africa.²) Chisomo explained that he needed a new urinary catheter. Looking at his passbook, the MA could gather as much. The book contained cursory notes scribbled during his recent visits. Most contain only two or three lines. The last one, from six weeks prior, read simply: “BPH, catheter change, return 2 weeks.” Chisomo said he had not returned for so long because he was in too much pain to walk, and did not have other means of transport until I offered to pay two young men to take us to Monkey Bay by bicycle.

The MA stepped out of the room to get a new urinary catheter set from the equipment room. She returned, asks Chisomo to lie on an exam table, and proceeded to replace the catheter without keeping the catheter tubing, or her gloves, sterile. When she finished Chisomo sat up and pulled up his pants. The MA wrote a prescription for ciprofloxacin in his passbook. This was, she explained, to treat a urinary tract infection that he had all but certainly developed from having catheter in his bladder for so long. She told him to return in another three weeks.

To any American medical provider this whole scene would seem highly unusual. BPH, a condition in which the prostate enlarges, is a common condition in older men around the world. It is almost never a life-threatening condition; its main effect is to render urination more difficult by blocking outflow of the bladder into the urethra. In the United States it

² Wicken, “African Contrasts.” Pages 23-24.

is often treated with medicines that allow urine to flow more readily. If symptoms do not improve, surgery to remove some of the prostate tissue might be indicated. In some cases, a catheter is placed directly into the bladder—this is known as a suprapubic catheter. But aside from some significantly impaired elderly patients, few people in the United States use Foley catheters (which run up the urethra to the bladder) for longer than a few months. Such a treatment almost invariably leads to a urinary tract infection that can damage the bladder and the kidneys.

Another curious feature of the way in which Chisomo was managed was the ready assumption, at all his visits, that BPH was his diagnosis. Difficulty passing urine in an elderly male does not automatically mean that male has BPH. He may, or he may not. There are other, more worrying diagnoses, including kidney stones, prostate cancer or bladder cancer that can cause similar symptoms. The notes in Chisomo's passbook detailed no prior workup to rule out these diagnoses. The persistence of Chisomo's pain (which left him on writhing in agony on a mat most days) and the high prevalence of *Schistosoma haematobium* (a well-established cause of bladder cancer) on the southern shores of Lake Malawi rendered unjustifiable the assumption that his only diagnosis was BPH.

A complete workup might have required a referral to one of Malawi's central hospitals, but there were things that could have been done even in the office. For instance, a rectal exam can help differentiate between BPH and prostate cancer. No such exam was noted in Chisomo's passbook. With only two years of training after secondary school, the MA

might not have known the full differential diagnosis for Chisomo's presenting complaints. More importantly, though, she felt rushed. More importantly, she was rushed. By the time Chisomo's visit was complete—which, unlike the others, had taken ten minutes—the line for the outpatient department had grown to sixty people. The MA was the only provider in the department that day. She expected to see about 100 patients, as she did most days. Thus, for want of time and training, a sick man was given a cursory exam and poor treatment for a condition he may not even have.

Even still, Chisomo reported feeling better in the days after his clinic visits. Like many, he found government medicine valuable, if hard to access and not at all adequate. Like many, he brought home the stories of relief (albeit partial and temporary) that lead many of Malawi's sick to form long queues outside outpatient departments every morning. But a week after his visit, I found Chisomo again lying on the ground outside his home, writing in pain. He was struggling to pass any urine, and reported the return of his excruciating abdominal pain.

Better care was on offer nearby, for those who could pay. After one of Francis's neighbors, an elderly woman named Dalitso, complained of diffuse abdominal pain, I offered to accompany her to Catholic Mission at Nankwhali. The mission was about six kilometers east of Mbeya village on a windy dirt path. The clinic was part of a beautiful campus, thick with foliage. Walking up the hill to the clinic on Wednesday morning, churchgoers could be heard singing hymns inside a majestic church. The walls of the clinic were painted white and sky blue. The floors looked freshly cleaned. Only one other

patient (a mother with a baby) was waiting to be seen on the bench outside the immaculate exam rooms. Patients at the mission clinic were seen by a clinical officer; clinical officers are given more training than medical assistants.³ The clinical officer, named Paul, admitted that his job was much easier than it would be in the public sector.⁴ The fees, he acknowledged, kept many sick people away, so he ended up seeing no more than 20 patients on an average day. This gave him more time to treat the patients who were able to afford to pay. After having her vitals taken by an attendant, Dalitso was examined by Paul. Rather than simply listening to a chief complaint and scribbling in her passbook, Paul took her history and performed a physical exam. Finding symptoms consistent with intestinal amoebiasis, he prescribed erythromycin. The visit and the medicine cost 1500 kwacha (roughly US\$5 dollars), much more than Dalitso, who lived

³ Medical assistants and clinical officers are the two major “mid-level” or “auxiliary” health cadres in Malawi. Medical assistants (and hospital assistants) have been trained at missionary schools in Malawi (by various names, with varied requirements), since the nineteenth century (see Chapter 1), and at government institutions beginning in the mid-1930s (see Chapter 6). Since 2000, the required training to become a medical assistant (by obtaining a Certificate in Clinical Medicine) was two years of post-secondary, pre-service didactic training. Since independence, medical assistants have mostly been tasked with outpatient care. Clinical officers were introduced in Malawi in 1980. To become a clinical officer (by obtaining a Diploma in Clinical Medicine), one must complete three years of post-secondary, pre-service didactic training and one year of internship. Clinical officers are expected to care for hospitalized patients and outpatients as well and to perform some surgical procedures, including Caesarean sections. While most of the country’s few physicians (260 for a population of 13 million) work in urban areas, medical assistants and clinical officers are often tasked with providing care in rural dispensaries and district hospitals. Government and missionary training institutions offer a number of nursing degrees, which require between one and three years of pre-service and in-service training. See Adamson S. Muula, “Case for clinical officers and medical assistants in Malawi,” *Croatian Medical Journal* 50 (2009); 1: 77-78. Also see “Nurse/Midwife Training Operational Plan: Field Assessments, Analysis and Scale-up Plans for Nurse Training Institutions.” Lilongwe: Ministry of Health, 2011.

⁴ In order of number of filled posts in 2010, the cadres of health workers in Malawi’s public health sector were nurses (including midwives), then medical assistants, then clinical officers, then environmental health officers (who are tasked with community public health work), and finally physicians. See Annex 2, Malawi Health Sector Strategic Plan, 2011-2016. Lilongwe: Ministry of Health, 2010.

alone in a decaying wattle-and-daub hut with a porous thatch roof and a wasp infestation, would have ever paid on her own.

The disparity between the care for those who can pay to attend the private clinics, and those who must attend the public sector clinics, is perhaps best summed up by the slogan for a USAID-funded behavior-change campaign. One such poster was taped to a wall near the hospital dispensary in Monkey Bay, but they can be seen at all public facilities. In brightly-colored lettering above a smiling African face, the sign reads “*Moyo ndi mpamba, samalireni!*” The literal translation, from Chichewa, is “Life is capital, take care of it!” The campaign’s purpose was to encourage Malawians to wash their hands and treat their drinking water with chlorine to prevent diarrheal disease. No Malawians I asked had ever heard the aphorism before the *Moyo ndi mpamba* campaign began running radio advertisements three years prior. But the mantra “life is capital” seemed to encapsulate much of the experience of being both ill and impoverished in Malawi. Unable to pay for the superior care offered at private clinics and missions, most relied on a perpetually-underfunded public sector, where a few overworked, underpaid staff struggle to deal with Malawi’s massive disease burden. Few Malawians doubted that more “capital” would help them to live longer, healthier lives. They needed no ad campaign to be convinced of what is perhaps the most obvious fact of Malawian life. The mantra, repeated in posters plastered on the walls of crowded hospitals, seemed less an exhortation than a cruel joke.

I. Introduction

“The native likes cough mixtures.” So explained Nyasaland Director of Medical Services Henry de Boer in a letter to the Chief Secretary in Zomba in June 1941. This was both an observation and a lamentation. De Boer wished it were not so; he yearned for the day when those prescriptions that were “actually necessary” were the same as those “desired by the patient.” But given the distance between prevailing medical opinion and the expectations of African patients, de Boer found it necessary to instruct his staff to use drugs with “great care” and not exhaust scarce supplies simply to appease patients.⁵

De Boer’s letter came in response to a request for medicines made by local chiefs a few weeks prior. Two native authorities (Mbwana and Boghogo) in Chinteche District told the Senior Medical Officer in Lilongwe that many of their people suffered from “coughing,” while the nearest dispensary had no drugs to treat them.⁶ The Medical Officer deployed Fred Nyirenda, a Hospital Assistant then stationed at Chinteche District Hospital—and a graduate of the Livingstonia Mission’s training course in the early 1920s—to tour the villages.⁷ Nyirenda reported that he found “only coughs and colds,” seasonal ailments that demanded no special treatment.⁸ The native authorities, and their people, would have to go without cough mixtures (the contents of the mixtures were not described in the letters, but they likely included opiates).

⁵ HS De Boer, “Letter from Director of Medical Services to Honorable Chief Secretary, Ref. Cen. Regy. MP No 1273/21,” June 21, 1941, S40/1/3/2, no. 124, MNA.

⁶ Mbwana, “Letter from Native Authority Mbwana to Senior Medical Officer, Medical Department, Lilongwe,” June 10, 1941, S40/1/3/2, no. 127, MNA.

⁷ Mkandawire, *Living My Destiny*. Page 47.

⁸ De Boer, “Letter from Director of Medical Services to Honorable Chief Secretary, Ref. Cen. Regy. MP No 1273/21.”

Even if Nyirenda had found seriously ill patients—he was likely worried about tuberculosis—the discord between patient and provider would not have been resolved. Through the late 1940s, the mainstay of tuberculosis treatment for Nyasaland’s African patients was indoor bed-rest. But, as colonial medical officer John Goodall remembered, patients were loath to follow these instructions, and preferred to “flock outside and lie in the sun.”⁹ The few tuberculosis patients who submitted to more heroic measures, at the hands of colony’s sole surgeon, had a procedure in which the affected lung was collapsed, and the phrenic nerve crushed.¹⁰ While patients suffering persistent coughs eagerly sought cough mixtures, few submitted to long hospitalizations or painful (and most often futile) surgical procedures.

But by the 1950s, the preferences of physicians and patients had both changed. With the arrival of novel therapeutics for a whole host of diseases (e.g. tuberculosis, malaria, syphilis, gonorrhoea), European doctors and African hospital assistants secured a new therapeutic armamentarium. Patients and providers had far greater confidence in the efficacy of the new therapeutics. Take, for instance, tuberculosis. The number of patients voluntarily presenting for treatment increased from 366 in 1948 (before the use of streptomycin, PAS and isoniazid) to 1,946 in 1958 (after these drugs had been introduced). As this chapter will show, this pattern was repeated for a number of symptoms and ailments. There was, then, a *convergence* of perceptions of efficacy

⁹ John Goodall, *Goodbye to Empire: A Doctor Remembers* (Edinburgh: Pentland Press, 1987). Page 79.

¹⁰ RM Morris, “Annual Report on the Public Health of the Federation of Rhodesia and Nyasaland for the Year 1956” (Salisbury, Rhodesia: Government Printer, n.d.), BL. Page 15.

between doctors and patients. As a result, inpatient admission and outpatient attendances rose markedly in the first two post war decades.

In an influential 1977 article, historian of medicine Charles Rosenberg described a “therapeutic revolution” in the United States during the nineteenth century. This revolution entailed a divergence of perception between doctor and patient. At the beginning of the century, Rosenberg explains, therapeutics was “part of a system of belief and behavior participated in by physician and layman alike.” This system was so convincing to both physician and layman because “all the weapons in the physician’s normal armamentarium worked—“worked,” that is, by providing visible and predictable physiological effects: purges purged, emetics induced vomiting, opium soothed pain and moderated diarrhea.”¹¹ Such visible activity demonstrated both the drug’s efficacy, and the physician’s competence.

The “revolution” over the course of the nineteenth century involved a divergence of perception between doctor and patient. By the second half of the twentieth century, physicians and patients no longer shared a view of the body, nor did they have the same understandings of drugs’ actions on it. Patients retained faith in therapeutics, but since many drugs no longer had perceptible physiological effects, patients’ faith was based on the “imputed status” of the physician.¹²

¹¹ Charles Rosenberg, “The Therapeutic Revolution: Medicine, Meaning and Social Change in Nineteenth-Century America,” *Perspectives in Biology and Medicine* 20, no. 4 (1977): 485–506.

¹² *Ibid.*

This chapter chronicles the consequences of the mid-twentieth century antibiotic revolution in British Nyasaland. This revolution can be likened to Rosenberg's revolution in reverse. Instead of a divergence of perceptions of efficacy between (both European and African) medical practitioners and (African) patients, this revolution involved a convergence of belief. Patients began appearing at government hospitals and dispensaries in far greater numbers once the drugs could meet shared expectations of efficacy. Patients did not seek drugs providing immediate physiologic effects, but rather those that provided lasting relief from their ills. Africans in pain were more likely to ask for aspirin than purgatives.¹³ "The native only judges by results," the missionary physician J.B. Christopherson had concluded in 1921.¹⁴ While yaws treatment of the 1920s had provided some temporary relief, and hookworm therapy of the 1930s could clear parasitic infestations, European therapeutics could not cure Nyasaland's worst illnesses before 1945. And thanks to the experience of the hut tax and the carrier service, Africans had little trust in government institutions. Unlike the American physicians described by Rosenberg, British colonial doctors could not rely on "imputed status" to secure patients' trust in Nyasaland. Colonial doctors were all too aware that news of their failures spread rapidly among Africans; patients, their families, and "witch doctors" shared these tales of woe.¹⁵ But the sick and their families proved ever willing to judge for themselves. When

¹³ Thomas D. Thomson, "Domasi Community Development Scheme Report, 1949-1954" (Zomba: Government Printer, 1956). Page 68. "There is no doubt about the popularity of European curative medicine. Bandages are displayed with pride, and there is a great local fondness for the taste of the stock cough mixture; Epsom salts are preferred to purgative pills and quinine to mepacrine; aspirin grows steadily in popularity... In 1953 less than half of the women whom began treatment for syphilis completed the cure, but in 1954 nearly two-thirds did so."

¹⁴ Christopherson, "The UMCA and Medical Work at Magila."

¹⁵ Gopsill, "A Few Notes on My Life in Zanzibar and Nyasaland from 1926 to 1945." Page 11. After a recovering surgical patient died in Port Herald after being struck by lightning, Gopsill

more effective therapeutics entered public clinics after the war so, too, did African patients.

A number of histories of colonial medicine in southern and eastern Africa have posited that the influx of these novel therapeutic agents, capable of curing common illnesses with fewer side-effects than their predecessors, drew patients to biomedical facilities.¹⁶ This argument is consistent with, but extends further, the ethnographic empirical data collected by John Janzen in what was then Zaire, which found that patients and the close kin who directed medical care-seeking decisions were empiricists. That is, the patients were likely to be brought to whichever healer—biomedical or “traditional”—had proven able to heal the sort of illness the patient seemed to be suffering.¹⁷ A number of other anthropologists studying patterns of care-seeking behavior among what used to be known

lamented the loss of “good propaganda.” He explained: “Apart from the loss of life we were sad to lose the male patient because he could have been good propaganda. He had a stone removed from his bladder, the stone was the size of a large duck’s egg, and the patient was due to be discharged in a few days time. I had imagined him trotting round the villages with his stone in his hand. What a story in the beer gatherings. In a new area a Medical Officer has to build up his surgical and medical reputation. The African Witchdoctors are quick to seize on failures. They also have the habit of sending one cases at death’s door. Those patients through neglect or sorry treatment are in such a bad way that they are cheerfully awaiting death to release them from their pains. They are too far gone to save. The Witch doctors taunt ‘See what happens when you go to hospital.’”

¹⁶ Messac, “Moral Hazards and Moral Economies”; *The Steamer Parish*; Iliffe, *East African Doctors*.

¹⁷ See John M. Janzen, *The Quest for Therapy in Lower Zaire* (Berkeley: University of California Press, 1978). Janzen explains the general course of care-seeking behavior for illness episodes among the patients he followed in the Lower Zaire in 1969: “All cases begin, by preference, either with Western medicine or with an *nganga*. If, in due course, healing results, or the expected death of someone like an old person occurs, a tacit evaluation is made that the illness was naturel, ‘of God.’ Many illnesses and etiological evaluations end here. But if the affliction does not respond to symptomatic treatment, then it is suspected to be ‘human caused,’ or ‘supernaturally caused’... These areas are researched, evaluated, and dealt with by the therapy managing group on its own or with the help of a ritual counselor.” p. 221.

as “traditional peoples” have argued in favor of what we can call the “pragmatic empiricist” hypothesis.¹⁸

But in the forty years since Janzen’s work, other anthropologists have posited determinants of demand for biomedicine among Africans that appear, to the allopathic physician, far less rational. Caroline Bledsoe and Monica Goubaud allowed that one criterion that the Mende of Sierra Leone used to determine whether to seek out “Western medicine” was “the reputed success of the drug in curing an ailment of a friend or relative that seems similar to their own.” Nevertheless, in her estimation, “the most important elements of logical consistency that governed people’s choices of medicines...seemed to be qualities such as shape, color, taste and consistency.” The logics underlying these criteria were unrelated to notions of efficacy recognizable to practitioners of Western medicine, relying instead on “Mende beliefs about the causes and cures of various types of illness.”¹⁹

Bledsoe and others have provided convincing evidence of the importance of locally- or regionally-specific beliefs about illness causation in their health care decision-making.²⁰

¹⁸ Writing in 1977, the anthropologist George Foster argued: “When, on the basis of empirical evidence, traditional peoples see that scientific medicine is more effective than their own, and when they can have scientific medicine on terms they deem acceptable, they are happy to turn to it.” George Foster, “Medical anthropology and international health policy,” *Social Science and Medicine*. 11 (1977); 10: 527-534.

¹⁹ Caroline Bledsoe and Monica Goubaud, “The reinterpretation of Western pharmaceuticals among the Mende of Sierra Leone,” *Social Science & Medicine* 21 (1985); 3: 275-282.

²⁰ For a brief and (somewhat dated) review of this literature, see Sjaak van der Geest, Anita Hardon and Susan Reynolds Whyte, “Planning for essential drugs: are we missing the cultural dimension?” *Health Policy and Planning* 5 (1990); 2: 182-185. A more recent bibliography of

Yet most of these studies are based on intensive ethnographic methods rather than extensive statistical analysis. Few such investigations were conducted prior to the late 1960s, meaning that they mostly missed the changing dynamics of health care seeking behavior with the initial introduction of effective antibiotic and anti-parasitic therapies during the colonial era. It remains unclear, then, how various logics of care-seeking behavior shaped patterns of demand for biomedicine in Africa, particularly during the late colonial era. This study uses colonial government disease returns over six decades to demonstrate that pragmatic empiricism is able to explain the major changes in patient attendances in Nyasaland's public sector hospitals and dispensaries. Even with the necessary caveats about the accuracy of this data (see the next section), this analysis demonstrates a rapid increase in attendance at government facilities after the introduction of novel, more effective, chemotherapeutics.

Even though it confirms an existing hypothesis, this study contributes to this literature in three ways. First, because care at government clinics was provided without charge throughout the colonial era, cost barriers to treatment were less important here than in settings with user fees, which include many post-colonial settings in which such care-seeking investigations have been carried out. This lessens the influence of the variable—access—that remains the overriding determinant of patient attendance figures in many impoverished settings, and allows for the more direct examination of patient

this literature is provided in Susan Reynolds Whyte, Sjaak van der Geest, Anita Hardon. *Social lives of medicines* (New York: Cambridge University Press, 2002).

preferences.²¹ Second, this is the first study of mid-twentieth century care-seeking behavior in southern or eastern Africa to make extensive use of colonial disease returns.²² In doing so, it provides national-level statistical series in which the pragmatic empiricist hypothesis holds tremendous explanatory power. Finally, this study uses both qualitative and quantitative archival data demonstrate more precisely the timing of the increase in attendance in Nyasaland for a number of common ailments. In doing so, this chapter shows the profound *specificity* of mid-century demand for government medical care among Africans in Nyasaland. Patients began to present in greater numbers for a given disease after new, more efficacious treatments reached the clinic shelves. The increases in attendances for common diseases were independent of one another, and almost entirely determined by the introduction of novel therapeutics.

This chapter seeks to address a literature on care-seeking behavior that was initially motivated by colonial-era concerns about “traditional...peoples’ underutilization of, or noncompliance with, the Western scientific medical system.”²³ The evidence below suggests that Africans’ reticence to seek care at government facilities for specific

²¹ A 1996 review of studies of treatment seeking for malaria concluded that “access, severity of illness, and cost are the major factors that determine the use of health facilities.” Even in colonial Nyasaland and postcolonial Malawi, health care was not accessible simply because it was free at the point of care. As this chapter will demonstrate, there remained significant barriers such as transport to distant facilities. SC McCombie, “Treatment seeking for malaria: a review of recent research,” *Social Science & Medicine* 43(1996); 6: 933-945.

²² For a West African study of care-seeking behavior that uses colonial disease returns, see S. Kojo Addae, *The Evolution of Modern Medicine in a Developing Country: Ghana 1880-1960* (Durham Academic Press, 1997). Though Addae does not foreground the pragmatic empiricist hypothesis, the timing of the introduction of new therapeutics and the increase in attendances at government clinics in the Gold Coast is consistent with it.

²³ Bledsoe and Goubaud, “The reinterpretation of Western pharmaceuticals among the Mende of Sierra Leone,” 276. Interest in this literature was reinvigorated in the 1980s by a concern among international health experts about the “irrational” use of antibiotics in developing nations.

ailments at certain historical moments might not be wholly attributable to locally-specific beliefs about illness causation. Instead, demand for biomedical care might be readily explained by perceptions of therapeutic efficacy that were *shared* by both physicians and patients. The rising popularity of biomedical facilities documented in this chapter also sets the scene for Chapters 8 and 9, which concern the political consequences of the newfound demand for government medical facilities.

II. The rise in attendances and spending at public sector health facilities, 1945-1969

a) A note on statistical production and interpretation

The use of medical and fiscal statistics in this chapter and the next demands at least a brief discussion of the circumstances attending their production. I take most government budget figures on revenues and expenditures at face value. Colonial-era figures, presented to the UK Colonial Office and Treasury, were so central to governance and so closely monitored that their veracity can be generally accepted. Even in the post-colonial era, Hastings Kamuzu Banda was widely reputed to run an efficient and honest civil service, and his supporters and detractors alike deemed his budget figures accurate.²⁴

Greater difficulties arise in the use of statistics related to the number of patients attending medical facilities. I base much of my account on the rise in annual outpatient “attendances.” These figures are based on monthly reports filed by medical officers at hospitals and medical assistants at dispensaries. These figures are surely not entirely

²⁴ Gerhard Anders, *In the Shadow of Good Governance : An Ethnography of Civil Service Reform in Africa* (Boston: Brill, 2010).

accurate, but there is little evidence to suggest any systematic bias that could account for the increase in attendance figures over time. One possible problem is raised in the work of David Stevenson, a former missionary doctor, who wrote of the government figure for 1962 that “out-patient attendances” represented “the number of treatments given, not the number of patients.”²⁵ This definition is not repeated in the Medical Department’s annual reports. Yet if this was indeed the definition of “attendances” during this period, the rise in this figure might conceivably reflect an increase in the number of prescriptions written for each patient, and not just an increase in the absolute number of patients. While this might account for some of the increase in this index, it is unlikely to provide the whole, or even much, of the explanation for its phenomenal increase. The first-hand accounts to follow of once-empty facilities that had become, by the 1960s, incredibly crowded speak to the increase in patient numbers, and not just prescriptions.²⁶

Other statistics have even more profound questions surrounding accuracy and interpretation. Disease returns are, of course, based on individual diagnoses. For diseases where diagnoses were particularly uncertain—syphilis, tuberculosis, and malaria were famously difficult diagnoses at mid-century—disease returns cannot be read as the number of patients presenting with undeniable evidence of a given infection or other malady. In fact, after the Second World War Nyasaland’s Directors of Medical Services were sufficiently doubtful of the accuracy of diagnoses by medical aides in dispensaries

²⁵ Stevenson, “The Health Services of Malawi.” Page 23

²⁶ Stevenson’s remark also begs the question of whether outpatient attendances at missionary facilities were also based on the number of treatments rather than the number of patients. I assume, in this chapter, that mission attendances and government attendances were measured in the same way.

that they did not include their disease returns in official statistics.²⁷ Thus, after 1940 the figures presented in Figures 7.6a and 7.6b include only those returns submitted by hospitals (though the total number of patient visits included dispensary attendance). But this actually renders the increase in attendance for certain diseases (e.g. tuberculosis, syphilis) after the advent of novel therapeutics after the war all the more impressive. Even though the figures compiled after the war included statistics from fewer facilities, total attendances nonetheless increased dramatically.

While statistics on patient attendance are uncertain, data on the incidence and prevalence of various diseases in the general African population were rarely collected. Individual medical officers conducted small surveys of such diseases as hookworm and schistosomiasis during the interwar era, but rigorous, large-scale studies of more life-threatening conditions were uncommon. Commentator (and committed Fabian) Joan Wicken surmised that the dearth of epidemiological studies may have been a deliberate omission in colonial data-collection, as the absence of evidence of disease helped mute calls for greater spending. She pointed to a temporary impasse in negotiations with the WHO and UNICEF to conduct a survey of tuberculosis incidence in Nairobi's slums

²⁷ Before 1940, the disease returns for African outpatients included both rural dispensaries and hospitals. During the war, reports often did not report disease return statistics for African outpatients. The 1943 report was the first to exclude disease return statistics from rural dispensaries. See PS Bell, "Report of the Medical Department for the Year 1947, Nyasaland Protectorate," 1948, 1, Box 15, No 9, SoMA. Page 5. "Dispensaries are staffed mainly by Medical Aides, whose standard of diagnosis is necessarily not high. Returns of diseases cannot be regarded as entirely reliable, and accordingly are not included in the tables at the end of this Report. The work done is nevertheless worth while, and is greatly appreciated by the African population which constantly requests additional dispensary services."

“because the [City] Council would not undertake the necessary treatment and follow-up work.”²⁸ Colonial settlers and officials recognized the fiscal benefits of ignorance.

Population statistics were also dubious. Little is known of the methods used in the 1901 “population count,” the first attempt to quantify the African population of Nyasaland (or, as it was known at the time, the British Central African Protectorate). The 1911 “census” was estimated by multiplying the number of hut-taxes paid by 2.8 (a protectorate-wide average of 2.8 people per hut had been estimated based on counts of people per hut in “certain selected villages”). Subsequent censuses in 1921, 1926, and 1931 ostensibly involved visits to by “enumerators” to every village.²⁹ Budget retrenchments led to the cancellation of the census in 1936, and the war led to the cancellation of the 1941 census.³⁰ The 1945 census was the last of the colonial era. Population statistics of the late colonial years were notoriously inexact, and recapitulated the methods of the 1911 census. David Stevenson remembered a Blantyre accountant admit that “the method of estimating the total population, in 1962, was to take the number of taxpayers, (supposedly all adult men, apart from those granted specific exemption for medical or other reasons), multiply by two to allow for those who avoided paying tax, and again by five to allow for dependents.”³¹

²⁸ Wicken, “African Contrasts.” Page 67. Wicken did observe that the City Council eventually agreed to the survey, and to appropriate £5,000 for a clinic.

²⁹ *Malawi Population Census, 1966, Final Report, Department of Census and Statistics (Zomba: Malawi Government, 1967)*. Page i.

³⁰ Berry, *Before the Wind of Change*. Page 9.

³¹ Stevenson, “The Health Services of Malawi.” Page 38.

The first post-independence census was conducted in 1966. In this census, enumerators visited all 1.5 million “dwelling units” in the country.³² Censuses then followed roughly every decade, with one in 1977, and another in 1987.³³ The relative infrequency of rigorous censuses during the twentieth century, and the lack of resources with which they were performed, should call into question the accuracy of any per-capita statistics. In the coming chapters, I use population statistics in order to provide rough per-capita figures. Though there is little evidence to indicate a systematic bias in these figures, they should not be regarded as accurate.

The same cannot be said of GDP figures, perhaps the most contentious statistic of all. Nyasaland was one of the first colonies for which national income was estimated. But, as I have explored in other work (and mentioned in Chapter 2), these figures systematically discounted the contributions of smallholder agriculture in general and women’s labor in particular. The rapid growth in GDP during the post-independence years was a product of increasing production of cash crops on large agricultural estates, and the rising prices these crops fetched on international markets. But, as I will explain in Chapter 10, this growth in cash crop production was hastened by exploitation of the smallholder agriculture, and justified by GDP statistics that discounted the contribution of smallholders to economic indices. Meanwhile, surveys of actual production in rural areas were so rare and so poorly funded that it is impossible to invest much faith in them. So

³² *Malawi Population Census, 1966, Final Report, Department of Census and Statistics*. Page i.

³³ William J House and George Zimalirana, “Rapid Population Growth and Poverty Generation in Malawi,” *Journal of Modern African Studies* 30, no. 1 (1992): 141–61. The United Nations Fund for Population Activities (UNFPA) funded both of these censuses. Also see Lemson Samson Chitsamba, “Malawi and the Politics of Foreign Aid” (PhD Dissertation, London School of Economics, 1990), Proquest. Page 393.

profound was the systematic bias in GDP figures that I will present them only rarely, and even then usually to explore their political uses.

And to say much about the effects of medicine on mortality statistics would require vital statistics. But the British colonial administration did not systematically register births and deaths in the African population.³⁴ There was not a biopolitical regime. There was relatively little inquiry into the kinds of concerns Foucault believes characterize such regimes: “propagation, births and mortality, the level of health, life expectancy and longevity, with all the conditions that can cause these to vary.”³⁵ The colonial administration certainly preferred to govern a productive and docile population, but it did little to achieve such an ideal. Its main interest in monitoring the population was in ensuring universal payment of the hut tax. This, in turn, was an instrument to force the men to work in the region’s plantations and mines.³⁶ In sum, there are few statistics

³⁴ There was compulsory vital registration of Nyasaland’s Asiatic and European population. The Medical Department undertook “experiments” in the registration of native births and deaths in Fort Manning in the early 1932, and nationally in 1947. But even in the 1947 attempt, all that was compiled was the total number of births and deaths occurring in each district. Records of individual births and deaths—information necessary to calculate such basic indices as the life expectancy and infant mortality rate—were not compiled. ADJB Williams, “Annual Medical & Sanitary Report for the Year Ending 31st December 1933” (Zomba, Nyasaland: Government Printer, 1934), Box 15, No 21, SoMA. Pages 14-15.

³⁵ Michel Foucault, *The History of Sexuality*, 1st American ed. (New York: Pantheon Books, 1978).

³⁶ If biopolitics was a motive force for the rise of the welfare state in Western Europe and, to a lesser extent, the United States, it never worked with equal fervor in sub-Saharan Africa and other late modern colonial and postcolonial contexts. Achille Mbembe has argued that Foucault’s biopolitics is insufficient to understand the political realities of African states where the balance of political concern lies in with the productive capacities of life but rather with sovereign power over death. For his part, Jean Comaroff, for seems to call for more biopolitics, for he finds in it the possibility for life-saving claims-making by citizens on the South African state, To be sure, the colonial and postcolonial endeavors involved efforts to inscribe state prerogatives on the bodies of subjects; one need only look to the last century of resettlement schemes, justified with racist and productivist arguments, to see this. But outside Europe, the imperative for docility

available for scholars seeking to discern the course of economic and demographic shifts in Nyasaland's population. Those statistics that are available were designed not for accuracy, but to buttress the interests of the colony's European elite.

b) Charting the post-war rise in patient attendance at government facilities

Writing in the *British Medical Journal* in 1960 Dr. Harry S. Gear, a Consultant to the Federal Ministry of Health in Salisbury, marveled at "the insatiable demand for European medicine. Where less than a quarter of a century ago the large majority of Africans avoided European hospitals and clinics, they are now overwhelming them." The situation had changed drastically since both Shircore (in his 1930 report) and de Boer (in his 1938 report) had lamented the sparse attendance by Africans in government hospitals and dispensaries (see Chapter 3). Africans in Nyasaland were turning to hospitals in much larger numbers than ever before. The number of outpatient attendances by Africans in 1965 (8,710,732), the first full year of Malawi's independence, was more than three times higher than in 1955 (2,505,547), and more than twelve times higher than in 1945 (719,316). On a per-capita basis, attendance increased from 0.45 in 1953 to 2.52 in 1969 (Figure 7.1). African inpatient admissions rose as well. Admissions in 1965 (92,892) were over two times greater than in 1955 (42,218), and almost four times greater than in 1945 (23,369).

has been achieved largely by means other than anatomo- and bio-politics. Biopower may be a two-edged sword, but its weakness in many parts of the globe cannot be called a blessing. See J.-A. Mbembé, *On the Postcolony* (Berkeley: University of California Press, 2001); J. Comaroff, "Beyond Bare Life: AIDS, (Bio)Politics, and the Neoliberal Order," *Public Culture* 19, no. 1 (January 1, 2007): 197–219.

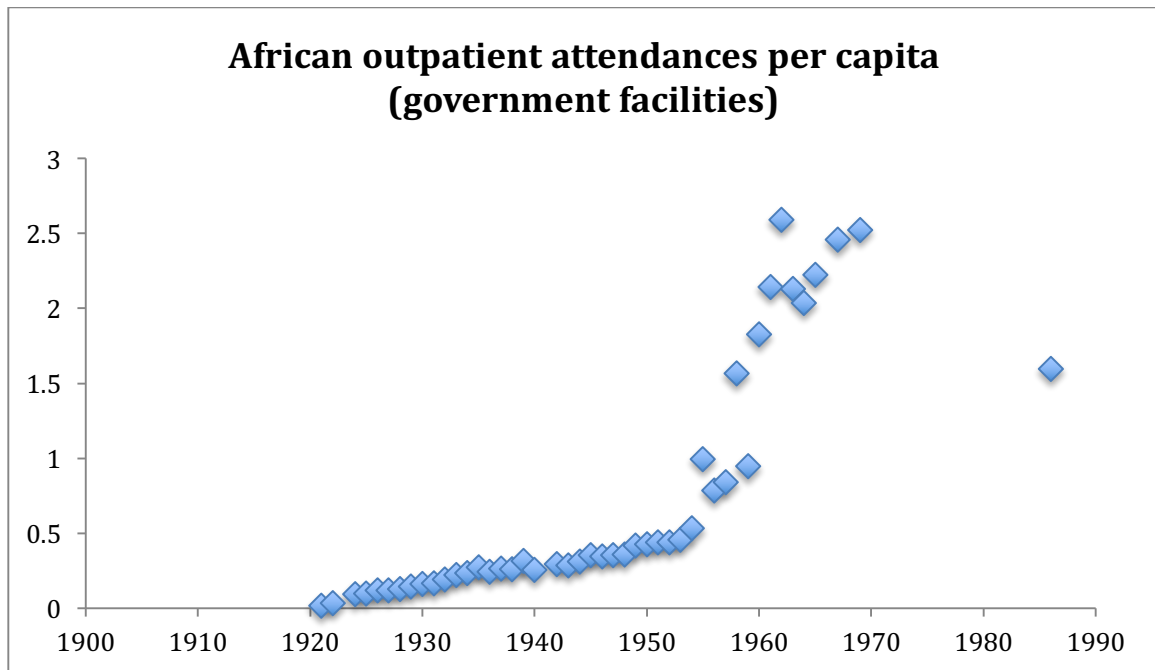


Figure 7.1: African outpatient attendances per capita at Nyasaland/Malawi government facilities. Sources: Annual medical reports (colonial era, 1914-1964) and World Bank reports (postcolonial era, 1965-1982).

c) Comparing government and mission outpatient attendances, 1940-1970

The attendance figures also reveal something else. By the end of the 1960s, African outpatients attended government facilities far more often than they attended missions.

Figure 7.2 shows that in 1940 outpatient attendances were more than six times higher at government facilities (559,189) than at missions (85,427). This ratio decreased during the 1950s: in 1957, government facilities (2,237,514) and missions (1,770,701) had similar numbers of African outpatient attendances. But by the late 1960s, the figures were disparate once more; in 1969 government facilities treated more than four times as many African outpatients (11,075,729) than missions (2,428,034).³⁷ Data on inpatients,

³⁷ Maurice King, "Development Plan for Health Services, 1970-1985" (Zomba Malawi: Ministry of Health and Community Development, 1970), Malawiana Collection, University of Malawi Library.

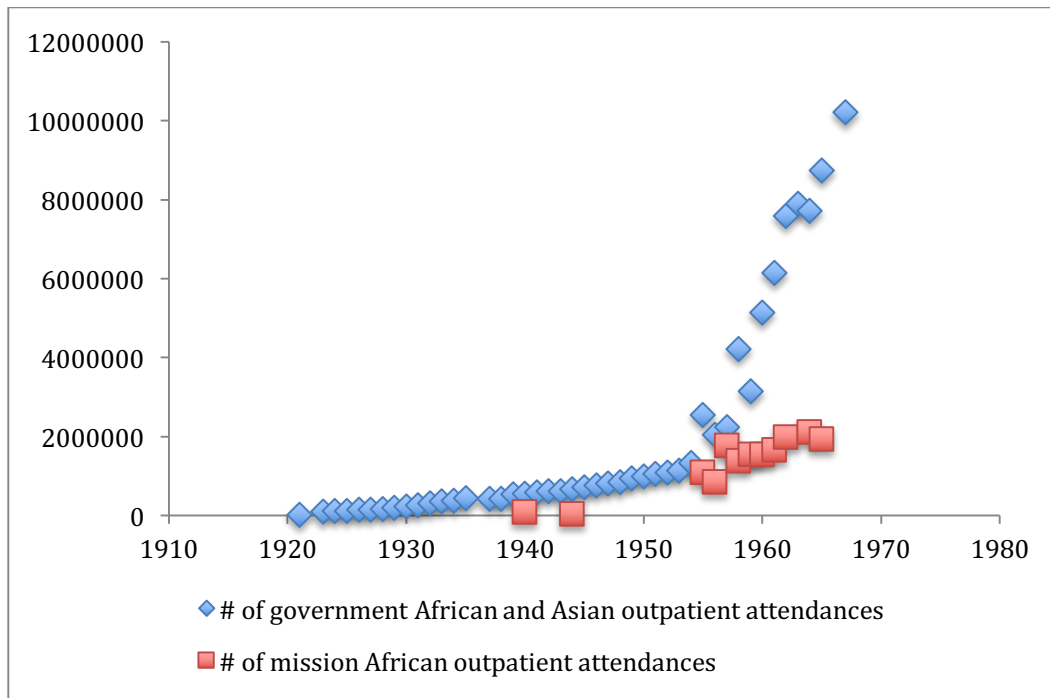


Figure 7.2 Government vs. Mission outpatient attendances in Nyasaland/Malawi. Source: Annual reports for Medical Department, 1914-1964 and World Bank Reports, 1965-1982.

depicted in Figure 7.3, indicate that government facilities and missions admitted remarkably similar numbers of patients throughout the 1950s and 1960s.

The parity between government and mission inpatient figures, and the disproportionate share of outpatients going to government facilities, complicates the portrait of Malawi, still shared by many Africanists, as a land dominated by missions. To some extent this assumption is a result of the comparatively rich trove of histories and memoirs of missions in Malawi, and particularly those connected to the nineteenth-century physician-explorer David Livingstone.³⁸ Colonial officials often highlighted the number of

³⁸ See, for instance, Charles Good, *The Steamer Parish*; James William Jack, *Daybreak in Livingstonia: The Story of the Livingstonia-Mission, British Central Africa* (Forgotten Books, 2012); Magomero Livingstone, *Laws of Livingstonia*; James Tengatenga, *The UMCA in Malawi*.

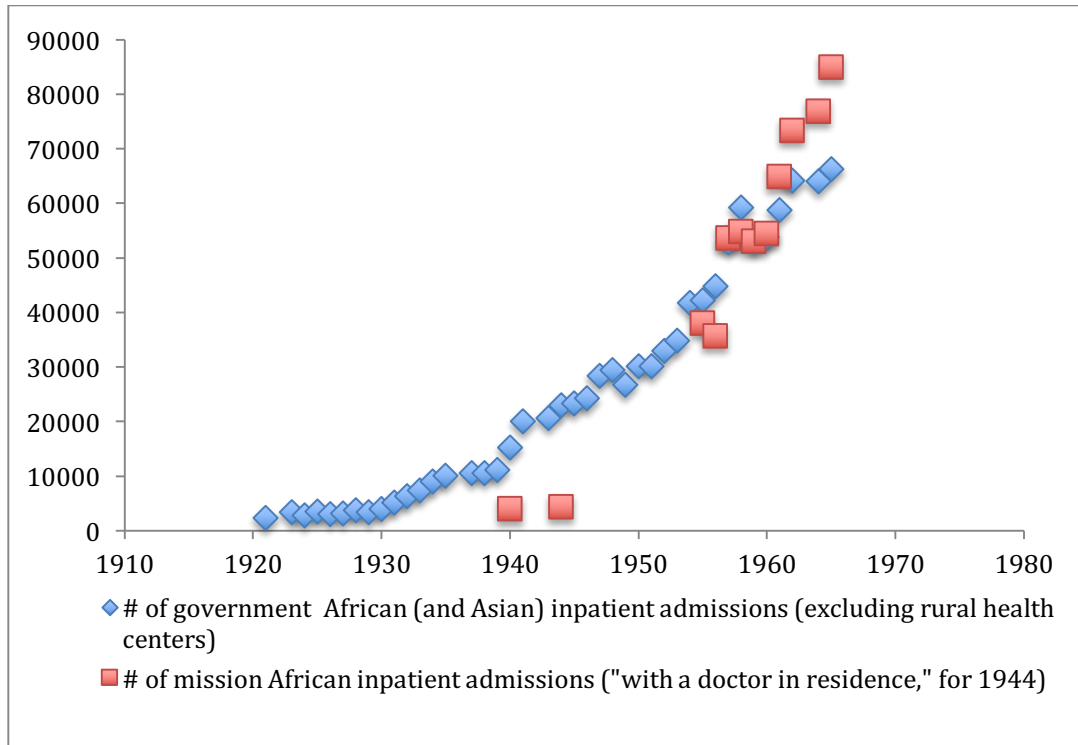


Figure 7.3: Government vs. Mission inpatient admissions in Nyasaland/Malawi. Source: Annual Medical Department Reports, 1914-1964.

missions, perhaps because making missions seem numerous absolved them of responsibility for expanding government healthcare. One historical account of medical services in Malawi begins with the observation that “the part played by the various Missions has been considerable.”³⁹ While missions were, in Gear’s words, “the early predominant medical force” in Nyasaland, by the Federation years that age had surely passed. By mid-century medical missions were no more important for most Africans in Nyasaland than for Africans in other British colonies of southern Africa. Nyasaland’s Africans were, during the mid-twentieth century, no more amply served by mission

A History of the Anglican Church 1861-2010 (Zomba Malawi: Kachere Series, 2010); Mary McCulloch, *A Time to Remember: The Story of the Diocese of Nyasaland* (Published for the Diocese of Nyasaland by the Universities’ Mission to Central Africa, 1959).

³⁹ Baker, “The Government Medical Service in Malawi.”

hospitals than were Africans elsewhere in the region. In 1962 Nyasaland had fewer mission hospitals (61) than either Southern Rhodesia (65) or Northern Rhodesia (80), even though Nyasaland had an estimated African population (2.93 million) higher than Northern Rhodesia's (2.46 million) and only somewhat lower than Southern Rhodesia's (3.64 million).⁴⁰

As the last chapter detailed, Government medicine for Africans was so absent in the early decades of the twentieth century that missions really were the only facilities open to them, even if few could reach them and even fewer could afford the fees most charged for care. But during the two decades after the Second World War Africans turned in larger numbers to both government facilities and missions. Most Africans able to afford mission fees preferred them to government facilities, as many had reputations for better-trained practitioners and better-stocked dispensaries. But the availability of care free at the point of service drew far more outpatients to government facilities. Missions also received grants from the government to pay salaries and purchase drugs. These grants became considerable during the Federation years, rising from £10,477 in 1952 to £72,000 in 1958, and continued to rise after independence, reaching £102,000 in 1969.

d) Explaining the rise in attendance at government facilities

What can account for the rise in attendance at government medical facilities during the quarter-century after the close of World War II? Here I examine four possible explanations: first, a growing appreciation for European culture; second, increasingly

⁴⁰ "Annual Report on the Public Health of the Federation of Rhodesia and Nyasaland for the Year 1962" (Salisbury: Government Printer, 1963), CSD 607, BL.

accessible facilities; third, better-stocked and better-staffed facilities; and fourth, the successful demonstration of new drugs.

The idea that newly crowded hospitals were evidence of a wholesale turn away from African “tradition” and towards “modern” European culture was often invoked by Southern Rhodesian officials during the Federation years. One of Gear’s explanations for “the insatiable demand for European medicine” by 1960 was “the general acceptance of European culture and education.”⁴¹ This claim is less than convincing, as it seems unlikely that appreciation for “European culture” would reach a zenith during the years of the Federation government. These were years marked by popular protests against rule by a white supremacist regime based in Southern Rhodesia. Furthermore, Africans living in Nyasaland had been exposed to Europeans for centuries, from the Portuguese traders and British missionaries of the nineteenth century, to the British and German troops of the First World War, to the employers and foremen in the mines and plantations of Southern Rhodesia and South Africa (where hundreds of thousands had sought paid labor since the start of the twentieth century). Most Africans in Nyasaland were no more familiar with European life and culture than they had been during the last half-century. The peak population of European settlers in Nyasaland (most of whom lived in Blantyre or Zomba) during the 1950s and 1960s was 9300 (in 1960); the ratio of Africans to Europeans in Nyasaland during that year was 302:1. The penetration of “European culture” via mass media could not have been too deep; in 1968 less than 7 percent of rural Malawians (who

⁴¹ Harry S. Gear, “Some Problems of the Medical Services of the Federation of Rhodesia and Nyasaland,” *BMJ* 2, no. 5197 (1960): 525-530.

made of 92 percent of the population) lived in a household with a radio.⁴² The timing and precipitous nature of the rise in attendance do not support the contention that it was a manifestation of some general love of things European.

ii) Hypothesis 2: increased access to medicine (new transport and facilities)

A second possible explanation is that the rise in attendance might be attributed to more accessible medical facilities. But available statistical data offer relatively little support to this claim. The number of rural dispensaries and rural hospitals (usually defined as hospitals not staffed by a medical doctor) did not increase much, growing only from 96 in 1946 to 112 in 1965. Though the Federal Ministry of Health proudly declared that the number of African hospitals had increased from 19 to 30 under their rule, most of these were smaller rural hospitals without medical doctors. Only three hospital construction projects with costs to the Federation of over £50,000 pounds were completed in Nyasaland between 1954 and 1960.⁴³ This rather slight increase in facilities is insufficient to explain a twelve-fold increase in outpatient attendances.

Changes in transportation, and in particular the spread of bicycle transport, did make medical facilities more accessible, but this can explain only a small part of the increase in attendances. While motor vehicle transport remained sparse throughout the colonial period, Nyasaland did experience a boom in bicycle ownership after the Second World War. The value of bicycle imports increased more than tenfold, from £26,000 in 1945 to

⁴² *Rural radio listenership survey for 1968: special report for Malawi Broadcasting Corporation*, Department of Census and Statistics, Government Printer: Zomba, 1968, Table 6.

⁴³ These four projects were: Queen Elizabeth Central Hospital in Blantyre: £702,000, Kochira Leprosy Hospital in Fort Manning, £99,000; Zomba Mental Hospital: £70,000; Nkhata Bay District Hospital: £59,000. Roy Welensky, "National Health Development," November 25, 1961, Welensky Papers, BLOU. Pages 7-8.



Figure 7.4: Scene outside Mlanje African Hospital, February 1964. Note the bicycle in the bottom right. Source: British Information Services, Central Office of Information, London, UKNA.

£310,000 in 1953.⁴⁴ By 1955, it was estimated that one in four able-bodied adult males in Zomba District owned a bicycle (Figure 7.4).⁴⁵ These bicycles increased the range over which the sick could be transported; they remain a popular means of transport to health facilities in the twenty-first century. For patients unable to walk (but able to sit), transport on the back of a bicycle could replace the much slower stretcher that often required four carriers. But the role of this rise in bicycle transport, concentrated in urban areas and lakeshore communities, should not be overstated. In the late 1960s patients presenting to hospitals and dispensaries still came overwhelmingly from the immediate areas

⁴⁴ McCracken, "Bicycles in Colonial Malawi."

⁴⁵ Fergus Chalmers Wright, *African Consumers in Nyasaland and Tanganyika: An Enquiry into the Distribution and Consumption of Commodities among Africans Carried out in 1952-1953* (Johnson Reprint Corp., 1970), Appendix B, in McCracken, bicycles in colonial Malawi.

surrounding hospitals. Even at the district hospital in the small lakeshore town of Nkhata Bay, 61 percent of outpatients came from less than two miles away.⁴⁶ In 1970 there was still only one “health unit” [a facility the size of a dispensary and above] for every 20,000 Malawians, about half of the recommended World Health Organization minimum at the time.⁴⁷

iii) Hypothesis 3: improved staffing and buildings

The third argument, that patients came because the quality of the facilities had improved, has much to recommend it. Roughly coincident with the rise in attendance at government facilities was a marked increase in recurrent expenditure on the government health sector. As seen in Figure 7.5, recurrent expenditure on health (in current UK pounds sterling) in 1965 (£1,068,377) was almost three times higher than in 1955 (£395,000) and nearly fifteen times higher than in 1945 (£72,896). The rate of the rise in spending far outpaced

⁴⁶ E. R. de Winter, *Health Services of a District Hospital in Malawi* (Van Gorcum and Company, 1972), 106.

⁴⁷ Maurice King, *The development of health services in Malawi, 1970-1985*. Zomba: The Ministry of Health and Community Development, 1970. Pg 2.

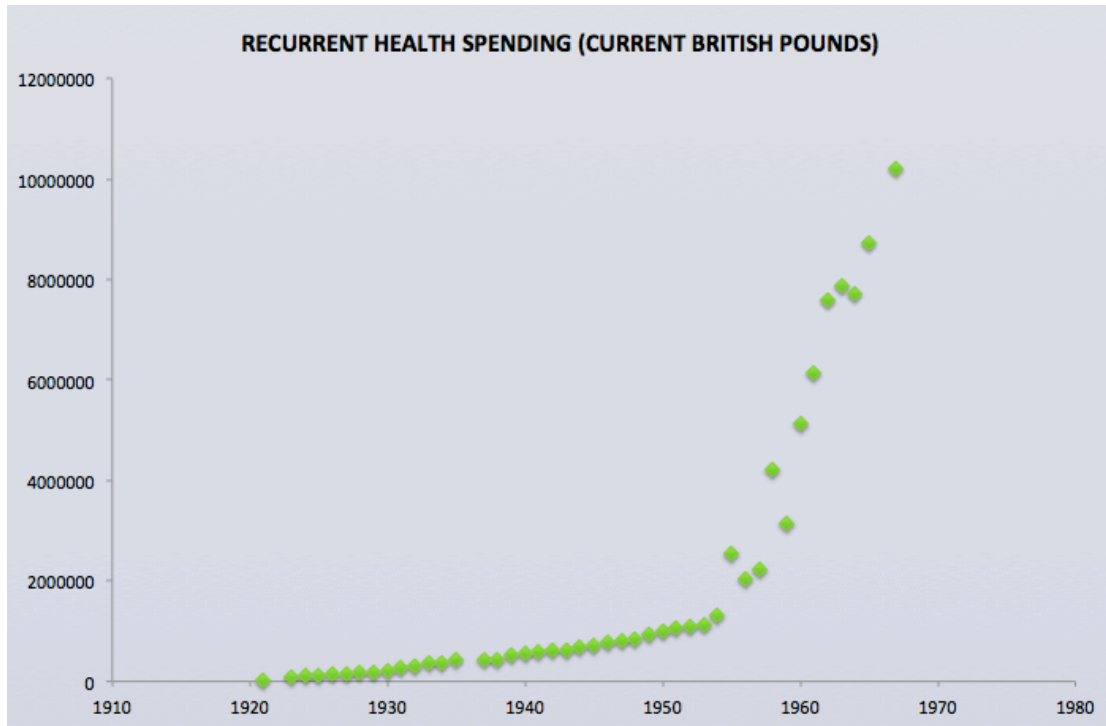


Figure 7.5: Recurrent government health spending in Nyasaland/Malawi (current UK pounds sterling). Source: Annual reports of Medical Department, 1914-1964.

the rate of population growth; recurrent expenditure on health per capita increased from 3/100 pounds sterling in 1945 to 55/100 pound sterling in 1965. Almost 40 percent of the increase in recurrent expenditure during the decade 1955-1965 went towards the personnel budget, which rose from £204,528 in 1955 to £471,672 in 1965. Much of the rest of the increase is accounted for by spending on supplies and medicines, which rose from £108,000 in 1954 to £381,000 in 1962.

Yet many deficiencies in staffing and procurement were never resolved. The budget included funding sufficient to employ 12 non-specialist, non-administrative government medical officers in 1949; this rose to 38 in 1953 before falling again to 12 again at independence in 1964. During most of these years the number of actual medical officers

did not reach these budgetary limits. For a few months in 1964 Malawi had only 3 government medical officers. And, as the next sections will elucidate, while spending on supplies and drugs rose significantly, rationing of drugs and supplies and even prolonged stock-outs of widely used medicines plagued government facilities throughout the colonial, Federation, and independence eras. Staffing and procurement improved during some of the postwar years, but it also deteriorated in others. All the while, patients came in ever increasing numbers.

iv) Hypothesis 4: new drugs and equipment

This leads to the final and, in many ways, most convincing of the explanations for the rise in attendance: the introduction of new drugs. The main event here is the revolution in antimicrobial therapeutics.⁴⁸ In the United States, the first sulfa drug reached the general public in the late 1930s; penicillin was first mass-marketed in 1945, followed in the coming years by bacitracin (1948) and chlortetracycline (1948). Effective therapy against pulmonary tuberculosis arrived with the use of streptomycin (1948) and isoniazid (1952) in combination.⁴⁹ The antimalarial chloroquine reached US markets in 1946, replacing mepacrine, a drug used by American troops during the Second World War and widely

⁴⁸ The mid-twentieth-century discovery of novel classes of pharmaceuticals included sulfa drugs, penicillin, tetracyclines, anti-tuberculosis and antimalarial agents, cortisone, vitamin B12, and anti-hypertensive agents. These drugs transformed the practice and reputation of medicine. This new therapeutic armamentarium prompted Lewis Thomas to call medicine the “youngest science.” It is this second “therapeutic revolution” to which I refer here. See Rosenberg, “The Therapeutic Revolution: Medicine, Meaning and Social Change in Nineteenth-Century America”; Richard Weinshilboum, “The Therapeutic Revolution,” *Clinical Pharmacology & Therapeutics* 42, no. 5 (December 1987): 481–84; Lewis Thomas, *The Lives of a Cell: Notes of a Biology Watcher* (New York: Penguin Books, 1978).

⁴⁹ James Le Fanu, *The Rise and Fall of Modern Medicine* (Basic Books, 2002); Messac, “Moral Hazards and Moral Economies.”

reviled for its neurologic side-effects.⁵⁰ Promin, the first in the class of sulfone drugs, was used to halt the ravages of leprosy (also known as Hansen’s disease) in patients in Carville, Louisiana in 1941; a less painful drug, Dapsone, came into use in the early 1950s.⁵¹

Years—even decades—passed between the introduction of these drugs in the United States and their arrival in Nyasaland’s public facilities. Even after their introduction to Nyasaland, these drugs were often strictly rationed (see Chapter 8). But compared to the therapeutic armamentarium available to colonial medical officers and African auxiliaries before the war, these were powerful new tools. Penicillin began to arrive, in small quantities, at the end of the war. This drug would save patients with many serious bacterial infections. It came, lamented WTC Berry, “too late to save the life of one of our medical officers who died from septicemia, contracted after doing a postmortem in 1944.”⁵² Penicillin also transformed therapy for syphilis. Previous therapy for Africans diagnosed with syphilis was a series of sodium bismuth tartrate injections (see Chapter 3). These were painful and did not lead to permanent cure. Berry, a medical officer in Mulanje between 1936 and 1943, remembered that he had responded “unfeelingly” to a syphilitic male who complained of the pain of this injection “that he would have been

⁵⁰ “Atabrine for Malaria,” *Tactical and Technical Trends, Prepared for Army Ground, Air and Service Forces by Military Intelligence Service, War Department* 26, no. 3 (June 3, 1943): 39; SR Meshnick and MJ Dobson, “The History of Antimalarial Drugs,” in *Antimalarial Chemotherapy: Mechanisms of Action, Resistance, and New Directions in Drug Discovery* (Totowa, NJ: Humana Press, 2001).

⁵¹ John Parascandola, “Miracle at Carville: The Introduction of the Sulfones for the Treatment of Leprosy,” *Pharmacy in History* 40, no. 2/3 (1998): 59–66.

⁵² Berry, *Before the Wind of Change*. Page 17.

wiser to have thought of that when he was making love with the woman.”⁵³ By the late 1940s, physicians could rid bodies of syphilis and prevent its ravages with a single injection of penicillin.⁵⁴

As demonstrated by Figures 7.6a and 7.6b, the number of patients suffering from a given disease who attended public sector clinics rose precipitously in the immediate aftermath of the introduction of novel therapeutics. For yaws, this increase followed the introduction of bismuth injections in the mid-1920s (see Chapter 1).

For hookworm, the rise in attendance followed the introduction of carbon tetrachloride. In the late 1920s this drug, which was first used earlier in the decade by American veterinarians on dogs, was distributed free of charge to plantations for use by employers of African labor.⁵⁵ By the early 1930s, mass *voluntary* anti-helminthic campaigns in the countryside drew thousands of African patients. Doctors ascribed the popularity of this

⁵³ Ibid. Page 18. Berry also remembered other commonly used therapeutics prior to penicillin’s arrival: “‘Prontosil’ [a sulphonamide] was the first antibiotic available, it turned the urine red. We used morphine and various milder pain relievers; antimony tartrate and Fuadin (by intramuscular injection) for bilharzia; arsenicals for syphilis and yaws.”

⁵⁴ Even though therapeutics for syphilis advanced with penicillin, as late as the early 1960s there was still no reliable serological test capable of differentiating venereal syphilis from nonvenereal treponematoses, such as yaws and endemic syphilis. David Stevenson, who had served as an Anglican missionary doctor in Nyasaland in the late 1950s and early 1960s, lamented this difficulty: “Syphilis is probably blamed for a lot of conditions for want of a better diagnosis. Full courses of penicillin may have to be given when the disease is only suspected. If reliable serology could be made widely available this could be avoided and valuable figures for the incidence of syphilis could be obtained.” Amy Beth Koff and Theodore Rosen, “Nonvenereal Treponematoses: Yaws, Endemic Syphilis, and Pinta,” *Journal of the American Academy of Dermatology* 29, no. 4 (October 1993): 519–35; Stevenson, “The Health Services of Malawi.” Page 100.

⁵⁵ Whitehead, “Annual Medical Report for the Year Ended 31st December, 1928.” Page 15.

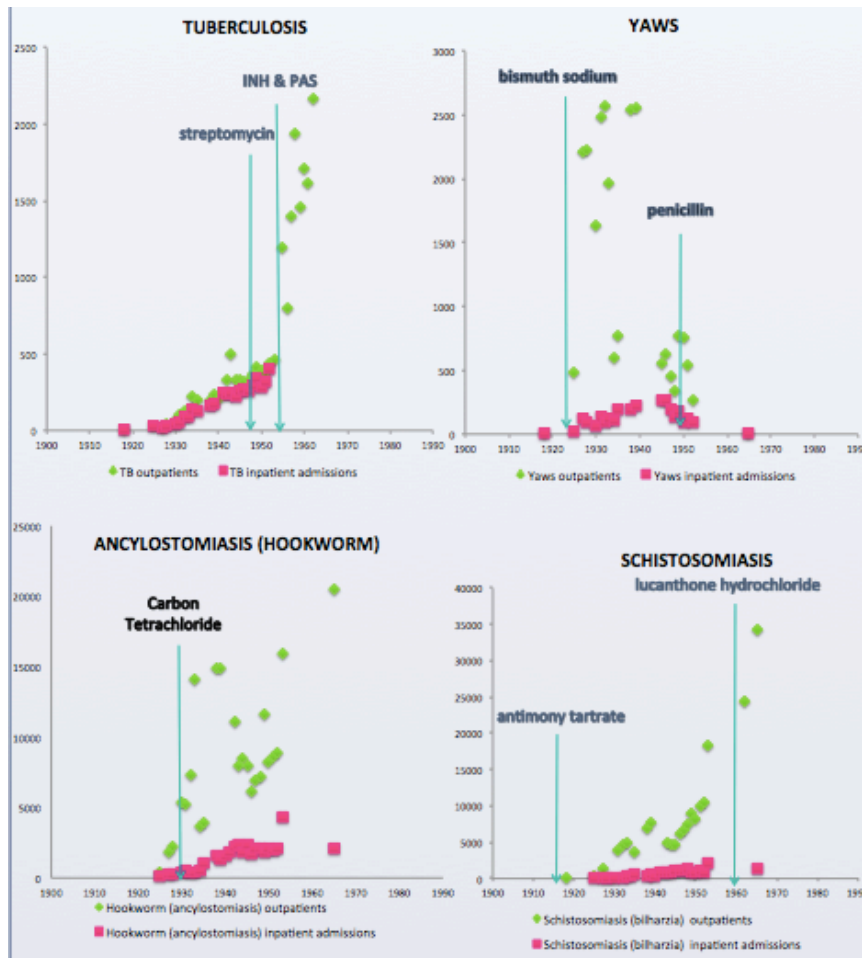


Figure 7.6a: Disease returns at public sector health facilities and new drug introductions for TB, yaws, hookworm, and schistosomiasis. Source: Annual reports of Medical Department, 1920-1964.

campaign to the visible and dramatic consequences of the therapy. While the doctors' main target in administering carbon tetrachloride was the microscopic hookworm (thought to be a major cause of anemia and low productivity, see chapter 2), patients given this therapy would also defecate macroscopic tapeworms.⁵⁶ One of the doctors leading the campaign, William Watson, became known as Dr. *Chimbudzi*, which translates to Dr.

⁵⁶ "Annual Medical Report on the Health and Sanitary Condition of the Nyasaland Protectorate for the Year Ending the 31st, December, 1930." page 40; De Boer, "Annual Medical & Sanitary Report for the Year Ending 31st December 1938."

Feces.⁵⁷ By the 1950s Nyasaland's doctors would complain what they saw as Africans' tendency to ascribe great therapeutic efficacy to over-the-counter laxatives, but at least in the 1930s they were grateful to see perceptions dovetail.⁵⁸ Yet carbon tetrachloride could also be highly toxic and even caused the death of a few patients; in medical reports, the deceased patients were blamed for not having heeded warnings to abstain from alcohol prior to treatment.⁵⁹

For gonorrhoea, the rise in attendance followed the introduction of sulphapyridine in the 1940s. Sulpha drugs had been strictly rationed in the late 1930s (see Chapter 5). But in May 1945, the Colonial Development and Welfare Fund awarded Nyasaland a five-year, £42,000 grant for free treatment of gonorrhoea and syphilis at government and mission institutions.⁶⁰ This money allowed more patients to access sulphapyridine than ever before, and patients receiving treatment for this condition rose accordingly.

During the 1950s demand for leprosy treatment increased after the introduction of another novel therapeutic. Dapsone was, leprologist Dr. Gordon Currie explained, "far from being the ideal drug." It had to be administered weekly, sometimes

⁵⁷ Michael King and Elspeth King, *The Story of Medicine and Disease in Malawi: The 150 Years Since Livingstone* (Malawi: Arco Books, 1992). Pages 99-100

⁵⁸ Carbon tetrachloride could also be highly toxic and even caused the death of a few patients; in medical reports, the deceased patients were blamed for not having heeded warnings to abstain from alcohol prior to treatment. Carbon tetrachloride is soluble in alcohol, and can be absorbed from the intestines into the bloodstream along with alcohol. Gopsill, "A Few Notes on My Life in Zanzibar and Nyasaland from 1926 to 1945." Page 12.

⁵⁹ Ibid. Page 12. Carbon tetrachloride is soluble in alcohol, and can be absorbed from the intestines into the bloodstream along with alcohol.

⁶⁰ Richards, "CDWAC No 527: Nyasaland. Venereal Disease: Purchase of Drugs for Treatment. Application for Free Grant of £42,000."

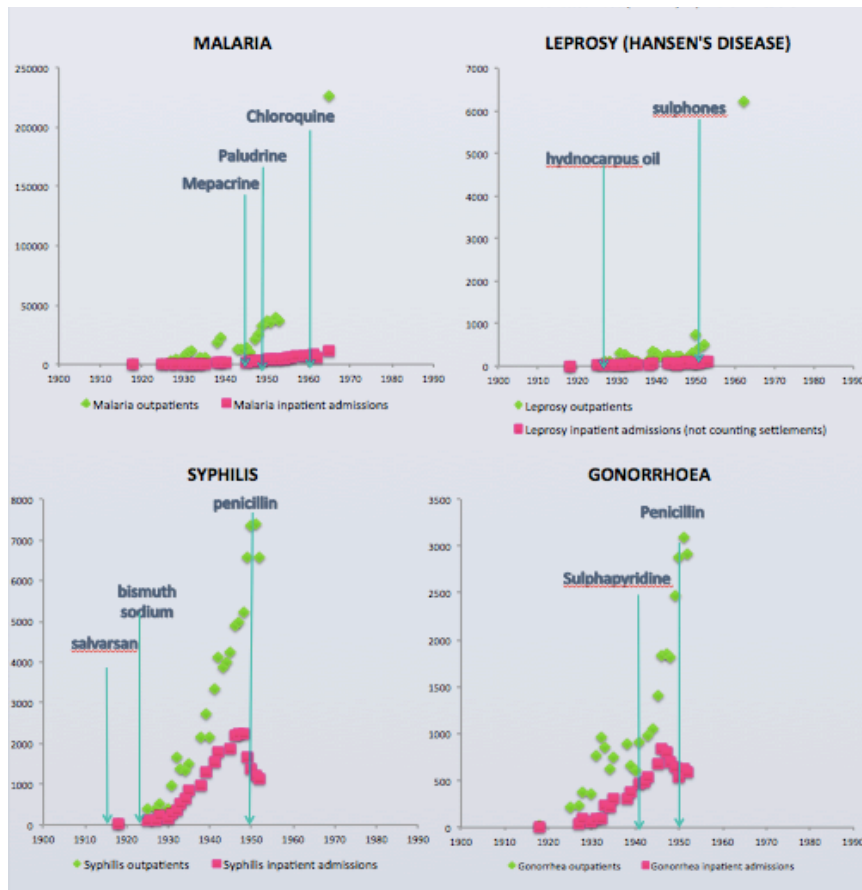


Figure 7.6b: Disease returns at public sector health facilities and new drug introductions for malaria, leprosy, syphilis and gonorrhoea. Source: Annual reports of Medical Department, 1920-1964.

for years, and it sometimes caused permanent nerve damage.⁶¹ But patients, doctors and nurses welcomed the end of the long era in which the mainstay of treatment had been infamously ineffective hydnocarpus oil. A number of missions had shuttered their leprosaria in previous decades, in part because, as John Iliffe explains, “the drugs did not work.”⁶² Many people had flocked to the mission leprosaria after the introduction of hydnocarpus oil injections in the 1920s. But by the 1940s neither patients nor providers had confidence in the efficacy of these drugs; those who lived on the settlements might

⁶¹ G. Currie, “A Clinical Trial of Etisul in Lepromatous Leprosy,” *Transactions of the Royal Society of Tropical Medicine and Hygiene* 57 (May 1963): 196–205.

⁶² Iliffe, “The Poor in the Modern History of Malawi.” Page 257.

have stayed for the meager food and shelter they provided, while outpatients often came for treatment because the staff could excuse them from the obligation to pay hut tax.⁶³ Electra Dory, who directed the UMCA leprosarium in Likwenu during the Second World War, recalled the “apparent dejection and indifference” of the lepers. “They called themselves The Dead.” She remembered the futility of their therapeutic regimens: “We rammed—I fear that is the only word that describes the treatment—we rammed in the oleaginous product of the *hydnocarpus wightiana*, causing in some cases more pain and destruction than the lepra bacilli.”⁶⁴ Curative treatment was only possible with the arrival of sulphone therapy.⁶⁵

This new efflorescence of public confidence was also seen in the patients with tuberculosis (following the release of streptomycin and isoniazid at public hospitals in the mid-1950s). In the 1960s attendances increased for schistosomiasis (after the introduction of lucanthon hydrochloride) and malaria (upon the dissemination of chloroquine).⁶⁶

⁶³ Mabel Drew, a nurse at Likwenu during the 1940s, remembered: “I found the crowds with their foul sores thinning, but some were waiting to obtain chits, which would exempt them from the hut tax.” Mabel Drew, “Nursing at UMCA Likwenu, Late 1940s,” in *Expatriate Experience of Life and Work in Nyasaland, Volume Three*, ed. Colin Baker (Cardiff, Mpemba Books, 2014), 286.

⁶⁴ Electra Dory, *Leper Country: A Candid, at Times Shocking, Account of a Medical Missionary's Life among Primitive People in Africa* (Frederick Muller Ltd, 1963). Pages 40, 44.

⁶⁵ Vaughan, *Curing Their Ills*. Page 84.

⁶⁶ Earlier treatment for schistosomiasis with antimony could be quite dangerous. As Gopsill explained of antimony treatment in the 1930s: “One had to take care when treating bilharzia, that the dosage was very gradually increased because if this was not so the antimony drugs given contracted the spleen and caused a flare up of malaria and after 3 injections the patient did not [come] back to have the 12 or more injections needed to form an effective cure.” Gopsill, “A Few Notes on My Life in Zanzibar and Nyasaland from 1926 to 1945.” Page 12.

Some prominent contemporary commentators on colonial medicine interpreted the increasing numbers of patients presenting for treatment (in the absence of any robust epidemiologic surveillance) as evidence of rising incidence of disease.⁶⁷ But the rise in attendance was more likely a product of greater confidence in the efficacy of biomedicine among those who were already sick. Such was the opinion of the medical officer in Mzimba, who reported in 1956 that “the increase in patients in hospital with Pulmonary Tuberculosis is not thought to represent an increase of the disease in the district as much as an increase in propaganda by Medical Aides in rural dispensaries. All but one of the cases in hospital were chronic in nature, mostly with fibrosis and cavitation.” Prior to the arrival of chemotherapy, the primary treatment for patients with tuberculosis in Nyasaland (and a common procedure elsewhere in the world) was a surgical procedure in which the affected lung was collapsed.⁶⁸ This treatment was invasive and largely palliative.⁶⁹ But by 1956, routine *curative* treatment in Nyasaland’s district hospitals was two out of three drugs (streptomycin, isoniazid, and PAS) “over a long period of time.” This was not, by Malawian standards, inexpensive therapy, and stock-outs of these drugs

⁶⁷ Harry S. Gear, “Some Problems of the Medical Services of the Federation of Rhodesia and Nyasaland,” *BMJ* 2, no. 5197 (1960): 525–31., and DM Blair, “Annual Report on the Public Health of the Federation of Rhodesia and Nyasaland for the Year 1958” (Salisbury: Government Printer, April 30, 1959), BL.

⁶⁸ Morris, “Annual Report on the Public Health of the Federation of Rhodesia and Nyasaland for the Year 1956.” Page 15.

⁶⁹ A Hurst, HM Maier, and R Dwork, “A Critical Study of Pneumoperitoneum and Phrenic Nerve Crush in Pulmonary Tuberculosis,” *Diseases of the Chest* 13, no. 4 (August 1947): 345–59; RY Keers, “Pneumoperitoneum: Its Place in Treatment,” *The British Journal of Tuberculosis and Diseases of the Chest* 42, no. 3 (1948): 58–66; James L Livingstone, “Observations on the Treatment of Pulmonary Tuberculosis at the Present Time,” *BMJ* 1, no. 4908 (January 29, 1955): 243–50.

were common in the 1950s (see Chapter 8). Still, they were standard of care, and the earlier surgical interventions were rarely performed.⁷⁰

Recent studies of AIDS treatment (with antiretrovirals) demonstrate that, in similarly impoverished settings, there exists a correlation between the introduction of effective chemotherapeutic agents and reported cases, particularly when treatment is given free at the point of care.⁷¹ There is plenty of reason to believe that the (often-delayed) availability of drugs was a major factor driving the increased attendance at government health facilities in Nyasaland.

But even as African patients began to appear in far greater numbers at hospitals and dispensaries, many government officials wished they would stay home. Whereas in the 1930s government officials had sought to bring more African patients to the clinic, by the late 1950s their successors were trying to stem the flow.⁷² Economic planners in Malawi (and their expatriate advisors) saw the claims on the government's purse that the rush of patients had created as a drain on economic growth. The government finally had healing

⁷⁰ Morris, "Annual Report on the Public Health of the Federation of Rhodesia and Nyasaland for the Year 1956." Page 15.

⁷¹ David A. Walton et al., "Integrated HIV Prevention and Care Strengthens Primary Health Care: Lessons from Rural Haiti," *Journal of Public Health Policy*, 2004, 137–58.

⁷² See, for instance, a March 1938 memo by Nyasaland's Chief Secretary, KL Hall who argued that African patients should continue to be provided government medical services free at the point of care in order to encourage them to come when sick: "In his present state of development it is essential that the Nyasaland native should receive every possible encouragement to present himself for European preventive and curative treatment and I can see no alternative, as a rule, to such treatment being given without charge until such time as the blessings of medical and surgical science are fully appreciated and the spending power of the indigenous population is improved." Messac, "Moral Hazards and Moral Economies." Pages 6-7.

technologies that Africans patients wanted, but as the next section will demonstrate those patients were, in some ways, no longer welcome.

III. Defying the experts: Increasing health spending against the tenets of modernization theory, 1950s-1960s

a) Modernization lessons from a prison cell: Dunduzu Chisiza and Walt Rostow, 1960

Sitting in a prison cell in Southern Rhodesia in January 1960, Dunduzu Chisiza penned a letter. He was continuing a correspondence with Walt Rostow, a renowned economist at the Massachusetts Institute of Technology and advisor to the presidential campaign of then-Senator John F. Kennedy. Chisiza apologized for his brevity: “We can use only two sheets of paper for each letter.” He continued, “There are many questions I would have liked to ask...but most of them would be classified as political by the authorities here—and we are not allowed to mail out anything political.”⁷³ The rest of Chisiza’s letter was not focused on his captivity, nor his captors, but rather on the future of his native Nyasaland, still under rule by the Federal Government in Southern Rhodesia. He sought, he explained, to write a “Master Economic Plan” [presumably to take effect after securing independence, though he could not write this from prison], and had found helpful guidance in this endeavor in summaries of Rostow’s Cambridge lectures on “the stages of economic growth,” which had recently been published in *The Economist* magazine.

⁷³ “Dunduzu Chisiza to Walt W. Rostow,” January 2, 1960, George Shepperson Papers, University of Edinburgh Archives.

In his letters Chisiza was effusive in his praise of Rostow's lectures. Rostow responded personally, and mailed him a draft of his soon-to-be-published book, *The stages of economic growth: a non-communist manifesto*. Chisiza's next letter called this work a "masterpiece" and "a very handy guide to those who are concerned with the problem of economic development in the underdeveloped countries."⁷⁴ Though still a young man—only 29 when he wrote to Rostow—Chisiza had a deep interest in economic planning. Educated at the Livingstonia Mission in northern Nyasaland and at the Aggrey Memorial College in Uganda, he secured a scholarship to study the Economics of Underdeveloped Countries and Political Science at Fircroft College in Birmingham in 1958.⁷⁵ During his time in the UK, Chisiza also took classes at the London School of Economics. But he had been in the UK only a few months before Hastings Kamuzu Banda asked him to return to Nyasaland to aid in the struggle to dissolve the Federation of Nyasaland with the Rhodesias. Within a year Chisiza, Banda and other nationalist leaders had been charged with attempted assassination and imprisoned in Gwelo, Southern Rhodesia, where Chisiza continued to read economics and struck up his correspondence with Rostow.

In his book, Rostow drew upon his analysis of the previous two centuries of European industrialization to propose that all societies fell somewhere along a five-stage process of economic growth. First, in traditional society "pre-Newtonian" science and "pre-Newtonian attitudes toward the physical world" do not allow people to systematically

⁷⁴ "Dunduzu Chisiza to Walt W. Rostow."

⁷⁵ "Dunduzu Is Dead," *Malawi News*, September 7, 1962., pg.2. Also see D. D. Phiri, *Dunduzu K. Chisiza: Malawi Congress Party Secretary-General, Parliamentary-Secretary, Brilliant Thinker, Pamphleteer and Essayist*, Malawians to Remember (Blantyre, Malawi: Longman Ltd, 1974). Pages 18-21.

apply knowable laws to increase productivity. People maintain a “long-run fatalism” in which they assume their grandchildren’s lot will be the same as their own. In the second stage came the “preconditions for takeoff”—which can be introduced by endogenous change (as in Europe) or by external shocks (the colonized world)—including the belief that economic progress was both possible and good; the emergence of enterprising men willing to mobilize savings in the pursuit of profit; and the establishment of centralized national states. Third, in the “takeoff” phase, growth became a normal condition, as the effective rate of investment and savings rose to 10% of national income, new industries in leading sectors expanded, and political authorities came to see modernization as “serious, high-order political business.” After this 20-year “takeoff” period came the penultimate stage, a 40-year-long “drive to maturity” involving “sustained if fluctuating progress, as the now regularly growing economy drives to extend modern technology over the whole front of its economic activity.” Finally came the shift from sector-led growth to expansion involving all sectors of the economy; this was the fifth phase, which Rostow called “the age of high mass-consumption.” Leading sectors of the economy had given way to “durable consumers’ goods and services,” income per capita had risen to allow most people to transcend concerns with “basic food, shelter, and clothing.” Much of the population was urban and employed in skilled factory labor or office work. Then, and only then, could society cease “to accept the further extension of modern technology as an overriding objective.”⁷⁶ In sum, government spending on medical care and other social services would have to wait.

⁷⁶ W. W. (Walt Whitman) Rostow, *The Stages of Economic Growth a Non-Communist Manifesto*. (Cambridge [Eng.]: University Press, 1960).

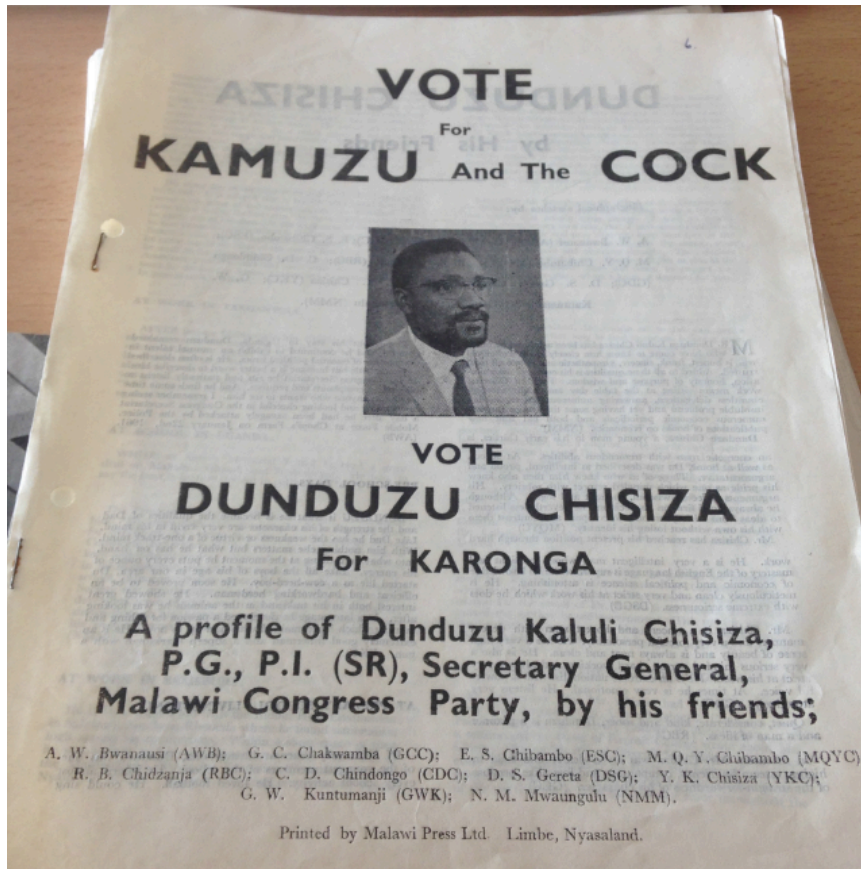


Figure 7.7: A campaign pamphlet for Dunduzu Chisiza's candidacy in the 1961 Nyasaland Parliamentary elections. Hastings Kamuzu Banda led the Malawi Congress Party, which had as a mascot the rooster (hence, "Vote Kamuzu and the Cock"). Printed by Malawi Press Ltd, Limbe, Nyasaland. From George Shepperson Papers, University of Edinburgh Archives.

b) Chisiza's vision for African modernization, 1961-1962

For Chisiza, the primary benefit of this schematization of the process of modernization was that it seemed to indicate a practical roadmap explaining "what and how much to undertake during the various stages of economic modernization."⁷⁷ Soon after his release from prison in 1960 Chisiza would win become a Member of Parliament in Nyasaland and become a prominent voice in postcolonial African economic thought (Figure 7.7). Though he did not criticize Rostow explicitly his writings indicated disagreement with a

⁷⁷ "Dunduzu Chisiza to Walt W. Rostow."

particular facet of his theory.⁷⁸ First, Chisiza believed that the establishment of social security programs—including state-supported healthcare—should begin immediately rather than await the arrival of the fifth and final stage, “the age of mass consumption.”⁷⁹ On this point, above all, Chisiza believed that Nyasaland could—and, largely due to new expectations among postwar publics, should—diverge from the historical experience of the United Kingdom and other Western nations:

Social security in an under-developed economy is something very close to a luxury. Scarcely any of the advanced countries ever provided it in the early stages of development. None could have afforded it without arresting capital formation. The same would seem to go for present-day under-developed countries. But there is a difference. At the time the advanced countries were shaping their economies, humanitarian ideals as we know them today had not been fully developed. The idea of social security had neither taken form nor caught the imagination of politicians. Today, however, the idea is echoed everywhere—even in the under-developed countries themselves. For the governments of under-developed countries, therefore, to refrain completely from making an initial step towards the provision of social security on an appreciable scale, would be a dangerous political omission for the ruling parties. On the other hand, as already pointed out, full-scale social security is simply not possible. The compromise seems to be the provision of some measure of social security for those of the aged, infirm and disabled who have no one to depend upon.⁸⁰

⁷⁸ In 1961, Chisiza became Parliamentary Secretary to the Ministry of Finance. *The Scotsman* lauded his role as “the guiding hand” in the “informed determination of the Malawi Congress Party leaders to promote policies conducive to sustained economic growth.” The article described Chisiza as follows: “Essentially eclectic in his economic thought and appraisals, he regards the doctrinaire forms of capitalism and Socialism alike as imported luxuries, which the Nyasa economy can ill afford. Mr. Chisiza’s immediate economic responsibility is to prepare the financial background for Nyasaland’s withdrawal from the Federation. His greater and more enduring task is to implement the economic policies outlined in the MCP election manifesto.” “Nyasaland and the Future: Room for Expansion in Tea, Cotton, Coffee,” *The Scotsman*, October 20, 1961.

⁷⁹ In Rostow’s *Stages*, social welfare and social security programs were instituted only in the final stage, which—by Rostow’s 1960 reckoning—only the US, Japan and some parts of Europe had reached. The key to moving through the stages was to increase savings; significant portions of GNP needed to be reinvested in the means of production. Social security programs were not, according to Rostow, forms of productive investment. Rostow, *The Stages of Economic Growth a Non-Communist Manifesto*.

⁸⁰ Dunduza Kaluli Chisiza, *Realities of African Independence* (The Africa Publications Trust, 1961), 17.

The history of the idea of “social security,” particularly following the 1942 Beveridge Report, in Nyasaland and the rest of the British Empire, was explored in Chapters 5 and 6. But here, it is important for our argument to note that Chisiza did not disagree with Rostow’s argument that social security was economically unproductive—he, too, saw state spending on ill and the aged as contrary to the primary goal of capital formation. Nevertheless, Chisiza warned that the absence of social security programs in a modernizing nation was “a dangerous *political* omission”—a lesson that Malawi’s post-independence leaders would learn following the unpopular and ultimately brief introduction of healthcare user fees in 1964 (see Chapter 8). Chisiza’s influence was evident in the 1961 election manifesto of the Malawi Congress Party—an election the party would win in a landslide—which decried existing health services under the Federation Government as “grossly inadequate” and “deplorably poor,” and promised to provide “social security for those of the aged, infirm and disabled who have no one to depend upon.”⁸¹

Chisiza believed the prolonged deferral of social spending was particularly unwise in African countries because Africans were social by nature. After winning a seat as a Member of Parliament in the 1961 Nyasaland elections, Chisiza became Parliamentary Secretary to the Ministry of Finance. After securing funding from the Ford Foundation, he convened a symposium of international development economists in Zomba. Yet though he had long shown deep interest in the quantitative tools and generalizable schemata of development economics, Chisiza’s speech at the symposium concerned not

⁸¹“Malawi Congress Party Manifesto for the General Election,” August 1961, MNA., pages 13-14

input-output ratios, but his vision of an essential African outlook. Chisiza argued that economists and other policymakers had to respect that Africans were temperamentally predisposed to concern themselves with the lot of their neighbors:

We of Africa...are fundamentally observers, penetrating others, relying more on intuition than on the process of reasoning. We excel in neither mysticism nor in science and technology, but in the field of human relations...We pursue happiness by rejecting isolationism, individualism, negative emotions, and tension, on the one hand; and by laying emphasis on a communal way of life, by encouraging positive emotions and habitual relaxation, and by restraining our desires, on the other...We believe in strong family relations, We have been urged by well-meaning foreigners to break these ties for one reason or another. No advice could be more dangerous to the fabric of our society. Charity begins at home. So does the love of our fellow human beings...But I believe that, once so conditioned, one behaves in this way not only to one's family, but also to the clan, the tribe, the nation, and to humanity as a whole.⁸²

Let us put aside the problematic essentialism of Chisiza's ideal-type African, and turn to his point of contention with "well-meaning foreigners." Chisiza was concerned here with the belief system that modernizers insisted that citizens of a developed nation must have. Chisiza believed Africans need not abandon their communal spirit in order to secure a prosperous future. In this claim Chisiza contradicted Rostow's MIT colleagues MF Millikan and Donald Blackmer, who in a 1960 report for the U.S. Senate Committee on Foreign Relations lamented the sharing of income amongst extended family members as a traditionalist practice that would prevent the accumulation of savings necessary for economic growth.⁸³ As Nils Gilman observed wryly in his history of modernization theory, "Letting the extended family go hungry was apparently one of the prices of

⁸² Dunduza Kaluli Chisiza, "The Temper, Aspiration and Problems of Contemporary Africa," in *Economic Development in Africa: Papers Presented to the Nyasaland Economic Symposium*, 1st ed. (Basil Blackwell, 1965). p 11.

⁸³ Rostow mentioned he was involved in this report in his correspondence with Chisiza, though he did not detail its argument. MF Milikan and Donald Blackmer, "The Emerging Nations: Report to the Senate Foreign Relations Committee," 1960.

modernization.”⁸⁴ Chisiza was an advocate of “economic modernization,” but not the kind envisioned by the MIT researchers, where social ties of obligation would shrink to the level of the nuclear family.

Much like the Colonial Office reports of the 1940s (see Chapter 6), Chisiza glorified “traditional” village social security, but unlike them he saw it as a supplement (rather than a substitute) for state social security. He believed Africans were demanding social security even though it not had been a part of the early history of European industrialization. Reducing inequality, taxing the wealthiest citizens, and providing for the vulnerable were part of Chisiza’s plans, he said, because they had become a part of the global social imaginary. Even if their country was not yet rich enough to provide benefits on the scale seen in Britain, they could not wait to make a start.

The nationalist leaders imprisoned in Gwelo were a cosmopolitan bunch. Many of them had witnessed the expansion of health services and social security elsewhere. For his part, Hastings Kamuzu Banda had lived his life on three continents. He was a student in the United States during the Great Depression and the Roosevelt’s New Deal.⁸⁵ He was a doctor in a working-class neighborhood in London at the dawn of the National Health Service in 1948. And when, in 1957, Ghana became the first black African nation to gain independence from colonial rule, Banda was there. In the years following Ghana’s independence—while Banda sweltered in a Rhodesian prison—the new nation would

⁸⁴ Nils Gilman, *Mandarins of the Future : Modernization Theory in Cold War America* (Baltimore: Johns Hopkins University Press, 2003). p 183.

⁸⁵ “Obituaries: Dr. Hastings Banda,” *Times (of London)*, November 27, 1997.

vastly increase spending on its Ministry of Health.⁸⁶ Spending on health rose from 2.7 percent of total recurrent government expenditure in 1954 to 6.3 percent in 1961.⁸⁷

But it was Chisiza, not Banda, who would speak at length about the need to bring the revolution in social and economic rights to Nyasaland. Shortly after independence in 1964, Banda warned civil servants seeking pay raises and generous pensions that Malawi would be “no welfare state.” But, for the most part, with Chisiza dead, Malawi’s discourse on development did not include much talk of social security or economic rights. Still, the furor that followed the introduction of healthcare user fees in 1964 would prove Chisiza’s warnings about the political significance of government social provision prescient (Chapter 9). Despite the propagandistic simplicity in his description of African culture, Chisiza was by no means the only observer to note the centrality of obligation and mutuality to southern African thought and social practice. His thought was both path-breaking in its own right and reflective of broader trends in thought and politics in late colonial British Africa.

c) The quest for growth: GDP in Malawian development policy, 1962-1968

Yet Chisiza’s influence should not be overstated, if only because he did not live long enough to exert it. On September 3, 1962, less than three months after the Nyasaland Economic Symposium, Chisiza was found dead in a car in a ditch. The historian Joey Power has written about both widespread rumors and a circumstantial evidence which point to Banda as the leader of a plot to murder Chisiza and frame his death as a car

⁸⁶ Short, *Banda*.

⁸⁷ Stevenson, “The Health Services of Malawi.” Pages 26-27.

accident.⁸⁸ Power interviewed a number of Malawians who believe Banda orchestrated Chisiza's death for fear of his rising prominence; Banda saw the young and charismatic speaker, with his international connections and a sterling reputation as a thoughtful, learned and popular leader, as a nascent threat.⁸⁹ In the habit of calling other nationalist leaders his "boys," Prime Minister Banda---whose autocratic tendencies would become clearer in the years to come, and who would be linked to politically motivated killings for the next three decades---was known to be unhappy with the regard given a man thirty years his junior.⁹⁰ But no one has ever produced definitive evidence of Banda's involvement in Chisiza's demise. Whatever the cause of his death, Chisiza did not live to see his country secure independence. It would not be Chisiza, but Banda (and the external financiers of development loans and grants) who would dictate Malawi's postcolonial economic policy.

Chisiza's objections to modernization theory's disregard for health and other "social" services largely concerned its philosophical underpinnings and political ramifications.

But he did not question the widespread belief among development experts of the era that

⁸⁸ Historian Joey Power explores the circumstances surrounding Chisiza's death. For instance, the police inquest determined Chisiza had died from wounds to the head after his car plunged off a bridge, yet there was no blood in the car, and Chisiza's wounds seemed old to a medical assistant who examined his body on the night of the "accident." See Power, *Political Culture and Nationalism in Malawi*. Pages 164-169.

⁸⁹ Chisiza was eulogized as "a man of vision and energy" in *The Guardian*. Clyde Sanger, "African Nationalism's Heaviest Loss: A Man of Vision and Energy," *The Guardian*, September 5, 1962.

⁹⁰ The most infamous incident of an apparently politically motivated killing orchestrated by Banda came in 1983, when three government ministers and a Minister of Parliament who had been critical of Banda perished in what officials claimed was a car accident. See Reuben Makayiko Chirambo, "'Mzimu Wa Soldier': Contemporary Popular Music and Politics in Malawi," in *Politics and Culture in the New Malawi*, Ed. Harri Englund (Sweden: Elanders Gotab, 2002), 103-22.

health spending was not a productive investment.⁹¹ By the 1960s, referring to public sector spending on healthcare as unproductive “consumption” was not terribly controversial. And both Rostow and Chisiza agreed with colonial officials and nationalist leaders across the continent agreed that the first task of development was aggregate production growth. Nyasaland itself had been the site of one of the first experiments in “national” income accounting for a colony. During the 1940s, the British researcher Phyllis Deane had dug up Platt’s papers and conducted her own surveys and fieldwork to estimate Nyasaland’s national income in 1938 and 1948. Though Deane herself had argued that the distribution of income should be as important to development as aggregate national income, this was not a widely shared concern among economists prior to the 1970s.⁹² During the 1950s and 1960s, an increasing gross national product was synonymous with development. As Derek Blades, Malawi’s chief statistician, explained in Malawi’s 1968 *National Accounts Report*, “The simplest indicator of economic progress of a community is the movement of real income per head of the population. This is not an unqualified measure of improvements in the standard of living for the average inhabitant of a country but has been found a useful guide.”⁹³

⁹¹ On more on the conflation of growth and development during this period, in Rostow’s writings and in the writings of others, see Reuben Makayiko Chirambo, “‘Mzimu Wa Soldier’: Contemporary Popular Music and Politics in Malawi,” in *Politics and Culture in the New Malawi*, Ed. Harri Englund (Sweden: Elanders Gotab, 2002), 103–22., and Luke Messac, “Far from the Tree: Keynesian Economists, British Social Anthropology, and the Political Uses of National Income Accounting in Postwar Southern Africa” (U.S. African Studies Association annual meeting, Indianapolis, Indiana, 2014).

⁹² Phyllis Deane, *Colonial Social Accounting*. (Cambridge [Eng.]: University Press, 1953).; Phyllis Deane, *The Measurement of Colonial Incomes: An Experiment* (Cambridge: Cambridge University Press, n.d.); Messac, “Far from the Tree: Keynesian Economists, British Social Anthropology, and the Political Uses of National Income Accounting in Postwar Southern Africa.”

⁹³ *Malawi National Accounts Report, 1964-1967* (Government of Malawi, Zomba, 1968), p. 7.

d) Origins of modernization: capital investment as the key to development, 1939-1946

Rostow may have been one of the most famous proselytizers of growth through the ruthless accumulation of savings for industrialization, but he was neither the first nor the only advocate of this approach. During the 1940s, widely cited theories of economic growth posited a central role for aggressive state-directed accumulation of financial resources (through external grants and loans and domestic taxation) to be spent on the machines, dams power plants and roads needed to operate factories and transport goods to markets. This was true for the (very similar) formal mathematical models devised independently by the British economist Roy Harrod in 1939 and the Russian émigré Evsey Domar in 1946; in both, aggregate production was assumed to be a linear function of the capital stock. And since “capital stock” was considered by development economists to refer primarily to physical capital (machinery, power, buildings, materials, etc.), prioritizing saving for “investment” over spending on “consumption”—that is, spending that did not build the capital stock—was the surest path to achieve growth.⁹⁴ The stock of physical capital was also central to a highly influential 1943 paper entitled “Problems of industrialization of Eastern and South-Eastern Europe” by Paul Rosenstein-Rodan, an economist then based at the London School of Economics (he would join Rostow’s institute at MIT a decade later). Rosenstein-Rodan argued governments had to rapidly build up the “social overhead capital” (power, transport and communications) that

⁹⁴ Roy Harrod, “An Essay in Dynamic Theory,” *Economic Journal* 49 (March 1939): 14–33; Evsey D. Domar, “Capital Expansion, Rate of Growth, and Employment,” *Econometrica* 14, no. 2 (April 1946): 137–47.; Arturo Escobar, *Encountering Development: The Making and Unmaking of the Third World*, With a New preface by the author edition (Princeton, N.J: Princeton University Press, 2011)., page 70

was a necessary precondition of industrial production before private companies could profitably pursue directly productive investments.⁹⁵

These authors did not directly address the potential for a productive role for healthcare services or healthy labor. They did not think to do so because health was not thought to play a role in the production function. The supply of labor was often assumed to be abundant, even “unlimited” (as the poor masses were occupied only with relatively unproductive subsistence agriculture), and because the productivity of factory labor was thought to depend mostly on physical capital and *not* on the workers’ level of health and education, the stock of physical capital was—in these models—the only meaningful determinant of economic growth.⁹⁶

e) Role of technology in economic growth and the continued absence of health, 1955-1958

Econometric analyses in the 1950s demonstrated that supplies of capital and labor were insufficient to explain past growth, but at the same time these methods seemed unable to establish the contribution of health interventions to macroeconomic statistics. Another MIT economist, Robert Solow, used a time-series of GDP estimates from the United States between 1909, and tested the relative contributions of capital and labor supplies (i.e. movement along the “production function”), on the one hand, and “technical progress” (i.e. a shift in the production function) on the other. Solow’s analysis found that

⁹⁵ Paul Rosenstein-Rodan, “Problems of Industrialization in Eastern and South-Eastern Europe,” *Economic Journal*, September 1943.

⁹⁶ W. Arthur Lewis, “Economic Development with Unlimited Supplies of Labour,” *The Manchester School* 22, no. 2 (1954): 139–91. Note that technological progress—an exogenous variable not explained by the model—was important to the Solow-Swan model developed in 1950s, but here, too, health was not explicitly invoked as a determinant of growth.

the 2.9 percent average annual growth rate of the US economy during the four-decade period could be explained as follows: 0.32 percentage points came from capital accumulation, 1.09 percentage points from labor, and 1.49 percent from “technical change in its broadest sense,” which he also called “total factor productivity.”⁹⁷ Over the coming decades economists studying growth would propose to explain the elements of total factor productivity, but at least in the 1950s and 1960s health was rarely among them.⁹⁸ Part of the problem was that rigorous investigation of the effects of population-level health interventions on aggregate production remained statistically intractable. Whereas in 1955 the Director of the Pan American Sanitary Board justified malaria eradication by declaring that malaria was “a serious burden on the economy of every malarious country,” by 1958 the chief of malaria eradication for the Pan American Health Organization lamented that it had proven impossible to ‘affirm that [economic] progress has been the result of the control or reduction of malaria.’⁹⁹ Among development

⁹⁷ Robert M. Solow, “A Contribution to the Theory of Economic Growth,” *Quarterly Journal of Economics* 70, no. 1 (1956): 65–94; Robert M. Solow, “Technical Change and the Aggregate Production Function,” *Review of Economics and Statistics* 39, no. 3 (1957): 312–20. Gerald M. Meier Konosuke Matsushita Professor of International Economics and Policy Analysis Stanford University (Emeritus), *Biography of a Subject: An Evolution of Development Economics: An Evolution of Development Economics* (Oxford University Press, USA, 2004), 97.

⁹⁸ Albert Hirschman, a German economist on the faculty at Yale (among other institutions) was an exception. In a 1958 book titled *The Strategy of Economic Development*, Hirschman included health as an element of social overhead capital. But he was generally against formalization and remained a non-mainstream (though prominent) voice in the field of development economics. Albert O. Hirschman, *The Strategy of Economic Development* (New Haven: Yale University Press, 1958); Paul Krugman, “The Fall and Rise of Development Economics, Eds. Lloyd Rodwin and Donald Schon,” in *Rethinking the Development Experience: Essays Provoked by the Work of Albert O Hirschman* (Washington, D.C.: Brookings Institution, 1995).

⁹⁹ Randall M. Packard, “Visions of Post-War Health and Development and Their Impact on Public Health Interventions in the Developing World,” in *International Development and Social Sciences: Essays on the History and Politics of Knowledge* (Berkeley, Calif.: University of California Press, 1997), 97, 105-106. Compare this late 1950’s pessimism with writings from the early 1950s, such as the declaration by Harvard epidemiologist CEA Winslow, who in 1952 declared: ‘When we consider on the one hand the wastage of the fruits of human effort with the

experts credence in the classification of health interventions as economic “investments” was, by the late 1950s, waning.¹⁰⁰

f) Arthur Lewis and health as consumption, 1954-1966

A clear articulation of the disbelief among development experts in the “health is wealth” argument came in 1966, when the LSE economist Arthur Lewis published *Development Planning: the essentials of economic policy*. Lewis was already an eminence in the field; his 1954 article entitled “Economic development with unlimited supplies of labor” was—and remains—a fixture in the canon of modernization. His “dual sector model” posited that growth through industrialization could be achieved fastest by drawing in laborers from “backward” rural areas and maintaining them at near-subsistence wages.¹⁰¹ By 1966, he had heard enough from advocates of the “health is wealth” argument to include the following passage:

rearing of children who will die before they are able to make any economic return to society and in the support by those adults who remain in good health, of a large proportion of invalids crippled by preventable disease, it is difficult to see how one can seriously question the importance of the contribution of public health to global prosperity.’ CEA Winslow, *The Economic Values of Preventive Medicine* (Geneva, Switzerland, 1952), http://apps.who.int/iris/bitstream/10665/101988/1/WHA5_TD_Preface_eng.pdf; CEA Winslow, *The Cost of Sickness and the Price of Health*, World Health Organization Monograph Series 7 (Geneva, 1951).

¹⁰⁰ In a 1972 article, Ruderman lamented, “No method is known for comparing returns from expenditure on health, education, agriculture, manufacturing, and other activities, since the only common unit available to measure returns on a single scale is money. Many ingenious efforts have been made to guess at the money value of health activity, but even if it were possible to assign money values to improved health or longer life it is not always possible to identify the direct contribution of health services. Multiple causation must be taken into account and such elements as higher incomes, more food, better housing, and higher levels of education are known to be positively correlated with lower infant mortality, higher life expectancy, and other available health indices.” Ruderman, “*General economic considerations in health planning*,” *International Journal of Health Services*, 1972, page 109.

¹⁰¹ Frederick Cooper, “Modernizing Bureaucrats, Backward Africans, and the Development Concept,” in *International Development and Social Sciences: Essays on the History and Politics of Knowledge* (Berkeley, Calif.: University of California Press, 1997).; and W. Arthur Lewis, ‘Economic development with unlimited supplies of labour,’ *Manchester School* 22, 2 (1954), pp. 139-91.

The social services are desirable in their own right, as a form of consumption, capable of competing with all other forms of consumption, and do not need to be defended as ‘investment.’ This defense, in any case, does not work, since in most cases, notably education and health, the quantity of service which the public seems to want is significantly greater than can be justified in the language of investment...At the margin the social services are consumption rather than investment.¹⁰²

Expanding on this argument, Lewis explained, “One cannot rest the case for medical expenditure in underdeveloped countries primarily on the economic value of the increased number of man-hours which it will provide, since most of them already have as many man-hours as they can cope with.” Lewis thought non-commercial agriculture inherently unproductive, and did not count small farmers as “employed” in his models. To his mind, economic production was in heavy industry and commercial large-scale agriculture, not smallholder farming. Farmers were not economically significant, whether healthy or ill.¹⁰³ There was, he believed, economic utility in some public health measures—in particular water supply improvements, environmental sanitation, and vaccination—as these decreased the prevalence of diseases that made even employed workers less productive while making more land habitable. But, Lewis continued, most governments already invested in these measures, and the question for the development

¹⁰² W. Arthur (William Arthur) Lewis, *Development Planning the Essentials of Economic Policy*, [1st U. S. ed.]. (New York: Harper & Row, 1966). Pages 161-163.

¹⁰³ Lewis explained that the only portion of the population were those who saved their income and thereby helped in the work of capital formation. “The central fact of economic development is rapid capital accumulation (including knowledge and skills with capital)... We are interested not in the people in general, but only say in the 10 percent of them with the largest incomes... The remaining 90 percent of the people never manage to save a significant fraction of their incomes... The central fact of economic development is that the distribution of incomes is altered in favour of the saving class. Practically all saving is done by people who receive profits or rents. Workers’ savings are very small... In the beginning, the national income consists almost entirely of subsistence income. Abstracting from population growth and assuming that the marginal product of labour is zero, this subsistence of income can be yielded up to the expanding capitalist sector without reducing subsistence output. Lewis, “Economic Development with Unlimited Supplies of Labour.” Pages 416-417.; W. Arthur Lewis, “Unlimited Labour: Further Notes,” *The Manchester School* 26, no. 1 (January 1958): 1–32.

planner was whether or not more expensive outlays for curative medicine were merited on economic grounds. The answer, to Lewis, was no.

Lewis spoke from a position of some experience. He had spent a year (1957-1958) in Ghana as an advisor to Kwame Nkrumah. At first he was excited to work with the first black-led postcolonial state in sub-Saharan Africa. But he had quickly become frustrated with what he saw as officials' inability to prioritize interventions, to recognize that with limited resources spending had to focus on projects most likely to spur rapid growth.¹⁰⁴ Given the imperative to focus resources on investment activities, the governments of poor countries could not afford to provide enough general physicians to care for their entire populations.¹⁰⁵ Still, Lewis admitted, as curative medicine was "the part of the medical service with which the public comes most into contact" and "what the public wants most," he allowed that some government spending might go towards it if only in the name of "sentiment."¹⁰⁶

¹⁰⁴ Robert L Tignor, *W. Arthur Lewis and the Birth of Development Economics* (Princeton, NJ: Princeton University Press, 2006). Pages 161-3.

¹⁰⁵ Lewis, *Development Planning the Essentials of Economic Policy*, pages 85-86. Lewis explained he did not actually object to governments building a few expensive hospitals. He thought primary care was actually much more expensive if done comprehensively. The key point, to him, was that health care spending should be recognized as consumption rather than investment. Lewis argued that spending on health was necessary, not for growth, but because: "The rate of growth of public discontent is a logarithmic function of the rate of growth of the ratio of domestic savings to national income... The Government should spend liberally on social services, especially education, health and welfare services, and take aggressive steps to improve working class housing; adequate opportunities for secondary education are especially valued because they give working class families the sense of an opening future."

¹⁰⁶ *Ibid.* 101-103.

The classification of healthcare provision as “consumption” and the general disregard for the role of health in economic growth helped to turn policy advisors and international aid agencies against health projects during the 1950s and 1960s. Sometimes it was just a useful cover for budget cuts. This was evident in Tanganyika’s Development and Welfare Plan for 1950-1956, which recommended a decrease in “social services” [including medicine] from the 16 percent of government expenditure it had claimed in 1947-1949, to 12 percent for the coming seven-year period. Though the decline was motivated in large part by the fact that the UK Colonial Office had made clear that all recurrent expenditure would have to be paid for by territorial revenues, the plan’s authors justified the cut in social service spending by declaring outlays on medical expenditures “are considered to be as large as can reasonably be set aside in view of their non-productive nature, except in the very widest sense of the term.”¹⁰⁷

g) Health as consumption in Nyasaland and Malawi, 1954-1971

Policymakers in Nyasaland during this two-decade period shared this opinion of health’s role as consumption and not investment. In a 1956 speech, Nyasaland Governor Geoffrey Colby explained that he planned to use grants from the UK Colonial Development and Welfare Fund on electricity, roads, communications and piped water in cities—the kinds of investments he believed could spur private enterprise and bolster public revenues—rather than social services.¹⁰⁸ A 1959 “Economic survey of Nyasaland” chaired by the British economist Daniel Jack acknowledged the territory’s inadequate health services but claimed “the need is so great it can only be met fully in the future when Africans are

¹⁰⁷ Beck, *Medicine, Tradition, and Development in Kenya and Tanzania. 1920-1970.*, 201

¹⁰⁸ Geoffrey Colby, “Recent Developments in Nyasaland,” *African Affairs* 55, no. 221 (October 1956): 273–82. Page 274.

able to meet the bulk of the cost themselves.”¹⁰⁹ Health and education were, according to Jack, “unproductive” social services, which should claim a far smaller portion of public budgets than “services on which industry depends.”¹¹⁰

This bright-line distinction between health as a social service, rather than an economic investment, continued after independence. Though the UK Treasury continued to provide budgetary support to the Malawi government from independence in 1964 through 1971, both Banda and the UK government sought to end such assistance as soon as possible; the UK advised spending on activities with rapid budgetary returns, and according to the historian Kathryn Morton these did not include health services.¹¹¹ In the annual reports prepared by Malawi’s Economic Planning Division, health was not even included in the body of the report until 1973, and even then it was included in a chapter entitled “education and social services.”

It can be difficult to trace the intellectual connections between the epistemic framework structuring reports by Malawi’s civil service and the peer-reviewed publications of leading development economists. But in this case, at least one connection is fairly direct. Henry Ord, a University of Edinburgh economics professor seconded to Malawi to serve as President Banda’s Chief Economist in the Economic Planning Division between 1968

¹⁰⁹ D.T. Jack, “Report on an Economic Survey of Nyasaland, 1958-1959” (Ministry of Economic Affairs, Federation of Rhodesia and Nyasaland, 1959), Box 4, No. 6, Society of Malawi Archive., pp. 33. DT Jack was Professor of Economics at the University of Durham, and became a favored expert of Federal Prime Minister Roy Welensky when he needed a pro-Federation voice. At Welensky’s invitation, Jack would serve on the Monckton Commission in 1960.

¹¹⁰ Ibid. Page 61, paragraph 39.

¹¹¹ Kathryn Morton, *Aid and Dependence: British Aid to Malawi*, 1 edition (London: Routledge, 2011). 117-118.

and 1970, wrote that he considered Lewis one of the world's leading theorists of economic planning, and observed that Lewis' writings had long been a mainstay of syllabi in courses on economic planning.¹¹² Like Lewis, Ord advised the government to concentrate its spending on "productive investment projects," namely "transport and power"; health is rarely mentioned in his papers.¹¹³ Malawi's civil service, still heavily European in the late 1960s, was steeped in an intellectual milieu in which health was not an integral component of development. If Malawi did need a "big push" of outside financing to get its economy growing, health interventions were not seen as part of the effort.

V. Conclusion

Historians of medicine have documented many shifts in health seeking behavior impelled by the promise—rather than the proof—of better health outcomes.¹¹⁴ But the history told in this chapter is not one of overblown and un-kept promises. With the arrival of new therapeutics there were diseases cured and sufferings relieved. According to physicians, patients and historians alike, the new drugs of the postwar moment to counter bacterial

¹¹² "Responses to Survey by Henry W. Ord, Conference on the Teaching of Economics, a Survey written by JF Rweyamamu, Dept of Economics, University College, Dar Es Salaam," June 10, 1969, EPD/15/01/Vol II (14-2-8R, Box 20610), National Archives of Malawi.

¹¹³ Henry W Ord, "Some Aspects of Economic Planning: Talk to Rotary Club, Blantyre, Malawi" (Blantyre, Malawi, July 10, 1969), EPD/15/01/Vol II (14-2-8R, Box 20610), University of Edinburgh Archives.

¹¹⁴ For instance, historian Judith Walzer Leavitt has chronicled the growing popularity of physician-attended childbirths among wealthy white women in the United States during the late-eighteenth and early-nineteenth centuries. Convinced that male medical school graduates could shield them from the dangers of childbirth better than midwives, women of means turned in increasing numbers to doctors. Yet, as Leavitt argues, as late as the early twentieth century "physicians' safety record when measured by mortality statistics matched or was worse than the record of midwives, who follow a basically noninterventionist birth policy...physicians, with all their expertise and intervention techniques, did not, as they had promised, enhance safety of the birth experience for women." Judith Walzer Leavitt, *Brought to Bed: Child-Bearing in America, 1750-1950* (New York: Oxford University Press, 1986). Pages 56-57.

and parasitic infections had demonstrable effects on mortality.¹¹⁵ The increase in demand for therapy was not based solely on promised benefits. As the next chapter will demonstrate, Nyasaland's Africans were unlikely to trust the promises of white officials and physicians during the late colonial era, an era of anti-colonial mobilization and profound racial strife. The colonized found proof of medicine's efficacy not in official propaganda, but in experiences of family members and neighbors once on death's door returning home healthy. This newly demonstrated efficacy had profound consequences. In the late colonial moment, medicine moved to the center of Nyasaland's contentious—even deadly—politics.

¹¹⁵ Walsh McDermott, "Medicine: The Public's Good and One's Own," *World Health Forum* 1 (1980): 128; Farmer, Basílico, and Messac, "After McKeown: The Changing Roles of Biomedicine, Public Health and Economic Growth in Mortality Declines."

Chapter 8

Counterrevolutionary therapeutics: medicine as a political palliative under Federation rule, 1953-1963

Abstract

This chapter is a political and social history of government medical care in Nyasaland during its final decade as a colony. During the 1950s and 1960s, recurrent government health spending in Nyasaland rose markedly. But what explains this rise in spending? After all, to many contemporary development experts government spending on curative medicine was fiscally imprudent, inapposite to the goal of GDP growth. Yet leading officials the Federation of Rhodesia and Nyasaland (1953-1963) publicized financial commitments to hospitals and health centers. This chapter argues that increased public outlays on medicine were a response to (and an attempt to quiet) protests among late-colonial African publics, particularly as new chemotherapeutics made government hospitals and dispensaries increasingly popular sources of health care. In the face of popular protests against rule by white supremacists in Southern Rhodesia, the Federation Government spent surprising sums on medicine in Nyasaland. But once the fate of Federation was sealed, officials in Salisbury cut spending and even shipped supplies from Nyasaland to Southern Rhodesia. Once the Federation's propaganda campaign was over, healthcare providers found themselves deprived of the tools of their trade.

Prelude: A brief history of 'medical pacification' in Africa

In southern African history, medicine has often been used to demonstrate good will and secure legitimacy, particularly during moments of great strife and uncertainty. Writing of his dealings with a people in what is today Botswana during his first African expedition (1852-1856), the Scottish missionary physician claimed, "English medicines were eagerly asked for and accepted by all; and we always found medical knowledge an important aid in convincing the people that we were really anxious for their welfare."¹ Livingstone and his acolytes would continue use medicine as such an "aid" when they established missions in present-day Malawi. It was, Livingstone and his followers believed, an important display of the beneficence of European civilization, and a peaceful

¹ David Livingstone, *Missionary Travels and Researches in South Africa : Including a Sketch of Sixteen Years' Residence in the Interior of Africa, and a Journey from the* (London: John Murray, 1857).

counterpoint to the wars they had begun with Yao communities that continued to engage in the East African slave trade.²

Within a few months of establishing the Livingstonia Mission at Cape Maclear (only a few kilometers from present-day Mbeya Village) in 1875, another Scottish doctor, Robert Laws, was performing surgeries on African patients. In his 1921 biography of Laws, William Pringle Livingstone attributes the early support the mission garnered among locals to Laws' medical work: "The natives were quietly taking stock of the white men, observing all their actions, and reading their character more accurately than perhaps they knew. What chiefly won them was the medical work of the Doctor. Stories of his skill and kindness were carried by the few whom he attended and retold in the villages, and one after another they ventured to the Station for medicine."³

French imperialists would come to share this creed about the power of medicine to secure political support, or at least quietus. In 1901, at the height of campaign to quell rebellious subjects in Madagascar, French military official Hubert Lyautey was reputed to have cabled his commanding general the following: "If you can send me four doctors, I will send you back four companies." In his later posts in North Africa, Lyautey became a leading proponent of what the historian Jim Paul has called "medical pacification." In western Algeria and later, as the first Resident General of the French Protectorate of Morocco, he saw medical teams as key components of any invasion or counterinsurgency.

² Livingstone, *David Livingstone's Shire Journal 1861-1864*.

³ Livingstone, *Laws of Livingstonia*. Page 92.

Often the very public demonstrations of goodwill were meant to quell critics of imperialism in Europe as much as restive African subjects. Concluding a speech before a medical audience in Brussels in 1926, shortly after his departure from Morocco, Lyautey described this strategy of pacification in terms both Machiavellian and principled:

From the day when a notable, a *qaid*, or just some suffering devil decides to see a French doctor and leaves his office cured, the ice is broken, the first step is taken, and the relationship begins to be established... Certainly the colonial expansion has its harsh aspects. It is not either beyond reproach or without blemish. But if there is something that ennobles it and justifies it, it is the action of the doctor, understood as a mission and an apostleship.⁴

As the coming chapter will demonstrate, this deployment of medicine as an antidote to political opposition was especially common during the late colonial era. Besieged by wholesale critiques of colonialism from prominent voices in Africa, Europe and the United States, colonial governments sought to propound the virtues medicine as proof of the veracity of the doctrines of “trusteeship” and “development.” Medicine figured prominently in political combat between proponents and opponents of the Federation of Rhodesia and Nyasaland during the 1950s and early 1960s, and it continues to play a major feature of in debates over the nature of late colonial British rule elsewhere in Africa. In a Letter to the Editor of the British daily *The Guardian* in 2012, a veteran British soldier who served in Kenya during the Mau Mau Revolt, objected to the assertion by columnist George Monbiot (drawing on Caroline Elkins’ *Imperial Reckoning*) that “the British detained...almost the entire population of one and a half million people, in camps and fortified villages” where thousands were beaten or left to

⁴ Jim Paul, “Medicine and Imperialism in Morocco,” *Middle East Research and Information Project Reports* 60 (September 1977): 3–12.

die of treatable illnesses.⁵ Allen contended these settlements were not “gulags,” as Elkins had called them, but rather humanely devised villages “where proper security could be provided.” As evidence of British intent, he pointed to the “health centres” built by the British in those new villages, as well as “water supplies...sports grounds, markets and schools.” The provision of health care was the key to Allen’s case. For Allen, the existence of clinics helped prove colonial officials were “fully dedicated to the wellbeing and advancement of the people they served.”

More recently, a number of African regimes have sought to make universal access to public sector health care a cornerstone of the post-conflict social contract. Côte d’Ivoire is one such example. After President Laurent Gbagbo refused to step down after losing an election in November 2010, forces loyal to challenger Alassane Ouattara revolted. An estimated 3,000 people were killed in six months of violence before French forces helped Ouattara’s militia capture Gbagbo in mid-April 2011.⁶ Immediately after Ouattara assumed the presidency, his government announced that long-standing fees at government health clinics had been suspended.⁷ The provision of free care was originally planned to last only until the end of May 2011, but in the government clinics remained free at the point of care for months. But after Laurent Gbagbo (who retained significant political support) been extradited to the International Criminal Court in The Hague in

⁵ George Monbiot, “Deny the British Empire’s Crimes? No, We Ignore Them,” *The Guardian*, April 23, 2012, sec. Opinion, <http://www.theguardian.com/commentisfree/2012/apr/23/british-empire-crimes-ignore-atrocities>; Caroline Elkins, *Imperial Reckoning: The Untold Story of Britain’s Gulag in Kenya*, Reprint edition (New York: Holt Paperbacks, 2005).

⁶ “Laurent Gbagbo: Ivory Coast Ex-Leader Denies War Crimes,” *BBC News*, accessed January 29, 2016, <http://www.bbc.com/news/world-africa-35424653>.

⁷ “Cote d’Ivoire: Free Health Care, for Now,” *IRINnews*, accessed January 29, 2016, <http://www.irinnews.org/report/92701/cote-d-ivoire-free-health-care-for-now>.

November 2011, Ouattara's government felt more firmly ensconced in power. Two months later, in January 2012 the health minister announced the government could no longer afford to maintain the policy of free care. Even after some fees were reinstated, care for mothers and children under six years old remained free.⁸

The most well-documented and dramatic example of the use of health in post-conflict reconstruction is Rwanda. In the decades after leading the invading army that put an end to the 1994 genocide—"the fastest mass extermination in history," in the words of journalist Tom Burgis⁹—Rwandan President Paul Kagame made health care a key priority of his rule. Writing in the pages of the *Wall Street Journal* on April 7, 2014, the twentieth anniversary of the start of the genocide, President Kagame recounted the deliberate efforts his administration had made to integrate health into the long process of reconciliation:

In Rwanda, we are relying on universal human values, which include our culture and traditions, to find modern solutions to the unique challenges we faced in terms of justice and reconciliation following the genocide... We chose to stay together... We passed a new constitution that transcends politics based on division... We extended comprehensive health and education benefits to all our citizens.¹⁰

Facing ongoing threats to internal instability, and external criticism of heavy-handed rule and meddling in Congolese affairs, President Kagame made public sector health care a

⁸ By IRIN part of the Guardian development network, "Ivory Coast Forced to Drop Free Public Healthcare System due to Rising Costs," *The Guardian*, January 27, 2012, sec. Global development, <http://www.theguardian.com/global-development/2012/jan/27/ivory-coast-free-healthcare-ends>.

⁹ Tom Burgis, *The Looting Machine: Warlords, Oligarchs, Corporations, Smugglers, and the Theft of Africa's Wealth* (PublicAffairs, 2015).

¹⁰ Paul Kagame, "Reflecting on Rwanda's Past—While Looking Ahead," *Wall Street Journal*, April 7, 2014, Opinion.

showcase of his government's benevolence and seriousness of purpose. In the immediate aftermath of the genocide the country was the poorest on the planet, political violence persisted and the infrastructure (in health and other areas) was completely wrecked. But even after the improvement of health and economic indices to pre-genocide levels, Kagame's government secured remarkable gains. Between 2000 and 2010 the maternal mortality ratio declined by 59.5 percent. Between 2000 and 2011 the under-five child mortality rate decreased by 70.4 percent. The decline in the crude mortality rate between 2000 and 2012 was the fastest in the world during that period.¹¹ The means by which these feats were accomplished—including high rates of community-based insurance enrollment and vaccination coverage—have been well documented.¹² By 2011, Rwanda devoted a higher share of its government expenditure to health than any other nation in the African Union.¹³ This dissertation suggests that the fact that such intense efforts came in the wake of genocide should not be entirely surprising.

Malawi has not experienced violence on the scale of Rwanda or Côte d'Ivoire in recent decades, but in the wake of its own (more peaceful) political transition the politics of health care showed some similarities. After years of labor strikes and ever more vocal calls from prominent quarters (including the Catholic Church) for an end to Hastings Kamuzu Banda's 30-year-long dictatorship, Malawi's held its first multi-party elections

¹¹ Farmer, Basilio, and Messac, "After McKeown: The Changing Roles of Biomedicine, Public Health and Economic Growth in Mortality Declines."

¹² Agnes Binagwaho et al., "Rwanda 20 Years on: Investing in Life," *The Lancet*, 2014, <http://www.sciencedirect.com/science/article/pii/S0140673614605742>; P. E. Farmer et al., "Reduced Premature Mortality in Rwanda: Lessons from Success," *BMJ* 346, no. jan18 1 (January 18, 2013): f65–f65.

¹³ "Abuja+12: Shaping the Future of Health in Africa" (UNAIDS, July 2013), http://www.unaids.org/sites/default/files/media_asset/JC2524_Abuja_report_en_0.pdf.

in May 1994.¹⁴ Bakili Muluzi defeated the nonagenarian Banda, becoming Malawi's second president. Shortly after taking office, Muluzi took steps to consolidate support among the rural poor (some of whom had seen Banda not as a democrat, but as a protector of material subsistence). He immediately abolished fees at government primary schools. Enrollment at primary schools increased from 1.7 million in 1993 to 3.9 million in 1994.¹⁵ He also refused to follow recommendations by the World Bank to institute user fees at Malawi's health clinics. Whereas Banda had repeatedly told the World Bank he would institute the fees without ever doing so, Muluzi spoke publicly about his disagreement with the Bank, He was particularly vocal about his opposition to user fees in the months leading up to Malawi's 1999 general elections.¹⁶ Heading into an uncertain election, which Muluzi's United Democratic Front would ultimately win, the President clearly wanted his name associated with free health care access for Malawi's people.

But do health services consummate officials' dreams of pacified populace? This chapter suggests the interaction between health and political unrest is more complicated.

Unprecedented expenditure on health could not prevent anti-Federation forces from winning the public support and imperial acquiescence necessary to end the regime they so detested. But, as Chapter 9 demonstrates, the new government of independent Malawi added kindling to an incipient rebellion when it tried to end the long-standing policy of free public sector health care. The provision of health services has not always proven an

¹⁴ Power, *Political Culture and Nationalism in Malawi*.

¹⁵ Bakili Muluzi, *Mau Anga: The Voice of a Democrat : Past, Present & Future* (Pretoria: Skotaville Media, 2002). Page 17.

¹⁶ *Ibid.* Page 183.

effective measure to pacify ongoing unrest, but the denial of public sector health care to the Malawian public has been a potent means to foster discontent. Health services may not be a cure-all for political regimes facing crises of legitimacy, but such regimes ignore health at their peril.

I. Introduction: Disobeying the economists: Malawi health spending peaks in the heyday of modernization

The Federation of Rhodesia and Nyasaland marked a decade-long, and ultimately abortive, political experiment at the close of the Nyasaland's colonial era. Beginning in the interwar years, white settlers in Southern and Northern Rhodesia sought to join their two territories under a single government. By the mid-1930s, white settlers in Nyasaland and then-Governor Harold Kittermaster argued that shared government would bring economic benefits to their territory as well. After putting their efforts on hold during the Second World War, settlers resumed advocacy for a shared regional government in the late 1940s. The white settlers were, as John McCracken explains, increasingly fearful that without a stronger union between their previously separate colonies, the seemingly inevitable move in holdings of the British Empire toward majority rule would sweep them from power. When the Conservatives retook power from Labour in the 1951 UK elections, the Colonial Office's erstwhile objections to a federated government vanished. In 1953, the Central African Federation—including Southern Rhodesia, Northern Rhodesia, and Nyasaland, with a capital in Salisbury—was inaugurated.¹⁷

¹⁷ McCracken, *A History of Malawi*.

The Federation era (1953-1963) coincided with the heyday of modernization theory; as shown in the previous chapter, modernizers tended to view public sector health spending as unproductive consumption. Given the esteem in which modernization theory was held by Federation and nationalist planners alike, it is surprising that health spending as a proportion of government spending rose to new heights during this period (see Figure 0.1). Particularly during the years when Nyasaland was a part of the Federation of Rhodesia and Nyasaland, this ratio reached unprecedented levels. The share of total recurrent government expenditure devoted to the Medical Department's budget rose from 4.2 percent in 1951 to 9.9 percent in 1958, before losing most (though not all) of the gains of the 1950s by falling to 5.7 percent in 1964. Combined with the preceding narrative, these figures reveal a curious fact: Malawi's health spending reached an *apex* (as a share of government revenue) at the very moment when regard for health spending among international development experts was at its *nadir*. The thesis (encapsulated by Keynes' dictum from the beginning of the chapter) that policymakers' prescriptions follow the ideas of academic economists overstates the influence of the latter on the former. As this chapter and the next will demonstrate, the trends in government outlays for health during the Federation and post-independence era had much more to do with local popular politics than with the advice of international advisers.

The relative impotence of the advice of modernization theorists during this period is all the more intriguing because officials in the governments of late-colonial Nyasaland and early postcolonial Malawi read—and actively sought out—the counsel of these leading lights in development economics. These officials believed the modernization theorists

were right about the unproductivity of spending on healthcare, but they devoted more money to it than ever before. Federation officials believed healthcare provision might mollify restive African publics. But if economic experts from the US and UK were unable to dampen outlays for health services in late-colonial Nyasaland and early postcolonial Malawi, the proponents of a new economic orthodoxy tried to shape health spending and health policy in Malawi during the late 1960s and 1970s. This period saw a recrudescence of interest in health among economic experts, but in contrast to the interwar era the most salient aspect of Malawian bodies was neither the microbes in their blood or the emptiness of their stomachs, but the fullness of their wombs (Chapter 9).

This chapter will proceed in three main parts. The first section examines the politics of medicine during the years in which Nyasaland was a part of the Federation of Rhodesia and Nyasaland (1953-1963); during these years, Federation officials in Southern Rhodesia made medicine the cornerstone of their public campaign to prove the beneficence of their rule and the moral depravity of the anti-Federation campaigners. The second section moves to medical practice in Nyasaland under the Federation, where the rhetoric of largesse encountered the quotidian realities of stock-outs and overcrowding. The next section moves to the close of Federation and the dawn of independence, when British officials demanded cuts in spending at public sector health facilities.

II. The tangled politics of medicine and Federation

a) The tumultuous advent of Federation: a partnership between a rider and a horse, 1953

The increase in demand for biomedicine generally and for certain proven treatments in particular, took place during a period of profound political ferment in Nyasaland. Though the construction or renovation of health facilities, the hiring and training of health professionals, and the stocking of pharmacy shelves did not keep pace with the demand, all increased during the 1950s and 1960s. Though medicine became a more central component of colonial development in most parts of British Africa during this period, the increases in spending in Nyasaland during this period were particularly marked. This newfound attention was tied to the fact that the health sector was a central locus of political conflict in the years of the Federation of Rhodesia and Nyasaland (September 1953-December 1963). Both elite urban Africans and rural smallholders in Nyasaland objected to a political system which moved political authority from London to Salisbury, where the white settler government had long presided over a more segregationist and exploitative regime than the UK's Colonial Office had ever pursued. Many Africans in Nyasaland had spent time in Southern Rhodesia; they knew its racist policies. They did not trust Godfrey Huggins, Prime Minister of Southern Rhodesia (and a physician himself), when promised the new federation would be a "partnership" between whites and blacks. Perhaps their concern derived from the fact that shortly after Huggins pledged to the Colonial Office that he would pursue "partnership," he reassured his fellow white settlers that it would be "the partnership between a rider and his horse."¹⁸ So opposed to Federation was Nyasaland's African population that on a tour of British Africa, the

¹⁸ In 1956, when Roy Welensky became Prime Minister of Southern Rhodesia, he spoke of "partnership" as a goal to be attained "over the next two hundred years." LH Gann, "Lord Malvern (Sir Godfrey Huggins): A Reappraisal," *The Journal of Modern African Studies* 23, no. 4 (1985): 723–28. Also see Alex May, *The Commonwealth and International Affairs: The Roundtable Centennial Selection* (Routledge, 2010). Page 107.

traveling writer Joan Wicken wrote, “Nowhere else in East or Central Africa did I find so much bitterness or nationalism among the emerging indigenous population.”¹⁹ This attitude surprised her, “for public discrimination is less widespread [in Nyasaland] than in many other places.” Africans there did not have to carry passes, and the colonial administration had alienated a relatively small portion of the land for European settlers. Wicken ultimately inferred that Nyasaland’s African population must have been so politically charged because they believed they “must do something now before we get into a position like that in Southern Rhodesia.”²⁰

Recognizing a crisis of legitimacy, officials in Salisbury consistently highlighted their concern for health in Nyasaland. At the same time, they sought to pin responsibility for epidemics on anti-Federation organizers.

Some aspects of the formation of the Federation remain a mystery. “For all the hundreds of pages that have been written on the introduction of the Federation,” notes McCracken,” no convincing explanation has yet been provided as to why Whitehall insisted on the inclusion of Nyasaland.” The Bledisloe Commission, convened by the UK

¹⁹ Wicken, “African Contrasts.” Page 23. Also see page 47: “I found not one African who favoured [Federation]..It is Congress which has braches throughout the country, and although it is strongest in the South, yet its influence is felt almost everywhere. And every Congress-man has one theme; Federation Must Go....Several times I tried to get a discussion on the economic benefits of Federation; these were either denied altogether, and economic ills ascribed instead, or they were shrugged off. The association with Southern Rhodesia which it involved was enough to condemn it, for ‘Southern Rhodesia is the country of apartheid.’”

²⁰ Wicken considered Southern Rhodesia’s racial policies indistinguishable from those of apartheid South Africa: “Separate post offices, park benches, counters in shops and the most rigid segregation in residence...Further, every African has to carry not only his general registration book, but also a pass to be in the town and another if he has to be out late in the evening, and sometimes others for special purposes.” Ibid. Pages 23-24.

Government in 1937, found that native authorities, native associations, and other organized groups of Africans in Nyasaland were adamantly opposed to any closer political ties to settler-dominated Southern Rhodesia. In the early 1950s even the Nyasaland Governor Geoffrey Colby, opposed the new union out of fear it would lead to unrest among his colony's African population. The inclusion of Nyasaland was, McCracken believes, likely part of a deal in which British officials agreed to allow Federation in exchange for handing off Nyasaland's debts to the new government.²¹ When, in the years following Federation, Africans in Nyasaland agitated for its dissolution officials in Salisbury reminded them that Britain was in no rush to take on these fiscal burdens again. In a 1962 pamphlet, Federation officials claimed they had included Nyasaland "at the insistence of the British Government... Britain had found the financial burden of the backward and impoverished Protectorate becoming increasingly onerous."²² Whatever the motivation, in 1953 Nyasaland became the unwanted, impoverished, rebellious third member in a Federation dominated by the white settlers of the other two territories.²³

b) Moving the Ministry of Health to Salisbury, 1954

Under the Federal constitution health was a federal, rather than a territorial, responsibility. Many governmental functions—including native and provincial administration, African education, European and African agriculture, fisheries, police,

²¹ McCracken, *A History of Malawi*.

²² *Federation and Nyasaland: The Facts* (Salisbury: Federation of Rhodesia and Nyasaland, 1962).

²³ Other officials—most notably Andrew Cohen, leader of the African Division of the UK Colonial Office under Labour—had written in 1950 that "the creation of a solid British block of territories in Central Africa" would defend against the spread of South Africa's apartheid ideology. McCracken, *A History of Malawi*. Pages 275-6.

environmental sanitation, and social welfare—remained in the portfolio of a Nyasaland's Governor, who answered to the Colonial Office. The Federal Government was to take responsibility for immigration, import and export controls, railways, posts and communications, external affairs, and health. Health was something of an outlier on this list; the general logic of the division of responsibilities was to leave functions “predominantly or exclusively affecting Africans” with the territorial governments.²⁴ But health, which would seem to fit into this category, was placed under the direction of a Federal Ministry of Health based in Salisbury.

The Southern Rhodesian negotiators who helped shape the Federal Constitution had two reasons to favor the designation of health as a federal responsibility. The first was that a Federal health service would be a good propaganda tool of the new government. As early as 1939, Viscount Bledisloe—chair of a 1937 Commission that had argued in favor of a Central African Federation—had argued before the UK House of Lords that Southern Rhodesian settlers were devoted to improving the health and education of Africans.²⁵ By the 1950s, the pro-Federation politicians thought the accomplishments of a Federal health service might help counter those British observers (including Fabian Colonial Bureau

²⁴ Ibid. Also see “Report of the Advisory Commission on the Review of the Constitution of Rhodesia and Nyasaland” (London: His Majesty's Stationary Office, 1960). Appendix VII: Possible Constitutional Changes, Pages 24-28.

²⁵ After criticizing the Northern Rhodesian government's commitment to Africans' health services, Bledisloe said the following of Southern Rhodesia: “You have got a real desire on the part of the white community to develop the country, to improve health conditions...no one can deny that during the last five to ten years there has been most notable progress in all these matters under the lead of the enlightened Prime Minister, Mr. Huggins.” Viscount Bledisloe, *Rhodesia-Nyasaland Royal Commission's Report*, 1939, http://hansard.millbanksystems.com/lords/1939/jul/31/rhodesia-nyasaland-royal-commissions#S5LV0114P0_19390731_HOL_94.

members Rita Hinden and Margery Perham, as well as the Nyasaland-born, London-based physician Hastings Kamuzu Banda) who argued the Federation would spread Southern Rhodesia's regressive racial policies to neighboring territories.²⁶

The second, and more important reason why Southern Rhodesian negotiators pressed to make health a responsibility of the Federal government was that doing so promised to save their own government a good deal of money. The Federation Government was in essence a massive financial transfer from Northern Rhodesia's copper mines (which had been nationalized in the early postwar years) to Southern Rhodesia and, to a lesser extent, Nyasaland. Between 1955 and 1961, Southern Rhodesia received roughly 64 percent of Federal expenditure, though it contributed only 50 percent of Federal revenue.²⁷

Foreseeing this advantageous arrangement, Southern Rhodesian officials at the Lancaster House constitutional negotiations in 1952 were eager to see expensive departments delegated to the Federal government. Northern Rhodesian settlers, who sought

²⁶ In his 1949 anti-Federation tract, Banda wrote the following of Godfrey Huggins, Prime Minister of Southern Rhodesia: "Is it not...reasonable to suppose that a man who has so vigorously and persistently pursued a policy of discrimination and segregation in Southern Rhodesia will extend this policy to Nyasaland and Northern Rhodesia?" Hastings Kamuzu Banda and Harry Nkumbula, *Federation in Central Africa* (London, 1949). Also see Philip Short, *Banda* (Boston: Routledge & Kegan Paul, 1974), 57-58; and Wood, *The Welensky Papers*, 146.

²⁷ According to Pearson and Taylor, Northern Rhodesia contributed the other 50 percent of the revenue, but received only 28 percent of expenditure. Nyasaland contributed almost none of the Federal government's revenue, and received 7.8 percent of the expenditure. See D.S. Pearson and W.L. Taylor, "Break-up: Some Economic Consequences for the Rhodesias and Nyasaland" (Salisbury, Southern Rhodesia: The Phoenix Group, 1963). Hazlewood and Henderson have slightly different statistics, which show Nyasaland did make payments to the federal government, of about £2-3 million per year. See Arthur Hazlewood and PD Henderson, "Nyasaland: The Economics of Federation," *Bulletin of the Oxford University Institute of Statistics* 22, no. 1 (1960). Also see William Roger Louis, "Misconceived Dominion: The Creation and Disintegration of Federation in British Central Africa," in *The Transfer of Power in Africa: Decolonization 1940-1960*, Eds. Prosser Gifford and William Roger Louis (New Haven: Yale University Press, 1982). Pages 215-216.

amalgamation with Southern Rhodesia in order to defend their place in the racial hierarchy, agreed, as did the UK and Nyasaland negotiators present.²⁸

Federal control over health took effect on July 1, 1954. Thereafter, health budgets for the three territories were decided by the Federal Parliament, a legislature designed to protect settler interests. The Parliament consisted of 35 members, 26 of whom were elected by European settlers in their respective territories. Nyasaland had only seven members of parliament. Four of these were elected by European settlers, while the Governor nominated two Africans and one missionary. The missionary was ostensibly selected to represent “African interests.”

c) “Our Mr. Chirwa must, like Oliver Twist, ask for more”: African discontent over health in an era of expansion, 1954-1960

In many ways, this was an unlikely historical moment for rapid increases in health sector spending. As was discussed in Chapter 7, the tenets of modernization theory—ascendant in the academy and among Western aid agencies during this period—referred to state appropriations for health as “consumption” that did not contribute urgent aim of increasing aggregate production. This argument against health expenditure on Africans beyond tax revenues garnered from Africans themselves recurred during the Federation years. A 1960 economic survey of Nyasaland, commissioned by the Federal Government and led by the University of Durham economics professor—and Federation apologist—Daniel Jack, explained that Nyasaland “is already receiving better health services than it can afford to pay for on account of heavy expenditure by the Federal Government, but the

²⁸ J.R.T. Wood, *The Welensky Papers: A History of the Federation of Rhodesia and Nyasaland* (Durban: Graham Publications, 1983). Pages 256-257.

need is so great that it can only be met fully in the future when Africans are able to meet the bulk of the cost themselves.”²⁹

Yet under Federation rule, spending on services in Nyasaland (including medical services) was *not* tied to taxation. In net terms, Nyasaland received more funding than it contributed to the Federal budget, and officials in Salisbury eagerly took every opportunity to remind anti-Federation African leaders of this fact. In the very first month of Federal responsibility for health, Manoah Chirwa, one of the two African members of parliament from Nyasaland, complained that African interests had been neglected in the Federation budget.³⁰ Reverend Percy Ibbotson, a white missionary selected to represent Southern Rhodesia’s “African interests,” chided Chirwa for his “slight exaggeration” and proceeded to list the projects related to African health and welfare slated for construction under the Public Works Vote. He also noted that even prior to Federation, the Southern Rhodesian government estimated it spent five times as much on African health, education, and welfare as it collected from Africans in taxes.³¹ An anonymous Letter to

²⁹ Jack, “Report on an Economic Survey of Nyasaland, 1958-1959.” Professor Daniel Jack became a leading defender of the Federation Government. In 1960, Prime Minister also tried to shape the findings the Advisory Commission for the Review of the Constitution of the Federation of Rhodesia and Nyasaland (also known as the Monckton Commission) by appointing Jack. Roy Welensky, *Welensky’s 4000 Days: The Life and Death of the Federation of Rhodesia and Nyasaland* (London: Collins, 1964). Page 692.

³⁰ During the Federation years, anti-Federation African members of the Nyasaland legislature criticized the inadequacy of medical services, though they were often ruled out of order when they tried to do so. These members also decried discrimination against African medical staff and African politicians and the dearth of medical specialists. They also claimed that African and European medical practitioners were opposed to working for the Federal government. See Baker, “The Government Medical Service in Malawi.”

³¹ “Mr Chirwa Exaggerates about African Neglect,” *Nyasaland Times*, July 20, 1954. Federation officials hastened to point out that in net financial terms, Nyasaland received more than it contributed to the Federation budget. According to a Ministry of Information pamphlet published in Salisbury, between 1954 and 1962, Nyasaland contributed £6 million, or 1.4 percent, of the

the Editor of the Nyasaland *Times* (signed by “Thoughtful, Limbe”), repeated Ibbotson’s statistics and concluded “Africans cannot have much to complain about in the provision of essential services. Our Mr. Chirwa must naturally ask for more, like Oliver Twist, but even he must agree that the Federal Development Plan coupled with the local projects in our own estimates, give Africans a very wide range of services that would take a long time to be paid with taxation.”³²

d) Health spending as a political palliative

Why might Federation government officials have felt the need to tout spending on the health sector in Nyasaland? As is evidenced by Ibbotson’s response to Chirwa, they did it to demonstrate beneficent intentions while countering accusations of neglect and exploitation. From the outset, the Federation Government was unpopular among Africans in Nyasaland. Hastings Kamuzu Banda had penned arguments against Federation beginning with a letter to the Bledisloe Commission in 1938. By 1949, as a doctor with a thriving practice in North London, Banda co-authored a pamphlet outlining his opposition to Federation.³³ In April 1953, just before the Federation came into being, the Nyasaland African Congress (NAC) organized a non-violent resistance campaign that included a strike by civil servants and farm laborers as well as boycotts of tax payments and purchases at European-owned stores.³⁴

Federation’s total ordinary recurrent revenue. During that same period, it received £41 million in Federation expenditure. *Federation and Nyasaland: The Facts*. Federal spending in Nyasaland

³² “Letter to the Editor: Should Taxes Pay for Services?,” *Nyasaland Times*, July 27, 1954.

³³ Banda and Nkumbula, *Federation in Central Africa*.

³⁴ McCracken, *A History of Malawi*., 330.

The NAC's campaign happened to coincide with growing resistance among smallholder farmers to other colonial policies. Chief Gomani of Ncheu told his people to disregard unpopular soil erosion regulations enacted by the Department of Agriculture (see Chapter 2). In May 1953 Geoffrey Morton, a colonial policeman who had become famous in 1942 after men in his command killed Zionist militant Avraham Stern in Palestine, went to Ncheu with thirty constables to apprehend Gomani. But Morton's mission ended in failure, as a crowd fended off the policemen while the chief escaped.³⁵ Though the agricultural regulations preceded the Federation, and though they were the work of Kettlewell and Colby far more than Federation officials, the NAC leadership linked opposition to the agricultural regulations with the anti-Federation campaign. In the Lower Shire Valley, women could be heard singing a song promising "death" to the "Federation *capitãos*" and to the "contour ridging *capitãos*."³⁶

None of these protests succeeded in preventing the advent of the Federation in August 1, 1953. But unrest—spurred by a variety of grievances—continued. In mid-August on the European-owned tea and tobacco estates of southern Nyasaland, African tenants (many of whom had come from Mozambique in previous decades) rebelled against increasing labor demands and shrinking land allocations. The tenants were particularly enraged by two stories, one of a plantation manager who had stripped naked a woman he had found collecting firewood on his estate, and another a rumor of a planter who had killed two

³⁵ John McCracken, "Coercion and Control in Nyasaland: Aspects of the History of a Colonial Police Force," *The Journal of African History* 27, no. 1 (1986): 127–47. Page 138.

³⁶ *Magomero*. Page 217. *Capitão* is a Portuguese word meaning "master" or "captain." The tea and tobacco estates were close to the border Portuguese East Africa (Mozambique), from whence many of the tenants had emigrated in previous decades, hoping to escape the even more demanding exploitative taxation and forced labor regimes of that colony.

men who were stealing oranges. These stories confirmed the commonly held image of whites as *chifwamba* (cannibals), seeking African bodies. After many tenants refused to work on the estates, strikes spread to the railway as well as a plywood factory. Gangs of men blocked roads with trees and trenches, cut telephone wires, destroyed the homes of a half dozen chiefs, vandalized European-owned homes and businesses, and beat tax collectors. With Nyasaland's police overwhelmed while the colony's troops fought Chinese guerillas in Malaya, Governor Geoffrey Colby had to request policemen from neighboring colonies to reassert control. They did so, but only after killing 11 Africans and injuring 72 more.³⁷

These kinds of mobilization were far more concerning to colonial officials than the *mchape* movement of the early 1930s (see Chapter 4). Unlike *mchape*, the work stoppages and sabotage campaigns of 1953 threatened both the profits of settler companies and the authority of the colonial state. While most officials in London and Zomba were content to focus on tax collection and budget retrenchment in Nyasaland during the 1930s and 1940s (even as they responded with increased health spending to riots in the West Indies and West Africa), the unrest of 1953 impelled Governor Colby and Federal Prime Minister Huggins to seek to expand both policing and health services in order to quell unrest in Nyasaland.

The police force remained a territorial responsibility under the Federal Constitution, so Colby worked to expand the police force. In 1954 Nyasaland's Police Commissioner,

³⁷ McCracken, *A History of Malawi*. Page 313.

Charles Apthorp, established a branch, called the Police Mobile Force, consisting of 14 European officers and 200 Africans. The main qualification was experience in battle. Most of the officers had served in Palestine before coming to Nyasaland, and each of the Africans had served at least five years in the Army. The force, designed for ‘use in disturbed areas,’ was quickly deployed to the restive southern districts, often beating villagers in house-to-house raids. By 1958 an expanded Mobile Force was tasked with patrolling the country to help enforce agricultural rules and put down civil disobedience.³⁸

But, as Bourdieu observed, the carceral “right hand” of the state is often accompanied by welfarist “left hand.”³⁹ In Nyasaland’s case, health services were not nearly so robust as in Bourdieu’s France (nor were they simply tools of state social control), but officials in Zomba and Salisbury did tout them in an effort to draw attention away from popular discontent. Government officials made medicine the symbol of imperial virtue, often in lavish ceremony and florid language. Built at a cost of £702,000, the Queen Elizabeth Central Hospital was dedicated at a ceremony attended by the Queen Mother in Blantyre in 1957, and opened to patients in 1958 (Figure 8.1).

The years after the start of Federation also saw rapid increases in spending on health, both in absolute terms and in the percentage of public spending. Recurrent Medical Department expenditure in Nyasaland more than quadrupled between 1951 and 1958,

³⁸ McCracken, “Coercion and Control in Nyasaland: Aspects of the History of a Colonial Police Force.”

³⁹ Pierre Bourdieu, *Acts of Resistance: Against the Tyranny of the Market*, Trans. Richard Nice (New York: The New Press, 1998).



Figure 8.1: Queen Mother planting a rose tree on hospital grounds of Queen Elizabeth Hospital, Blantyre, Nyasaland, 1957. Source: Central African Journal of Medicine, August 1957.⁴⁰

increasing from £233,000 to £798,000 in that period (Figure 8.2).⁴¹ Recurrent medical expenditure as a total of total recurrent expenditure (including territorial expenditure as well as Federal expenditure on Nyasaland) increased during this period, rising from 7.3 percent in 1952 to 9.9 percent in 1958.⁴² New construction of hospitals and dispensaries also accelerated. While the Nyasaland Medical Department's capital expenditure (on new hospitals and dispensaries and equipment) totaled £26,082 in 1953, by 1959 this figure

⁴⁰ "Mr Chirwa Exaggerates about African Neglect," *Nyasaland Times*, July 20, 1954.

⁴¹ Harry S. Gear, "Some Problems of the Medical Services of the Federation of Rhodesia and Nyasaland."

⁴² Hazlewood and Henderson, "Nyasaland: The Economics of Federation"; Jack, "Report on an Economic Survey of Nyasaland, 1958-1959."

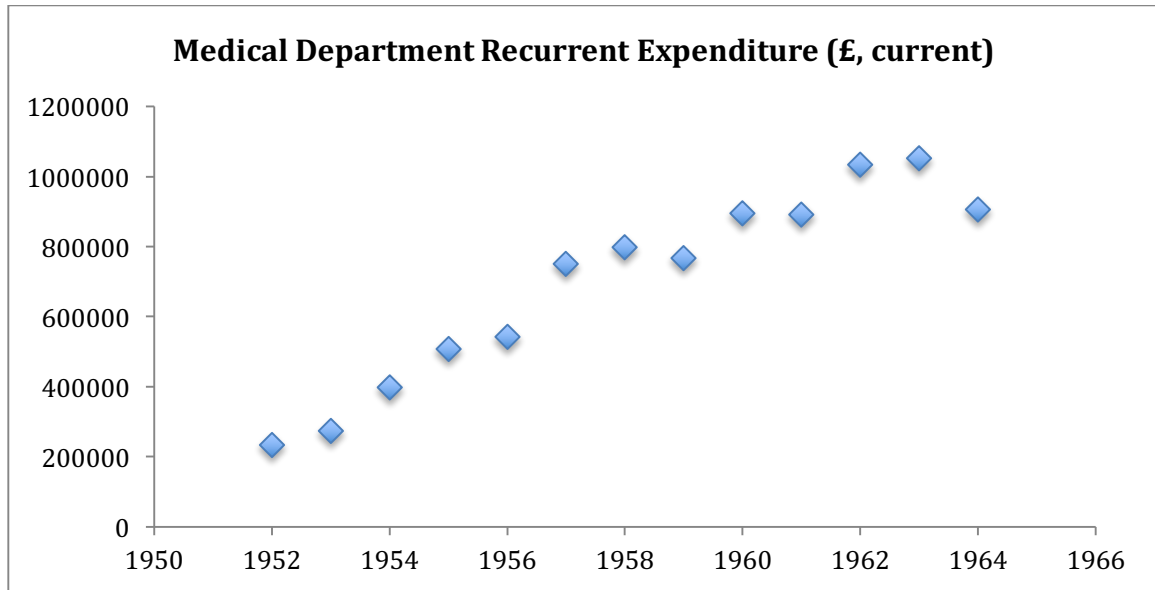


Figure 8.2: Medical Department recurrent expenditure, 1952-1964. Note: Years 1952-1958 drawn from Daniel Jack, *Economic Survey of Nyasaland*, 1959. Table 15. Years 1959-1964 drawn from Malawi Ministry of Health, *A Conspectus*, 1965.

had risen to £198,554.⁴³ All in all, the increase in medical expenditure during Federation era far outpaced the expansions of the interwar or post-independence periods.

Despite the increase in medical spending, opposition to the Federation Government continued. Nyasaland was a net recipient from the Federation budget, but Africans scarcely felt like beneficiaries from this arrangement. Rural Africans opposed the continuation of the *thangata* system and the harsh enforcement of *malimidwe* regulations. Native poll tax rates increased during the Federation years, from 17s-6d in 1954 to 30s in 1961.⁴⁴ Indirect tax increases and cuts to maize subsidies disproportionately affected

⁴³ Harry S. Gear, "Some Problems of the Medical Services of the Federation of Rhodesia and Nyasaland." The 1953 figures include UK Colonial Development and Welfare funds, while the 1959 figure includes only Federation expenditure.

⁴⁴ GF Pollard, "Letter to the Editor from District Commissioner, Blantyre District," *The Times (of Nyasaland)*, August 27, 1954, MNA; David TT Frost, "The Economic Outlook for Nyasaland," *Race & Class* 4, no. 2 (1963): 59-72. Page 61.

Africans. At the same time, spending on social services (particularly on education) favored Europeans.⁴⁵

In any case, to many of Nyasaland's Africans the problem with Federation lay not in fiscal policy. They fundamentally resented being ruled by avowed white supremacists in Southern Rhodesia. In July 1958 Hastings Kamuzu Banda returned to Nyasaland to a hero's welcome, after a cadre of young anti-Federation organizers had deliberately built him into a sort of Messiah that could garner the support of rural Africans. Banda and other members of the recently formed Malawi Congress Party toured the nation, denouncing the "stupid Federation."⁴⁶ SJ Kaphale was, in 1958, a 24-year-old schoolteacher. He was among the crowd at Chileka airport outside Blantyre to welcome Kamuzu back to Nyasaland after a half-century abroad. In a 2013 interview, Kaphale recounted his political commitments in that moment:

In those days, the colonial government, once you misused cultivation in the garden, without putting bunds or, you were taken to prison, and they would uproot your entire maize stock. So when you come back, after six months, you get nothing. You are hungry. So we were not happy about what the colonial government was doing. So that is why we stood hard, fighting against the colonial government so that we should have our own government.⁴⁷

In March 1959, rumors circulated among settlers that members of the MCP were plotting a massacre. Nyasaland's Governor's declared a "State of Emergency," and imposed martial law. Hundreds of Africans (including Kamuzu) were imprisoned, and over 50

⁴⁵ William J. Barber, "Federation and the Distribution of Economic Benefits," in *New Deal in Central Africa*, Eds. Colin Leys and Cranford Pratt (New York: Frederick A. Praeger, 1960), 81–97. Exploitation also took other forms.

⁴⁶ Short, *Banda*.

⁴⁷ SJ Kaphale, Oral history interview conducted by Luke Messac in Matandani Village, Neno District, Malawi, July 14, 2013.



Figure 8.3: Protest during Nyasaland's State of Emergency at Chileka airport, Blantyre, 26 January 1960. Source: HK Banda Archives, University of Indiana Library.

were killed.⁴⁸ During the State of Emergency, protests continued (see Figure 8.3), as Africans called for Kamuzu's release and an end to Federation rule.

In the midst of the resurgence of unrest, Federation officials redoubled their efforts to demonstrate legitimacy (to Whitehall as well as Nyasaland's Africans) by increasing health spending, and by publicizing this spending. Recurrent expenditure on Nyasaland's Medical Department rose from £766,329 in 1959 to £1,034,549 in 1962. This spending also showed health to be a greater priority in government budgets than ever before.

⁴⁸ SJ Kaphale, Oral history interview conducted by Luke Messac in Matandani Village, Neno District, Malawi, July 14, 2013.

Medical Department expenditure accounted for 9.9 percent of Nyasaland's total recurrent expenditure (including both the Federation and territorial budgets) in 1958.⁴⁹

Health also occupied a central position in official rhetoric during and after the State of Emergency. On New Year's Day in 1960, the *Nyasaland Times* announced that the new 90-bed Nkata Bay District Hospital was "virtually complete"; it had been built, the article noted "with funds provided by the Federal Government," and it had "a modern operating theatre and X-ray plant."⁵⁰ That same year, Dr. Harry S. Gear, who had been a senior official in South Africa before leaving government to become assistant Secretary-General of the World Health Organization, penned an essay in the pages of the *Lancet*, declaring: "Medicine's true teachers and disciples give more to Africa than medical care in a hospital or clinic. Their integrity and philosophy are a demonstration of the goodness to be found in their culture."⁵¹ Citing *Proud Record*, an apologia written by Southern Rhodesian physician Michael Gelfand and published by the Government Printer in Salisbury, the *Nyasaland Times* announced in May 1960 that there was "twice as much for health" in 1958 as in the year before federation (1952).⁵² Recognizing that the ultimate fate of their regime lay in the hands of London-based officials, Federation officials ran advertisements in British dailies. One such ad, in the November 23rd edition

⁴⁹ "A Conspectus Including the Development Plan for 1965-69" (Blantyre: Ministry of Health, June 14, 1965), MNA.

⁵⁰ "Nkata Bay Hospital," *Nyasaland Times*, January 1, 1960, MNA. Page 1.

⁵¹ Harry S. Gear, "Medicine and the New Africa: The Passing of Colonialism South of the Sahara," *The Lancet*, Originally published as Volume 2, Issue 7158, 276, no. 7158 (November 5, 1960): 1020-23. Page 1023. Gear also spoke of the "flood of patients" and the "hordes" that the Federation was treating in African hospitals and dispensaries. Harry S Gear, "Some Problems of the Medical Services of the Federation of Rhodesia and Nyasaland."

⁵² "Twice as Much for Health," *Nyasaland Times*, May 24, 1960. Also see Gelfand, *Proud Record*.

of the *Evening Standard*, made health care facilities a barometer of benefits of the Federation to African subjects: “Only a rapidly expanding Federal economy can provide the educational and health facilities and employment needed by this rapidly growing population...The health service has been greatly extended.”⁵³

Federation Prime Minister Roy Welensky lost no opportunity to brandish health care as a political weapon. He spoke of the “diagnostic X-rays and simple laboratories and operating theatres” that had become “a *sine qua non* at all hospitals from the district level upward.” He concluded that the Federation had “made a very great effort” in expanding the capacities of the health sector.⁵⁴ He made clear links between his own efforts to highlight public sector medical provision and the need to quell social unrest. Speaking in the immediate aftermath of Nyasaland’s State of Emergency, he noted “the time is now more than ripe for the Federation to take a completely fresh look at what the nation now has provided in capital works and all the recurrent expenditure that results therefrom in the provision and maintenance of the...services and facilities, staff to run the institutions, drugs, food for the patients and all the other items that contribute to the total cost of providing hospital services.”⁵⁵

⁵³ The advertisement was quite explicit in linking the health benefits of Federation to the quest for continued legitimacy. In bold letters at the end of the ad, the copy read: “It would be a tragedy for all races in the Federation if this remarkable progress were stopped or reversed, if these great achievements were nullified, if economic and financial order were to break down and give way to chaos.” Federation of Rhodesia and Nyasaland, Office of the High Commissioner. “The first steps in Central Africa: Let facts have a hearing,” *Evening Standard*, November 23, 1960. Page 20. BL Newspaper Collection.

⁵⁴ Welensky, “National Health Development.” Pages 7-8.

⁵⁵ *Ibid.* Pages 7-8.

By early 1962, Federation officials were engaged in a last-ditch struggle to maintain a regime on the verge of dissolution. Wearing by years of rebellion in restive territories, particularly Mau Mau in Kenya and the Emergency in Malaya, the UK Government under Conservative Prime Minister Harold MacMillan had long signaled his preparedness to grant independence to many of the Empire's remaining holdings. As early as January 1960, after a visit to Nyasaland, MacMillan had a dour opinion of "the cause of Federation." It was, he observed, "almost desperate because of the strength of African opinion against it."⁵⁶ In response to Macmillan's acknowledgement of a "wind of change," the Ministry of Information in Salisbury published a pamphlet on the benefits of the Federation to Nyasaland. The introduction sounded like a plea: "In light of current developments...it now seems opportune to survey the tremendous benefits Nyasaland has received from Federation and what the cost would be should that Territory decide to break away."⁵⁷ The first chapter was a paean to the growth of the health sector. The pamphlet told of "the human drama of the most undeveloped and backward part of the Federation being lifted in less than a decade to a parity in health services with its more highly industrialized and sophisticated neighbors."⁵⁸

e) Did the Malawi Congress Party sabotage health? 1959-1962

It was during this period (the early 1960s), as the Malawi Congress Party gained popular support and the Colonial Office edged closer to dissolution of the fractious Federation, that Federation officials in Salisbury and Zomba accused Banda and other MCP leaders of denying patients access to health facilities. In a session of Nyasaland's Legislative

⁵⁶ McCracken, *A History of Malawi*, 384.

⁵⁷ *Federation and Nyasaland: The Facts*.

⁵⁸ *Ibid.*

Council in July 1960, Michael Blackwood said MCP members were forcing sick African patients to leave government and mission hospitals. Turning to MCP members on the council, he chided, "I hope you are ashamed of this."⁵⁹ Nyasaland Governor Glyn Jones claimed similar acts of "foul and monstrous" intimidation had occurred in the Central Province, where a pregnant woman was made to deliver her child in the bush and the superior of the mission had warned personnel against reporting such incidents to the police. Kanyama Chiume, the MCP's Publicity Secretary, denied the accusations, calling them "a pack of fabrications like the massacre plot [a reference to an alleged plot to kill Europeans that officials had used in 1959 to declare a State of Emergency] to try and discredit the Malawi Congress Party in the eyes of the world."⁶⁰

Accusations against the MCP only grew more heated in the coming months. In October 1960, the *Nyasaland Times* reported that a compulsory smallpox vaccination campaign had run into opposition in the Central Province: young children ran away from vaccination teams; a Native Authority told another team to leave his area before they could do their work; and another team was chased and stoned by a crowd.⁶¹ Initially this resistance was reported without any mention of the Malawi Congress Party. But by late November, the pro-Federation *Nyasaland Times* blamed the opposition to smallpox vaccination on "intimidation" by "Malawi Congress Party followers."⁶² On December 6,

⁵⁹ "Sick Had to Leave," *Nyasaland Times*, July 8, 1960. Page 1.

⁶⁰ "Government Doing Everything Possible," *Nyasaland Times*, July 8, 1960.

⁶¹ "Death by Smallpox Is Stalking Nyasaland," *Nyasaland Times*, October 11, 1960, MNA.

⁶² "Have Your Child and Yourself Vaccinated," *Nyasaland Times*, November 25, 1960, MNA. Pg



Figure 8.4: Infant with smallpox, Central Province, Nyasaland. Source: Nyasaland Times, December 6, 1960, MNA.

the *Times* ran a front-page photo of an African infant suffering from smallpox (Figure 8.4). Below the horrifically pock-marked body, a caption read:

Take a good look at this little pain-ridden child. He's barely six months old—and will be scarred for life if he does not die. This picture is not a 'Federal' picture. It was taken by a man with no political axe to grind. Take another good look at smallpox and remember the handiwork of political agitators in the Central Province of Nyasaland.⁶³

Public health reports and medical publications echoed the accusation of “political” sabotage of the campaigns, though they did not always explicitly name the MCP as the culprit. The *Annual Report on Public Health in the Federation for 1960* lamented, “Attempts to bring the outbreak under control were hampered by the political unrest and the incitement and intimidation of the people to evade and disrupt vaccination

⁶³ “Infant with Smallpox, Central Province, Nyasaland,” *Nyasaland Times*, December 6, 1960, MNA. Page 1.

programmes. Apart from the circulation of rumours that vaccinations were intended to cause sterility and death, there were many instances of active hostility and on several occasions teams had to be withdrawn for their protection.”⁶⁴ Writing in the pages of the *British Medical Journal* in July 1961, months after resistance to vaccination had ceased, J. Mowat Sword, the Senior Medical Officer for the Central Province, attributed the smallpox “epidemic” to “political opposition to vaccination campaigns.”⁶⁵

A full-throated denunciation of MCP interference in the health sector is found in the 1962 pamphlet *Federation and Nyasaland: The Facts*, which refers to health in Nyasaland during the Federation as a “Success—marred by politics.” After recounting statistics on the increases in spending, patient attendance, and new facilities, the pamphlet lamented:

But this happy picture was sadly marred some 18 months ago when a campaign of disturbance and intimidation was started against the Federal health services... The efforts of Ministry of Health teams to vaccinate the people of Nyasaland against smallpox and other diseases were largely frustrated by leading officials of this political party who, while taking great care to obtain their own vaccinations, travelled around the country, urging villagers and schoolchildren to boycott the vaccinators... Nyasaland’s Minister of Education refused to allow the staff of the Federal Ministry of Health to visit African schools for that purpose and, in some areas, smallpox epidemics broke out among schoolchildren, and many of them died as a result.⁶⁶

The Federation pamphlet argued, “The attitude of extremist politicians in Nyasaland is that if health services have to be Federal Government ones they would rather have no

⁶⁴ DM Blair, “Annual Report on the Public Health of the Federation of Rhodesia and Nyasaland for the Year 1960” (Salisbury, Southern Rhodesia: Government Printer, May 27, 1961), BL. Page 9.

⁶⁵ J Mowat Sword, “Smallpox in Central Province, Nyasaland,” *BMJ*, July 15, 1961, 165–66.

⁶⁶ *Federation and Nyasaland: the facts*. This publication also accused MCP leaders serving in government of refusing to adopt a Federal scheme of freely distributed oral vaccine for children living in urban areas against polio. The pamphlet charged further that the MCP ministers had refused to allow a chosen site for a new leprosarium to be assigned to Federal authorities, thereby delaying construction of the facility.

health services at all.” But, it continued hopefully, “with the wonderful hospital facilities all over the country, and the experience of the deaths from smallpox of unvaccinated children...the people of Nyasaland...are becoming more and more aware of the anarchy in health matters which would arise once the Federal services were completely taken away.” The use of health services as a symbol of legitimacy and beneficence was now explicit.

Malawi Congress Party leaders denied these charges in their entirety. In the pages of *Tsopano*, an MCP newsletter, Publicity Secretary Kanyama Chiume called the accusations “unfounded and false.” Instead, he countered, “it was a man with UFP [Welensky’s party] sympathies, perhaps employed as an *agent provocateur*, who went to persuade people not to accept vaccination as it would cause sterility” to incite the people to boycott the vaccination teams. Far from being the culprits, he continued, MCP leaders were the saviors: “It is our officers who helped to save the situation.” Aboard a taxi bearing the flag of the party, the Provincial Chairman of the MCP had taken a vaccination team to a resistant village, “and since that time, work has been going on smoothly.” The entire “comic opera,” Chiume wrote, was an attempt to slander Dr. Banda and the MCP, similar to the “massacre plots” that served as pretext for the State of Emergency. Turning the charge of sabotaging health against the Federation, Chiume chided, “This sort of thing must come to an end so that...the nation can canalize the energy of its people into

doing those things that can and will eradicate poverty, disease and ignorance in the country.”⁶⁷

Historian John McCracken and Banda biographer Philip Short both dispute the charge of MCP intimidation. Resistance to vaccination was, McCracken argues, “more an expression of popular mistrust than the result of political action.”⁶⁸ Given the contemporary reaction to agricultural regulations and the imposition of the Federation government, compulsory vaccination campaigns were likely to face as least as much opposition as they had in the past.⁶⁹

The resistance was also likely a function of the demonstrable lack of efficacy of vaccination. Africans in Nyasaland had long experience with smallpox vaccination. Compulsory since 1908, it was the only vaccine that black Malawians routinely received prior to 1973.⁷⁰ The inability of government-run campaigns to prevent recurrent epidemics had become evident to many Africans by the first decade of the twentieth

⁶⁷ Kanyama Chiume, “Smallpox: The Truth,” *Tsopano*, January 1961. Page 7.

⁶⁸ McCracken, *A History of Malawi*; Short, *Banda*.

⁶⁹ In addition, popular opposition to coercive smallpox vaccination was by no means unique to Nyasaland or to Africa. Histories of Europe, the United States and South Asia provide ample evidence that such campaigns have been disrupted without the concerted efforts of political parties. For an example of resistance to smallpox vaccination in the nineteenth-century United States, see J. W. Leavitt, “Politics and Public Health: Smallpox in Milwaukee, 1894-1895,” *Bulletin of the History of Medicine* 50, no. 4 (1976): 553–68.. For a contemporary episode in England, see D Porter and R Porter, “The Politics of Prevention: Anti-Vaccinationism and Public Health in Nineteenth-Century England,” *Medical History* 32, no. 3 (July 1988): 231–52. For an account of opposition to coercive vaccination in South Asia during the last stages of the global Smallpox Eradication Programme in the 1970s, see P. Greenough, “Intimidation, Coercion and Resistance in the Final Stages of the South Asian Smallpox Eradication Campaign, 1973-1975,” *Social Science & Medicine* (1982) 41, no. 5 (September 1995): 633–45.

⁷⁰ Alister C. Munthali, “Determinants of Vaccination Coverage in Malawi: Evidence from the Demographic and Health Surveys,” *Malawi Medical Journal* 19, no. 2 (June 2007): 79–82.

century (see Chapter 1). By the 1930s, official reports of “evasion” and even refusal to submit to compulsory vaccination were commonplace.⁷¹ Another intensive campaign had been launched in the Central and Southern Provinces in 1948, but a new epidemic arose less than a decade later, in 1956. When vaccinators returned to affected villages in Kasungu in 1956, they found “a great deal of prejudice against vaccinations. The women and children run away and hide in the bush until the vaccinators have left. Some of the villages have been visited five or six times without managing to vaccinate all the inhabitants.”⁷²

It is unsurprising then, that in the midst of the State of Emergency in 1960, rural Africans in some villages would again prove unwilling to submit to a procedure of seemingly dubious merit administered by a regime that had already shown nefarious intent through mass incarceration.⁷³ Compulsory vaccination (as well as the burning of huts of smallpox cases) resembled other forms of commonly practiced coercive state action, including tax collection, forcible labor recruitment or door-to-door beatings by the Police Mobile

⁷¹ HG Bevan-Pritchard, “Letter on ‘Evasion of Smallpox Vaccines,’” 1930, M2/5/16, MNA. In John Lwanda, “Politics, Culture and Medicine in Malawi: Historical Continuities and Ruptures with Special Reference to HIV/AIDS,” 2002, <http://www.era.lib.ed.ac.uk/handle/1842/1792>. Also see Vaughan, “Health and Hegemony: Representation of Disease and the Creation of the Colonial Subject in Nyasaland.” Pages 185-187.

⁷² RM Morris, “Annual Report on the Public Health of the Federation of Rhodesia and Nyasaland for the Year 1956” (Salisbury, Rhodesia: Government Printer, 1957), BL. Page 15.

⁷³ Kanyama Chiume, “Smallpox: The Truth,” *Tsopano*, January 1961. Also see Blair, “Annual Report on the Public Health of the Federation of Rhodesia and Nyasaland for the Year 1960.” Pages 9 and 13. It should be noted that the (often harsh) control measures might have been quite effective at stemming the smallpox epidemic; Federation statistics indicate that the 1956-60 smallpox outbreak (10,264 cases, 1,739 deaths) was not nearly as deadly as two earlier outbreaks, from 1930-36 (20,861 cases, 762 deaths) and 1945-51 (10,264 cases, 1739 deaths).

Force. While voluntary curative medicine at hospitals and dispensary was becoming increasingly popular in Nyasaland, compulsory vaccination was as unpopular as ever.

The inefficacy of the vaccine itself, or the poor coverage of previous vaccination campaigns, could also explain the 1960-61 epidemic. According to Federation statistics, the smallpox epidemic of 1960 was no worse than other recent epidemics in the Federation. Sword's article in the *British Medical Journal* reported 620 cases and 95 deaths during the five months between November 1960 and March 1961.⁷⁴ Compare this to the 1955-56 outbreak, which was worst in Northern Rhodesia though it did spread to Nyasaland. During 1955, Federation authorities reported 3,526 cases and 499 deaths in Northern Rhodesia alone.⁷⁵ In 1956, Nyasaland officials reported 248 smallpox cases and 6 deaths.⁷⁶

Official reports did not blame this epidemic on political agitation, either in Nyasaland or Northern Rhodesia. In fact, medical authorities in both territories mainly blamed inefficacious vaccines. "Many cases showed signs of previous vaccination," and few newly vaccinated children showed "takes" (a "take" is a central lesion at the injection site, appearing between days 6 and 8 post-injection, which demonstrates a successful immune reaction to the vaccine).⁷⁷ By 1956, the Federation Ministry of Health had

⁷⁴ Sword, "Smallpox in Central Province, Nyasaland."

⁷⁵ "Annual Report on the Public Health of the Federation of Rhodesia and Nyasaland for the Year 1955" (Salisbury: Government Printer, 1956). Page 7.

⁷⁶ Morris, "Annual Report on the Public Health of the Federation of Rhodesia and Nyasaland for the Year 1956." Page 6.

⁷⁷ "Annual Report on the Public Health of the Federation of Rhodesia and Nyasaland for the Year 1955." Page 7. For a primer on "takes," see "Evaluation of Takes and Non-Takes" (Centers for

discontinued use of lanolinated lymph, which had been produced in the Central Laboratory in Zomba, in favor of glycerinated lymph. This new lymph showed “immediate and noticeable improvement” in the rate of takes, but it was known to lose potency at high ambient temperatures, and in many of Nyasaland’s facilities it was not refrigerated.⁷⁸ Anticipating this, Southern Rhodesian officials used more expensive freeze-dried vaccines (which had been available since 1909), but only in parts of their own territory.⁷⁹ Yet four years later, during the 1960-61 epidemic in Nyasaland, Federation authorities blamed only the Malawi Congress Party; their reports contained no discussion of the rate of takes, or of potential problems with the vaccine itself.

At the same time, Banda did not do as much as he could have to quell opposition to vaccination. Having just arrived in London on November 27, 1960 for negotiations with Welensky and Whitehall officials over the future of the Federation, Banda held a photo opportunity. As Banda stood holding a spear (“Because I am here to take and not to give,” he explained), a reporter from the Salisbury-based *Rhodesia Herald* asked him to tell his people to stop resisting smallpox vaccinators. The reporter claimed (in an account not repeated in other newspapers) that Banda refused to do so. Instead he insisted there

Disease Control, February 7, 2003), <http://emergency.cdc.gov/agent/smallpox/vaccination/takes-non-takes.asp>.

⁷⁸ Morris, “Annual Report on the Public Health of the Federation of Rhodesia and Nyasaland for the Year 1956.” For contemporary studies of the heat-stability of the glycerinated smallpox lymph, see W. Chas Cockburn et al., “Laboratory and Vaccination Studies with Dried Smallpox Vaccine” (World Health Organization, October 3, 1956). Writing of his work as a medical officer in Nyasaland in the late 1950s, David Stevenson remembered: “I fear that in the past a lot of dead vaccine must have been used in vaccination—having seen out of date and unrefrigerated liquid vaccine in use.” Stevenson recommended the shipment of freeze-dried vaccine to rural areas. Stevenson, “The Health Services of Malawi.” Page 72.

⁷⁹ Morris, “Annual Report on the Public Health of the Federation of Rhodesia and Nyasaland for the Year 1956.” Page 6.

was no smallpox epidemic in Nyasaland, only a propaganda campaign by the pro-Welensky press. Furthermore, he explained, he had come to London not as a physician, but as a politician.⁸⁰

Though it was recounted by an unsympathetic newspaper, Banda's response does seem to indicate a disinclination to quiet popular resistance, whatever the form, if it could destabilize the Federation's hold on power. Unrest, Banda knew, was his ally in fighting the Federation. When addressing crowds of thousands or the press, he did not use measured tones. His message was simple and direct; he sought an immediate end to the "stupid Federation."⁸¹ So even as the MCP blamed the opposition to vaccination on an *agent provocateur*, Banda, the most popular figure in the country at the time, would not speak out to end it.

Banda's refusal to explicitly call for Africans to follow the edicts of government authorities also reveals how crucial it seemed to him not to admit the value of any Federal government activities, even vaccination. To do so would, to the colonizer's ear, be to concede the truth of Gear's claims of Federal beneficence. The physician and revolutionary anti-colonial writer Frantz Fanon argued as much a few years later, when he explained the conundrum faced by the colonized who sought out European medicine: "In certain periods of calm, in certain free confrontations, the colonized individual frankly recognizes what is positive in the dominator's action. But this good faith is

⁸⁰ "No smallpox epidemic in Nyasaland says Dr. Banda," *The Rhodesia Herald*, Monday, November 28, 1960, page 1. BL, Newspaper Collection.

⁸¹ Short, *Banda*.

immediately taken advantage of by the occupier and transformed into a justification of the occupation...The colonizer perverts his meaning and translates, ‘Don’t leave, for what would we do without you?’”⁸²

The contrast between Banda’s rhetoric during this era, and the language he used once he became Life President a few years later, is striking. As President, Banda extolled “discipline” and “obedience” as paramount ideals of citizenship. As will be demonstrated in later chapters, he swiftly and violently put down any hint of disquiet. Jehovah’s Witnesses who refused to buy the compulsory Malawi Congress Party (because the cards carried Banda’s image, Jehovah’s Witnesses considered them a blasphemous challenge to God the Father) found their religion outlawed. Popular healers who tried to claim earthly authority were forced to end their practices. Cabinet ministers who criticized government policies were found dead in ditches (see Chapters 7 and 9).⁸³

More importantly for public health, Banda’s leadership in the fight for independence won for him and his government the trust of many Malawians. Popular belief in the beneficence of Banda’s new government helped break the cycle of self-reinforcing doubt, in which resistance to vaccination campaigns (by a distrusted colonial government) had helped spur repeated outbreaks, which in turn spurred more distrust of the vaccination

⁸² Frantz Fanon, *A Dying Colonialism* (New York: Grove Press, 1965). Page 122.

⁸³ Boston Soko, *Nchimi Chikanga: The Battle Against Witchcraft in Malawi*, Kachere Text 10 (Blantyre, Malawi: Christina Literature Association in Malawi, 2002) Pages 79-80; Joey Power, *Political Culture and Nationalism in Malawi: Building Kwacha* (Rochester, NY: University of Rochester Press, 2010). On the persecution of Jehovah’s Witnesses after independence, see Lwanda, “Politics, Culture and Medicine in Malawi.” Page 107.

campaigns.⁸⁴ Medical authorities in the Federation reported a “much readier acceptance of vaccinations” in Nyasaland in the year following the 1961 elections, which Banda’s Malawi Congress Party won in a landslide.⁸⁵ Progress against smallpox accelerated after independence. With freeze-dried vaccine donated by UNICEF and without popular opposition, smallpox was eradicated from Malawi in 1971.⁸⁶ But a decade earlier this feat seemed a long way off, and smallpox control remained an arena for political conflict. Banda, for his part, was a fomenter of opposition. Disorder of any kind, even in public health, was his ally.

A contemporary—and much more successful—disease eradication campaign in Nyasaland during the late Federation years demonstrates that Nyasaland’s Africans were discriminating in their shows of resistance. While smallpox vaccination had a long-standing association with coercion, anti-yaws campaigns had always been voluntary (see Chapter 1). And though bismuth injections for yaws had only temporarily resolved lesions, they were sought out by patients in the 1920s. By the 1930s, on the other hand, smallpox vaccinators were already facing opposition in Nyasaland villages. Little wonder, then, that when another novel therapeutic, procaine penicillin, was used to conduct a yaws eradication campaign in Nyasaland during the Federation years, it was welcomed around the country. The yaws campaign, promoted worldwide by the World

⁸⁴ Stevenson, “The Health Services of Malawi.” Page 72. Stevenson wrote that “*until 1963* vaccination teams could meet with difficulties because of their association with the Federal Government.” This language indicates that opposition to vaccination fell away after the Federation came to an end.

⁸⁵ “Medical Events: Big Drop in Nyasaland Smallpox Cases,” *CAJM*, March 1963, 120.

⁸⁶ F Fenner et al., *Smallpox and Its Eradication*, History of International Public Health 6 (World Health Organization, 1989). Pages 975-981.

Health Organization and the United Nations Children’s Fund (UNICEF), was launched in 1952, the year before Nyasaland was forced into the Federation. By the early 1960s, according to Austin Mkandawire, then a hospital assistant, “yaws had been entirely eradicated in Nyasaland.”⁸⁷ The disparate experiences of yaws and smallpox campaigns suggests that opposition to vaccination was a product not only of anti-Federation politics, but of a legacy of coercion and recurring epidemics that left itinerant vaccinators without the trust they needed to convince communities to submit their bodies yet again.

III. Medical practice under Federation: quotidian experience

Beneath the slogans and propaganda campaigns that formed the discursive contests over medicine, what was the lived experience of medical practice in Nyasaland during the Federation years? In this section, the focus turns from political parties and pamphlets to correspondence between doctors, auxiliaries and pharmacists. Given the centrality of drug availability to the rise in attendance at public sector hospitals and dispensaries—and to the propaganda campaigns chronicled earlier—healthcare providers’ near-constant frustration over stock-outs and rationing of essential medicines and supplies is a jarring departure from public rhetoric. The administrators running central pharmacy stores and apportioning medical budgets denied hospitals and dispensaries the supplies they said they needed to treat the influx of patients. Yet medical practitioners—even those British doctors with a firm belief in the superiority of European over African life—were loath to

⁸⁷ Mkandawire, *Living My Destiny*. Page 129. Worldwide, the eradication campaign effected an estimated 95 percent reduction in the prevalence of yaws. See Kingsley Asiedu, Bernard Amouzou, and Akshay Dhariwal, “Yaws Eradication: Past Efforts and Future Perspectives,” *Bulletin of the World Health Organization* 86, no. 7 (July 2008): 499–500.

practice what they considered sub-standard medicine.⁸⁸ The acrimony of these debates recapitulates (at a lower level of the colonial administration) the ardor of the disputes between a miserly Colonial Office and Directors of Medical Services (like de Boer and Shircore) calling for greater spending during the 1930s (see chapters 3 and 4).

a) Rationing drugs to African patients

i) Penicillin

Limits on spending for new drugs meant that, for the average patient in Nyasaland, new therapeutics arrived much later than in America or Western Europe. This delay is clearest in the cases of penicillin and streptomycin, perhaps the two most famous drugs of the postwar decade. In the first years of their availability, Director of Medical Services had to personally decide how to apportion scarce supplies of these drugs. Penicillin, a remarkable new treatment available to Allied troops during the Second World War, was first mass marketed in the United States in 1945. But in Nyasaland, procaine penicillin was distributed to hospitals on a strict quota system as late as 1953. The three European hospitals (in Blantyre, Zomba, and Lilongwe) received far more, for their patient loads, than any of the African hospitals, but all were asked to limit its use to the treatment of

⁸⁸ Austin Mkandawire, a hospital assistant in Zomba African Hospital during the Federation era, remembered some of the racial stereotypes and epithets he heard a white doctor utter in 1955: “A new doctor by the name of Jeffrey had just arrived from Zomba African Hospital to relieve Dr. Eberlie who had gone on leave. He had been put on the medical side with me. Dr. Jeffrey was one of the federal new recruits to replace the many doctors who had resigned in protest against Federation. Most of these new recruits had ben brainwashed into treating Africans as inferior. They had quickly learnt to loathe the Africans and they willingly demonstrated their antipathy against Africans on the flimsiest excuse...He would sometimes...refer to all Africans as ‘the scum of the earth.’ Indeed other times he would simply make sarcastic remarks about Africans as ‘thieves or liars.’ On many occasions Sister E Burnham, with whom I had worked, would avoid joining the doctor on rounds because of his attitude to Africans. During the rounds he would tactlessly make foolish jokes about the patient who had just died saying ‘well, let’s say he has kicked the bucket. Sister Burnham and I were never amused by this childish behavior.” Mkandawire, *Living My Destiny*. Page 140.

venereal diseases (“in particular congenital and primary syphilis and gonorrhoea”).⁸⁹

Supplies were so limited that as late as 1954, venereal disease cases in rural dispensaries were not treated with penicillin, but rather with the arsenical compound neosalvarsan, a less effective drug with much more severe side effects that had been in use since 1912.⁹⁰

In August 1953 the Director of Medical Services informed hospitals that another formulation of penicillin—crystalline penicillin—was more abundant and could be used for bacterial infections beyond gonorrhoea and syphilis, but within months the Medical Officers in charge of the African Hospital in Lilongwe and Mlanje complained that despite placing strict controls on their use both formulations were either out of stock or in short supply.⁹¹ In March 1954 the Director of Medical Services continued to warn against “indiscriminate use” of penicillin, but announced that the procaine penicillin quota would

⁸⁹ Kingsley Asiedu, Bernard Amouzou, and Akshay Dhariwal, “Yaws Eradication: Past Efforts and Future Perspectives,” *Bulletin of the World Health Organization* 86, no. 7 (July 2008): 499–500. Page 10, and EH Murcott, “Letter to All Stations, Re: Procaine Penicillin,” August 14, 1953, Ref No D2/1/349, No 31, MNA.

⁹⁰ “Letter from Medical Officer, African Hospital, Mlanje to Director of Medical Services EH Murcott, Zomba,” March 9, 1954, Ref No M3/54/9, No 28, MNA.

⁹¹ “From the Medical Officer in Charge, African Hospital, Lilongwe to Director of Medical Services, Zomba Re Penicillin Supplies,” February 2, 1954, Ref no MS&S.G.3/15/80, No 15, MNA. “There seem to be,” explained the medical officer, “two main reasons for the high consumption of penicillin, the first being the at the amount of major surgery performed here is progressively increasing and secondly we have recently had to treat several medical cases for example subacute bacterial endocarditis, lung abscess and so on, with prolonged courses of penicillin in high dosage (These cases incidentally have done very well so that the use of penicillin has been well worth it).” Also see 9 March 1954, From Medical Officer, African Hospital Mlanje to DMS, and Response from DMS to Medical Officer in charge Mlanje on 15th March 1954.

be doubled.⁹² Three years later, the Medical Officer at Zomba African Hospital was still writing letters pleading for a larger supply of procaine penicillin.⁹³

ii) Ampicillin

For years following the introduction of new treatments, Nyasaland officials closely guarded their use. In 1961 the British pharmaceutical company Beecham began selling ampicillin, a drug in the penicillin family with greater efficacy against gram-negative bacteria than earlier drugs. In January 1962 DJ Bail, the Medical Superintendent overseeing Zomba's European and African hospitals asked HR Durrant, the Director of Medical Services (hereafter, DMS), if he could obtain a supply of the new drug.⁹⁴ Durrant's staff replied that a very limited supply of ampicillin would be purchased for the Protectorate, and distributed in individual cases upon the personal approval of the Medical Specialist based at Queen Elizabeth Hospital. The letter made clear that Durrant's primary concern in limiting the use of the new drug was cost containment.⁹⁵

iii) Streptomycin

⁹² EH Murcott, "From the Director of Medical Services, Zomba, to All Officers in Charge of Stations and Provincial Medical Officers," n.d., Ref No M. 1/13/1114, No 36, MNA.

⁹³ "From the Medical Officer in Charge, African Hospital, Zomba, to Director of Medical Services, Zomba," January 11, 1957, 3405(I), Medical Department, Zomba Hospital Drugs and Medical Equipment, No 48, MNA.

⁹⁴ DJ Bail, "For the Medical Superintendent, Zomba, to the Director of Medical Services Re: Penbritin, Beecham Research Laboratories," January 30, 1962, 3405(I), Medical Department, Zomba Hospital, Drugs and Medical Equipment, No 214, MNA.

⁹⁵ E Burnett Smith, "For the Director of Medical Services to the Medical Superintendent, Zomba Hospitals," February 27, 1962, 3405(I), Medical Department, Zomba Hospital, Drugs and Medical Equipment, No 225, MNA. Ampicillin, the letter noted, cost 5 shillings per capsule. The letter did not state the cost of penicillin.

New drugs against tuberculosis also arrived in African health facilities in Nyasaland much later than in wealthier countries.⁹⁶ While supplies of streptomycin had been limited in the United Kingdom in 1946, patients in Nyasaland faced stock-outs of the drug almost a decade later.⁹⁷ In 1954, streptomycin was distributed to Nyasaland's hospitals on a strict quota that was insufficient to treat all of the patients with active pulmonary tuberculosis infections, while isoniazid (INH) remained completely out of stock at the central pharmacy for months at a time.⁹⁸ "What do I do for pulmonary TB?" asked an exasperated Medical Officer at Mzimba in a letter to the Director of Medical Services.⁹⁹

Two years later Dr. John Goodall, Nyasaland's Medical Specialist, complained to Director of Medical Services Howard Murcott that patients were again being denied

⁹⁶ Delays in access to tuberculosis drugs were also seen among poor and socially marginalized patients in the United States. Barron Lerner chronicles the transition from surgical treatments for tuberculosis (often involving the excision of parts of the lung) to chemotherapeutic regimens following the entry of streptomycin (1948) and isoniazid (1953) in Baltimore. The transition was not immediate, especially for homeless patients with histories of alcoholism; even in the mid-1950s these patients were deemed unlikely to comply with drug regimens, and were put under the knife. See Barron H. Lerner, *Contagion and Confinement: Controlling Tuberculosis along the Skid Road* (Baltimore, Md.: Johns Hopkins University Press, 1998).

⁹⁷ In chronicling the midcentury rise of the randomized controlled trial, Meldrum argues placebo-controlled trials were initially justified on the basis of economic and pharmaceutical scarcity. Bradford Hill was able to conduct the MRC trial in Britain using placebo-controls in 1947 because the US had made only a limited supply of streptomycin available to the UK. Marcia L. Meldrum, "A Brief History of the Randomized Controlled Trial: From Oranges and Lemons to the Gold Standard," *Hematology/Oncology Clinics of North America* 14, no. 4 (August 1, 2000): 745–60.

⁹⁸ "From the Medical Officer in Charge, African Hospital, Lilongwe, to the Director of Medical Services, Zomba, Re: Streptomycin Supplies," March 5, 1954, Medical Department, Medical Requisitions, No 27, Ref No MS&S, SG3/27/165, MNA. EH Murcott, "From Director of Medical Services to the Medical Officer in Charge, Karonga," March 8, 1954, Medical Department, Medical Requisitions, No 25, M.1/15/875, MNA. EH Murcott, "From Director of Medical Services EH Murcott to the Medical Officer in Charge, African Hospital, Zomba," March 20, 1954, Medical Department, Medical Requisitions, No 32, MNA.

⁹⁹ "Letter from Medical Officer in Charge, Mzimba to Director of Medical Services, Zomba," April 29, 1954, Medical Department, Medical Requisitions, No 49, Ref No 19/54/69, MNA.

treatment because the central pharmacy was completely out of streptomycin. The Federal Ministry of Health in Salisbury, he lamented, had not dispatched the amount ordered.

“Under these circumstances,” Goodall reported, “it appears that it is impossible to continue to treat tuberculosis patients in any satisfactory way.”¹⁰⁰

Treatment of tuberculosis with the newer therapeutics was, in the scope of Nyasaland’s meager Ministry of Health budget, expensive. In a 1964, a year of therapy for a single patient using isoniazid plus PAS cost £7-7s per person, while a year of therapy with isoniazid plus streptomycin cost £15-19s per person.¹⁰¹ That same year, per-capita government spending on the Medical Department was approximately 9s.¹⁰² The missionary physician David Stevenson estimated that the 2173 patients receiving tuberculosis treatment (at missionary and government facilities) in 1962 represented less than ten percent of total cases of active tuberculosis in the colony.¹⁰³

¹⁰⁰ “From JWD Goodall (Medical Specialist, Zomba African Hospital) to EH Murcott (Director of Medical Services),” June 8, 1956, File No 3405 (Zomba Hospital Drugs and Medical Equipment), MNA; “From EH Murcott (Director of Medical Services, Nyasaland) to Secretary to the Federal Ministry of Health, Southern Rhodesia,” June 12, 1956, File No 3405 (Zomba Hospital Drugs and Medical Equipment), MNA.

¹⁰¹ These prices are quoted by Wallace Fox in an article in the *British Medical Journal* (he gives the prices in US dollars; I have converted them here using the average 1964 conversion rate of USD to British pounds sterling (\$2.79 per £1). In the article, Fox proposed that poor countries should treat tuberculosis patients with isoniazid alone, rather than these more expensive combination therapies. Isoniazid alone, he noted, cost 9s per person per year of therapy. Yet, as David Stevenson argued, isoniazid treatment alone is not only less effective at curing TB, but fosters resistant strains that could render even combination therapy ineffective in future years. See Wallace Fox, “Realistic Chemotherapeutic Policies for Tuberculosis in Developing Countries,” *BMJ* 1, no. 5376 (January 18, 1964): 135–42. Also see Stevenson, “The Health Services of Malawi.” Page 87.

¹⁰² “Annual Report on the Work of the Nyasaland/Malawi Ministry of Health for the Year 1964,” 1965, UMMC.

¹⁰³ Stevenson, “The Health Services of Malawi.” Page 85.

But Goodall was not satisfied with persistent shortages of necessary drugs. Like Henry de Boer, Goodall had first witnessed colonial medicine in South Asia, where he had grown used to medical services more amply funded than in Nyasaland. Goodall had trained in Edinburgh before taking a post in the Indian Medical Service prior to the Second World War. During the war, he was stationed in Singapore, and even endured captivity under the Japanese. His sympathies were definitely pro-colonial, and he had no personal objections to the Federation. Goodall blamed Hastings Kamuzu Banda for “starting off riots and civil strife” after his arrival in 1958. “Until Dr. Banda arrived on the scene,” Goodall wrote in his memoirs, “Nyasaland was a happy and contented country.” When, prior to his imprisonment, Banda came to visit patients in Queen Elizabeth Central Hospital, Goodall refused to be formally introduced to him, “because I thought he was anti-government.”¹⁰⁴ Like the colonial physicians who had preceded him, Goodall did not see Africans and Europeans as equals. But, like them, he did expect to find the drugs and equipment he felt necessary to maintain his own professional standards.

iv) Mepacrine

In the treatment of malaria, one of the most common illnesses among Africans in Nyasaland, patients attending government facilities suffered even greater delays in access to new treatment. Mepacrine, an antimalarial synthesized in Germany in 1931 (and used extensively by Allied troops during World War II after the Japanese cut off access to cinchona, which was needed for quinine), fell into disuse in the pharmacies of wealthier countries by the mid-1940s. The drug, known for its severe neurologic side effects and prolonged treatment course, was overtaken by chloroquine. But in the early 1960s

¹⁰⁴ Goodall, *Goodbye to Empire: A Doctor Remembers*. Page 92.

mepacrine was still the standard of care for the treatment of Africans in Nyasaland. Again cost was a factor in the delay; in 1954 the DMS noted that chloroquine was almost seven times the cost of mepacrine.¹⁰⁵ Even among the Federation's African population there were discrepancies in the standard of care. In 1957, malaria eradication activities in Southern Rhodesia included mass treatment campaigns with over half a million tablets of chloroquine.¹⁰⁶ A year later, the Medical Superintendent at the Zomba African Hospital complained to the DMS that there was no chloroquine at all in Nyasaland's central pharmacy.¹⁰⁷ Only when the price of chloroquine treatment for pediatric cases (by injection) fell below that of mepacrine did it become the treatment of choice in Nyasaland.¹⁰⁸

v) Alcopar for hookworm

A new treatment for hookworm emerged during the later years of the Federation but, to the chagrin of medical officers, it would not be made available in public clinics in Nyasaland. In 1958, clinical trials in Ceylon (Sri Lanka) of bephenium hydroxynaphthoate found the recently synthesized compound to be an effective cure for hookworm infection. Burroughs Wellcome began to market the drug as "Alcopar." Alcopar was as effective and less toxic than tetrachlorethylene, then the standard of care

¹⁰⁵ Mepacrine cost 20/- per 1000 tablets, while chloroquine cost 140/- per 1000 tablets. See "Letter from DMS to Medical Officer In Charge, Zomba African Hospital," March 20, 1954, File 6186, 7.6.11R, Box 13375, MNA.

¹⁰⁶ RM Morris, "Annual Report on the Public Health of the Federation of Rhodesia and Nyasaland for the Year 1957" (Salisbury, Southern Rhodesia: Government Printer, 1958). Page 8.

¹⁰⁷ "From Medical Superintendent, Zomba African Hospital to Director of Medical Services, Re: Anti-Malarial Drugs," October 27, 1958, File No 3405 (Zomba Hospital Drugs and Medical Equipment), Document No 130, MNA.

¹⁰⁸ "From JAD Bradfield, Provincial Medical Officer, to Medical Superintendent, Zomba, Re: Requisition for Medical Supplies," October 22, 1962, File No 3405 (Zomba Hospital Drugs and Medical Equipment), Document No 250, MNA.

for hookworm, which caused nausea and dizziness in many patients. Unlike tetrachlorethylene (chemically similar to the carbon tetrachloride used in the 1930s, see chapter 7), treatment with Alcopar did not require patients to fast and drink saline before and after treatment to prevent (potentially fatal) gut absorption.¹⁰⁹ Despite these benefits, the Federal Ministry of Health refused to procure Alcopar, claiming its cost (2 shillings per dose) was too high. David Stevenson, then a missionary doctor with the Anglican Church, considered the Federation's decision penny-wise and pound foolish. Though tetrachlorethylene itself was cheap, many patients had to be hospitalized in preparation for treatment.¹¹⁰

b) Equipment

i) X-ray machines

Physicians also complained about long delays in obtaining equipment they considered necessary. In a March 1957 letter to the DMS, Medical Specialist Dr. John Goodall described the condition of the X-ray machine at the Zomba African Hospital:

I cannot at present screen chests or do barium meals. In addition, X-rays of spines and skulls are unsatisfactory... It appears that the requisite number of milliamps are not forthcoming to enable good pictures to be taken. The machine has given shocks to the radiographer. I have had to inform [a patient] today that I cannot X-ray him till the machine is put in order.¹¹¹

¹⁰⁹ Martin D. Young et al., "The Comparative Efficacy of Bephenium Hydroxynaphthoate and Tetrachlorethylene against Hookworm and Other Parasites of Man," *American Journal of Tropical Medicine and Hygiene* 9, no. 5 (September 1960): 488–91; LG Goodwin, LG Jayewardene, and OD Standen, "Clinical Trials with Bephenium Hydroxynaphthoate against Hookworm in Ceylon," *BMJ* 2, no. 5112 (December 27, 1958): 1572–76.

¹¹⁰ Stevenson, "The Health Services of Malawi." Page 94.

¹¹¹ "From JWD Goodall (Medical Specialist, Zomba African Hospital) to Director of Medical Services," March 23, 1957, File No 3405 (Zomba Hospital Drugs and Medical Equipment), MNA.

Dr. William Oliver Petrie, Medical Superintendent of the Zomba African Hospital, followed up two months later with another letter on the same topic, explaining that the X-ray unit had broken down “once every fortnight” for two years.¹¹² The problem remained unresolved in October 1957, when Goodall’s tone became more pointed: “I think you will agree that a Medical Specialist without X-ray facilities is extremely handicapped.”¹¹³ DMS Durrant approved the purchase of a new machine in December 1957, but it was not installed until October 1958.¹¹⁴

ii) Bone drills

Medical officers reserved their most colorful expressions of frustration for the poor quality of their surgical supplies. One said the set of plaster shears in a European hospital “would make a very suitable foundation exhibit when a medical museum is started.”¹¹⁵ In commenting on the DMS’ decision to substitute his request for bone drills with “ordinary engineer’s twist drills” supplied by a local firm,¹¹⁶ another physician resorted to language that was—by the standards of this genre of correspondence—dripping with condescension:

¹¹² “From William Oliver Petrie (Medical Superintendent, Zomba African Hospital) to Director of Medical Services, Re: X-Ray Unit at Zomba African Hospital, Zomba,” May 6, 1957, File No 3405 (Zomba Hospital Drugs and Medical Equipment), Document Number 72, MNA.

¹¹³ “From John WD Goodall (Medical Specialist, Zomba African Hospital) to Director of Medical Services, Re: X-Ray Plant African Hospital,” October 9, 1957, File No 3405 (Zomba Hospital Drugs and Medical Equipment), Document No 90, MNA.

¹¹⁴ “From J. Steinberg (Manager, Protea Medical Services Ltd., Salisbury) to Director of Medical Services,” September 2, 1958, File No 3405 (Zomba Hospital Drugs and Medical Equipment), Document No 117, MNA.

¹¹⁵ “From Mitchell (Medical Officer in Charge, European Hospital, Lilongwe) to Director of Medical Services,” April 26, 1954, File No 3405 (Zomba Hospital Drugs and Medical Equipment), MNA.

¹¹⁶ “From HR Durrant (for Director of Medical Services) to Medical Officer, Karonga (through Provincial Medical Officer, Northern Province),” November 1, 1961, File 2205 (Karonga Hospital Medical Requisitions), MNA.

The drills fit. However unless they are made from Vitallium or stainless steel there is a very real risk of bone porosis due to small pieces of the drill metal wearing off in the process of drilling. I imagine that is why the proper bone drills are more expensive—they are made for the job.¹¹⁷

c) Personnel

Drugs and equipment were not the only essential components of a health system that were in short supply during the Federation era. Even as overall spending increased rapidly, the number of personnel in Nyasaland's Medical Department steadily *decreased* during the 1950s. In 1959, doctors, nurses, and hospital assistants and other medical personnel stationed in Nyasaland and working for the UK Colonial Medical Service had to decide whether they would transfer into the Federal Service or resign. Up until that point, they had been allowed to remain in the Colonial Service (and work for the Federal Ministry of Health on secondment) for the first five years of the Federation. Many did not wish to make the transfer. African staff objected to rule by Southern Rhodesia. Some expatriate physicians also had political and ideological objections to Southern Rhodesian racial policy, but for many the greater drawback to the transfer was the fact that they would have to relinquish the career prospects and benefits (including pensions) of the Colonial Service. In the years leading up to this mandatory transfer, many of Nyasaland's medical personnel resigned. The Medical Department's staff numbered 1241 in 1951, but by the end of June 1958 it had dropped to 599. In all, less than half of the African staff employed by Nyasaland's Medical Department at the start of Federation transferred to the

¹¹⁷ "From Medical Officer, Karonga Hospital to Director of Medical Services (through Provincial Medical Officer, Northern Province, Mzuzu)," December 18, 1961, File 2205 (Karonga Hospital Medical Requisitions), MNA.

Federal Service.¹¹⁸ So even as health spending increased, the number of African and expatriate medical staff fell during the Federation years.

d) Colonial Service medical officers: *not* socialized for scarcity

Physician-anthropologist Paul Farmer and others have written of the phenomenon of “socialization for scarcity,” wherein doctors, public health professionals, and patients in resource-poor settings become accustomed, after years of paltry budgets, to dismal standards of medical provision.¹¹⁹ But in Nyasaland, the persistence of such vocal dissatisfaction from medical officers indicates that many of them never became socialized for scarcity. In unceasing demands for sufficient stocks of essential medicines, better drugs, functional diagnostic equipment and proper surgical supplies, the doctors objected to irksome delays, requisition denials and substitutions made in the name of cost containment. The tone of correspondence between medical officers and officials in the colonial capital often turned testy, as central administrators objected to cost overruns while medical officers rested their claims on inviolable professional standards. A Medical Officer in Karonga justified his request for a bronchoscope in a district hospital by declaring: “I would be failing in my duty if I did not ask for one.”¹²⁰

¹¹⁸ Baker, “The Government Medical Service in Malawi.”

¹¹⁹ Paul Farmer, “An Anthropology of Structural Violence,” *Current Anthropology* 45, no. 3 (June 1, 2004): 305–25. See also Luke Messac and Krishna Prabhu, “Redefining the possible: the global AIDS response,” in *Reimagining Global Health: an introduction*, eds. Paul Farmer, Arthur Kleinman, Jim Kim, Matthew Basilio. Berkeley: University of California Press, 2013.

¹²⁰ “From Medical Officer, Karonga Hospital, to Director of Medical Services, Blantyre (through Provincial Medical Officer, Northern Province, Mzuzu), Re: ‘Requisition,’” November 14, 1961, File 2205 (Karonga Hospital Medical Requisitions), MNA.

In Chapter 5, I argued that the prosopographical profiles of the colonial medical service helped explain their expectations of colonial medicine. Nyasaland's doctors were not a racially progressive lot, even for their times. Joan Wicken observed during the mid-1950s that while the Gold Coast had integrated hospitals (even before independence), Nyasaland retained racially segregated facilities.¹²¹ Nyasaland's white doctors did not object to this segregation, but they did resent stock-outs of drugs and broken equipment. Rather than resorting to claims of racial equality or rights to healthcare, medical officers invoked the dignity of their profession. Facing budgets so limited that officials rationed soap and denied requests for bed sheets, medical officers persisted in demanding recently released chemotherapeutics and specialized equipment.¹²² They insisted that they could only faithfully discharge their duties if given the tools they had been trained to use.

e) Wars for legitimacy lost, London and Salisbury order cuts in health spending, 1962-1964

Federal officials had worked assiduously to paint a picture of generosity in Nyasaland's medical provision, but once the Federation's fate was sealed budget cuts sparked a crisis in public sector health facilities. After years of accusing the MCP of sabotaging health campaigns, by 1963 Federal Officials were shipping drugs and supplies *out of* Nyasaland's hospitals and back to Southern Rhodesia.¹²³

¹²¹ Wicken, "African Contrasts." Page 67.

¹²² For a denial of bed-sheets, see "From EH Murcott (Director of Medical Services) to Senior Hospital Assistant in Charge, Fort Manning (through Provincial Medical Officer, Central Province, Lilongwe)," April 13, 1954, File No 3405 (Zomba Hospital Drugs and Medical Equipment), Document Number 44, MNA. For soap rationing, see Murcott, "From the Director of Medical Services, Zomba, to All Officers in Charge of Stations and Provincial Medical Officers."

¹²³ EH Murcott, "From the Director of Medical Services, Zomba, to All Officers in Charge of Stations and Provincial Medical Officers," n.d., Ref No M. 1/13/1114, No 36, MNA.

By early 1962, officials in the Colonial Office in London had concluded that popular opposition in Nyasaland was too widespread for the Federation government to survive. In August 1961, in the most open elections before Banda's fall from power in the 1990s, the MCP (running on a secessionist platform) won 99 percent of the vote on the overwhelmingly African "lower roll" of voters. MCP candidates even secured some European votes in three of the eight seats elected by the mostly European and Asian "higher roll."¹²⁴ Hastings Kamuzu Banda had been transformed from imprisoned firebrand to legitimate politician in little more than a year. British officials feared his threats of unrest could cause Nyasaland to devolve into their own version of France's Algeria, or Belgium's Congo, where insurgent wars and social conflagration had turned decolonization into imperial nightmares. One month after a conference in London to decide upon details of the transition, Richard Austen ("Rab") Butler, head of the Colonial Office's Central African Office, announced to Parliament in December 1962 that Nyasaland would withdraw from Federation. Butler and Banda had agreed, by that point, that Nyasaland would gain full independence from Britain by mid-1964.¹²⁵

Welensky and other Federal officials were incensed by Britain's decision to allow Nyasaland to secede. They feared, above all, that if Nyasaland left the Federation, Britain would not allow the Federation to continue. Nyasaland remained a debt-ridden, economically insignificant, and restive colony. One of the primary benefits of the

¹²⁴ McCracken, *A History of Malawi*. Pages 380-381. The remaining five seats went to Welensky's UFP. One of the three seats "won" by the MCP was secured by Colin Cameron, a white MCP-supporting independent candidate from Soche.

¹²⁵ McCracken, *A History of Malawi*, 384-389.

Federation to the UK Treasury had been the displacement of Nyasaland's financial burdens on to the Rhodesias. Southern Rhodesians feared (rightly) that once Britain's Colonial Office regained full responsibility for Nyasaland's finances, it would side with opponents Federation (namely, British leftists and African nationalists). Settler control of both colonies would face grave threats.¹²⁶

While anti-Federation forces in Nyasaland finally convinced the Colonial Office to end the experiment in amalgamation, the balance of power in Southern Rhodesia shifted in favor of more ardent white supremacists. In Southern Rhodesia's December 1962 election the Federal Party lost power to the Rhodesian Front, a white nationalist organization that sought to make Southern Rhodesia an independent state under white rule. This they would do in November 1965, but in the interim the Rhodesian Front dispensed with the pretense of "partnership."¹²⁷ Officials in Salisbury used the final months of Federation rule to remove supplies and equipment from north of the Zambezi. Between July 1962 and July 1963, the Federal Ministry of Health organized the uncompensated transfer of £11,000 in medical stores from Nyasaland to Southern Rhodesia.¹²⁸ Sally Hubbard, a visiting British nurse working in Zomba's African Hospital in 1963, ruefully recalled "a frustrating morning with an official who could not believe that there just was not any more linen or other equipment lurking somewhere."¹²⁹

¹²⁶ Ibid, 386.

¹²⁷ Roberts, "A History of Zambia." Page 225.

¹²⁸ Baker, "The Government Medical Service in Malawi." Baker notes that this transfer "still rankled years later." Also see Michael King and Elspeth King, *The Story of Medicine and Disease in Malawi: The 150 Years Since Livingstone* (Malawi: Arco Books, 1992), 155.

¹²⁹ Hubbard, "Nursing in Zomba, 1963-64."

After the handover of health services to Nyasaland's government, budget cuts and a rash of resignations further depleted Nyasaland's medical system. As Prime Minister in pre-independence Nyasaland—then as Prime Minister of independent Malawi, Banda tried to limit spending on health and other social services. The main impetus for these cuts was Banda's determination to keep a promise he had made to Butler in their 1962 negotiations on the transition to independence; Banda had pledged to move the new country from an unavoidable initial reliance on British aid to budgetary self-reliance (with domestic revenues matching recurrent government expenditure) within ten years.¹³⁰ In a move intended to keep this pledge, at the end of 1963 Henry Phillips (Banda's Minister of Finance until independence) slashed spending on all former Federal services—including health—by 15 percent.¹³¹

At the same time, so many doctors and professionals left the payroll that Nyasaland had trouble spending even its newly shrunken personnel budget. Most of Nyasaland's small cadre of physicians, fearing for their livelihoods after the dissolution of Federation and independence, left the colony. A large number of health staff had already left in 1959, the year in which Nyasaland's health sector employees had been required to transfer from the UK Colonial Service to the Federal Ministry of Health. But even for those few who had

¹³⁰ Jones et al., Colloquium on Nyasaland Finance. Page 56.

¹³¹ McCracken, *A History of Malawi*, 423; Phillips, *From Obscurity To Bright Dawn: How Nyasaland Became Malawi, An Insider's Account* (London: I. B. Tauris, 1998), 177. The idea that Nyasaland had to cut back drastically on social services was repeated by many foreign observers. In 1963 David Frost, a Harvard researcher who had received funding from the Ford Foundation, wrote that "expanded public expenditure on social services which are not likely to have any immediate and fairly direct effect on the development of the territory is not feasible, however strong the humanitarian arguments in their favour may be." Frost, "The Economic Outlook for Nyasaland." Page 68.

stayed, this second transition seemed more uncertain. In May 1964, two months before independence, Nyasaland had no radiologist, no psychiatrist, and no Director for its Public Health Laboratory. Only 3 of 13 District Hospitals had a medical officer, while Medical Assistants ran the rest by themselves.¹³² The number of government medical officers in Nyasaland fell from 30 in 1962 to 12 in 1964.¹³³ Largely as a result of this exodus, Ministry of Health spending on “personal emoluments” fell not by the required 15 percent, but by over 27 percent (from £514,754 in 1963 to £375,650 in 1964).¹³⁴

Spending on drug supplies also decreased during this transitional period. Once the dissolution of Federation had been decided, officials in Salisbury cut spending on drugs in Nyasaland, from £380,922 in 1962 to £347,378 in 1963.¹³⁵ This was, according to a 1965 report by the Malawi Ministry of Health, a deliberate “running-down of stocks in Nyasaland before the Ministry was handed over.”¹³⁶

Between the announcement of dissolution in 1962 and the transfer of responsibility for health services to Nyasaland on November 1, 1963, doctors and nurses complained ever more bitterly about stock-outs and shortages. Hubbard remembers a trip to visit a Medical Assistant at rural dispensary in a mud hut: “The poor man had totally run out of

¹³² “From HR Durrant (for Acting Director of Medical Services) to Medical Superintendent, Zomba General Hospital (through Provincial Medical Officer, Southern Province, Blantyre),” April 23, 1963, File No 3405 (Zomba Hospital Drugs and Medical Equipment), Document Number 201, MNA. Page 1.

¹³³ Goodall, *Goodbye to Empire: A Doctor Remembers*; “Annual Report on the Public Health of the Federation of Rhodesia and Nyasaland for the Year 1962”; “Annual Report on the Work of the Nyasaland/Malawi Ministry of Health for the Year 1964.”

¹³⁴ “A Conspectus Including the Development Plan for 1965-69.”

¹³⁵ *Ibid.*

¹³⁶ *Ibid.*

penicillin, the most commonly used and cheapest antibiotic, dressings and bandages. We had to tell him to wash the dressings and bandages and use them again, as we had none to spare in Zomba. We were able to send some penicillin...but he would then have to send a messenger to collect it.”¹³⁷ To save money, Hubbard remembers, an administrator in Zomba’s African Hospital removed light bulbs at random from the wooden boxes being used to incubate premature babies. Orders of more specialized drugs were out of the question; in April 1963 Acting Director of Medical Services Durrant wrote to Zomba’s Medical Superintendent that his requisition for Viomycin, a second-line drug for tuberculosis, had to be denied “because of the present financial stringencies.”¹³⁸ Spending on drugs decreased further after the handover of responsibility of the medical services, falling to £315,092 in 1964. This was due less to Phillips’ cuts (which had already been achieved through the personnel exodus) than to the absence of an administrative staff sufficient to monitor stocks and place orders.¹³⁹

V. Conclusion

Biomedicine was a political symbol put to creative use by both rulers and ruled, Europeans and Africans, practitioners and patients. Medicine proved such a powerful symbol—of beneficence to some, or neglect to others—because of a rapid change in the popularity of government medical facilities among Africans during the 1950s and 1960s (see Chapter 7). The increase in attendance in the years immediately following the

¹³⁷ Hubbard, “Nursing in Zomba, 1963-64.”

¹³⁸ “From HR Durrant (for Acting Director of Medical Services) to Medical Superintendent, Zomba General Hospital (through Provincial Medical Officer, Southern Province, Blantyre),” April 23, 1963, File No 3405 (Zomba Hospital Drugs and Medical Equipment), Document Number 201, MNA.

¹³⁹ “A Conspectus Including the Development Plan for 1965-69.”

Second World War only accelerated in the 1960s. The number of outpatient attendances at government facilities increased from 1.05 million in 1951 to 11.08 million in 1969.

Such rapid change had profound political effects. Government hospitals and dispensaries were more popular than ever during the Federation era. As officials in Salisbury were wont to point out, African patients flocked in increasing numbers to health facilities. Their celebratory rhetoric about health became ever more self-laudatory during moments of unrest and political uncertainty. This pattern is evident in Figures 8.5 and 8.6, which track mentions of Nyasaland in *Hansard*, the official record of the UK legislatures (House of Commons and House of Lords). Mentions of Nyasaland peaked during the Federation era, and particularly during the two moments of the most profound unrest, 1953 and 1959-1960. During these moments, when politicians in the UK debated the political future of Nyasaland, health became a central point of propaganda for both pro- and anti-Federation forces.

But while public spending on medical services increased at unprecedented rates, and to unprecedented heights, both medical providers and patients realized that public facilities left much to be desired. Nyasaland's overcrowded facilities were always low on drugs and short of personnel. These shortages would only grow worse as Malawi moved toward independence. But to the millions of Malawians who had endured colonial and Federation rule, free medicine had become, by 1964, a popular and widely expected service. So when, just after independence, the new government of Hastings Kamuzu Banda decreed that government health services would no longer be free at the point of



Figure 8.5: Number of “Nyasaland” in UK Hansard (Houses of Commons and Lords), 1900-1970.

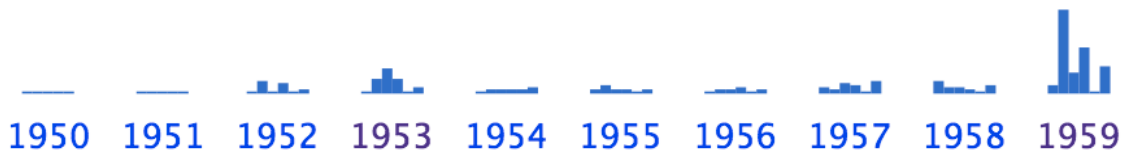


Figure 8.6: Number of “Nyasaland” in UK Hansard (Houses of Commons and Lords), 1950-1960.

care, the backlash was swift and fierce. Malawians would remind Banda, in ways he could not afford to ignore, that they had not fought for freedom only to lose access to medicine.

Chapter 9

Birthing a nation: the role of health in Hastings Kamuzu Banda's political calculus, 1964-1975

Abstract

This chapter examines two controversies in health policy in the years immediately following Malawi's independence in 1964. The first is the short-lived "ticky fee," Malawi's first and—thus far—its only experiment with health care user fees. Popular outrage over the fee, and Banda's need to retain legitimacy among the country's rural masses in the midst of the Cabinet Crisis and, led him to renounce the fees. The second moment is President Banda's debate with the World Bank over population policy. Malawi's government was not unique in opposing outside efforts at population control, but Banda's ideology, which invoked what anthropologists of the 1970s called "wealth-in-people," made birth control particularly unacceptable. Medicine was not a priority of Banda's early years. But there were certain policies that Banda would not enact, for he saw in them the potential for unrest. After 1964, he would countenance neither user fees nor birth control, and he would make grand displays of any of his government's few developments in the health sector. Health, of a certain kind, remained a part of Banda's ideology of protection and abundance, even if the budgets for health were anything but plentiful.

Prelude: "They were not very helpful, I daresay"

Growing up in the British Protectorate of Bechuanaland (today's Botswana), Quett Masire was a true believer in the Protestant Ethic. Fiscal prudence and hard work figure prominently the stories he tells of his own life. He heard these virtues lauded as a student at Tiger Kloof, a secondary school for blacks in South Africa founded by the London Missionary Society. Masire also saw them in his father, a "jack-of-all-trades" and a man of great "drive." As his family's eldest son, at age 21 it fell to Masire to look after his siblings when his parents died. He admits he could be a harsh taskmaster with his brothers on the family farm. "It was," he remembers, "virtually a punishment to work

with me.”¹ He imbibed—and preached—colonial officials’ exhortations that “if one did things properly, then one would be properly rewarded.”²

Later in life, as Botswana’s Minister of Development Planning and Minister of Finance (1966-1980) and President of Botswana (1980-1998), he made fiscal prudence a central tenet of policymaking. Though it had been a poor backwater during the colonial era and was considered economically unviable by many upon independence in 1966, some of the world’s richest seams of diamonds were discovered in the next decade. After driving a surprisingly hard bargain in negotiations with the DeBeers diamond cartel, the government began to receive half of the revenues from mining by the mid-1970s. Thanks in large part to diamond mining, Botswana had the world’s fastest growing economy between 1970 and 2000.³ But despite the poverty of Botswana’s populace, and the enormity of social needs, under Masire’s stewardship Botswana’s government would consistently store away a significant portion of its diamond revenues as savings. “As farmers,” he wrote in his autobiography, “we have always known the importance of saving for a rainy day, or in our case for a dry day. So it was easy for us to adopt the idea of a budget policy that would build up reserves of foreign exchange or government cash deposits in relatively good years, knowing we would have to use them in years of difficulty.”⁴ Development economists have hailed Botswana its record of prudent

¹ Sir Quett Ketumile Joni Masire, *Masire: Memoirs of an African Democrat: Very Brave or Very Foolish?*, ed. Stephen R. Lewis Jr. (Gaborone, Botswana: Palgrave Macmillan, 2008). Page 9.

² *Ibid.* Page 15.

³ Dickson Eyoh and Paul Tiyambe Zeleza, *Encyclopedia of Twentieth-Century African History* (Routledge, 2005).

⁴ Masire, *Masire*. Pages 163-164.

macroeconomic management, which has it to escape the “resource curse” that leaves many other countries wholly reliant upon volatile global mineral prices.⁵

But even the fiscally conservative Masire thought that World Bank policy of the late 1960s took a too-narrow view of the determinants of growth and the aims of development. In the immediate post-independence years, Botswana and Malawi occupied similar positions as labor reserves on the periphery of the global economy. Not yet able to draw upon domestic mineral revenues to finance government programs, Botswana’s new government sought donor funding. When I spoke to the still-sharp-witted nonagenarian Masire in his Gaborone home in November 2015, he recalled his conversations with Bank officials during those years:

The World Bank didn’t want to touch social infrastructure, because the rule of the day was expenditure should have a rate of return. . . . And so we had a very difficult time to justify raising money for schools, raising money for hospitals.⁶

“Social infrastructure” was Masire’s favored term of government health and education spending. He said that while the Bank and would provide concessional loans for “physical infrastructure” (e.g. roads, bridges, power plants and factories), they would not support additional social infrastructure.

⁵ In a 2001 paper, economists Acemoglu, Johnson and Robinson wrote that Botswana’s “fiscal policy has been prudent in the extreme and the exchange rate has remained closely tied to fundamentals.” Daron Acemoglu, Simon Johnson, and James A. Robinson, “An African Success Story: Botswana,” SSRN Scholarly Paper (Rochester, NY: Social Science Research Network, July 1, 2001), <http://papers.ssrn.com/abstract=290791>. Page 3.

⁶ Personal Interview with former President Quett Masire, Gaborone, Botswana., November 6, 2015.

During this era, the most important source of support for newly-independent British colonies was the UK Treasury.⁷ The UK government agreed to provide transitional grant-in-aid to a number of former colonies for a few years immediately independence. But with the aim of ending grant-in-aid as soon as possible, the British government allowed its funds to be used only for projects it thought would result in rapid increases in aggregate production. Recounting discussions with the British during Botswana's grant-in-aid period (1966-1972), Masire said:

They were not very helpful, I daresay. They wanted to finance [health] only to the extent they were doing it during the colonial period, which was so minimal, because at the time the only government hospital was the Athlone Hospital in Lobatse, and even that hospital was built by the people of the Southern District, who had paid 1 shilling six pence each. Any other hospitals were church hospitals.⁸

Botswana's officials were constrained even from spending their own paltry domestic revenues to increase health expenditures. Even after independence, the British Treasury maintained effective veto power over Botswana's government expenditures. Between 1966 and 1972 they reviewed every proposed budget. "If they did not like something we proposed to do with our own resources, they would reduce their Grant-in-Aid by the same amount. Their pretext was that, since we used it for something they did not think appropriate, we did not need the money!"⁹ Because the British had made it known that they did not think health expenditure a good use of public funds, and because they so readily exercised their veto power, Masire and his staff did not seek to include significant increases in health spending in budgets during the grant-in-aid period.

⁷ "Britain was our only major donor and financial supporter at independence. We could never have succeeded without that aid which initially provided over half our total expenditures of P12 million." Masire, *Masire*. Pages 153-154.

⁸ Personal Interview with former President Quett Masire, Gaborone, Botswana.

⁹ Masire, *Masire*. Page 218.

By the mid-1970s, however, World Bank President Robert McNamara and a number of bilateral aid agencies (including the UK's Department for International Development) expressed greater enthusiasm for health spending in poor countries. Breaking into a grin, Masire suggested African political leaders should claim some credit for this shift:

We would like to think we educated them. Because we said to them, look, without health, people cannot be productive. Without education, people cannot improve their production. It's a question of time. It's a long-term investment. For health, sometimes you can even look at it in the short-term. If people don't show up for work, if people who are experts in a certain sector are dying, what they were doing suddenly were doing suddenly will come to a stop...So slowly, slowly, slowly, the penny dropped.¹⁰

By the time this shift occurred, however, Botswana's government was less reliant on donors, and could chart its own development policy.¹¹ With substantial diamond revenues on the horizon, in 1972 the government announced it no longer needed British grant-in-aid.¹² Nine years later, when plunging commodity prices and soaring interest rates led the leadership International Monetary Fund to insist that developing nations seeking assistance adopt fiscal austerity in exchange for financial assistance, Botswana declined their conditioned aid. Early in his first term as President, Masire was "determined" to use savings accrued from previous years so that "development efforts

¹⁰ Personal Interview with former President Quett Masire, Gaborone, Botswana.

¹¹ "Before 1972, every thebe of development expenditure was funded by donors. In the late 1970s, over half was donor-funded, and in the late 1980s, one-third of our development expenditures were funded by donors. Even during my last few years in office, donors contributed 10% of our development budget, and donor aid was substantial in absolute amounts." Masire, *Masire*. Page 153.

¹² *Ibid.* Page 156.

should proceed and not be seriously interrupted.” Botswana successfully weathered the temporary downturn without IMF aid.¹³

Botswana’s government was quite explicit in categorizing public sector health spending as “investment expenditure.” While modernization theorists like W. Arthur Lewis had long argued that health spending was unproductive “consumption,” Botswana’s policy-makers framed improvements in health as integral to economic growth. The government began to use mineral revenues to finance recurrent health expenditures as soon as the grants-in-aid period ended.¹⁴ Beginning in the 1980s, the Ministry of Finance set a “Sustainable Budget Index” that directed the vast majority of spending derived from mineral revenues to “investment expenditure.” The government’s definition of “investment expenditure” included the entire development budget (one-time spending on infrastructural projects); the only categories of recurrent expenditure considered to be “investment expenditure” were education and health. Most of the recurrent expenditures for, say, the police or military or general administration had to be funded from non-mineral revenues.¹⁵

None of this is to suggest that Botswana’s government has proved particularly ambitious in its health spending, or that it has achieved particularly good outcomes. Absolute spending on health increased, but did not ever command pride of place among the

¹³ Ibid. Pages 165-166.

¹⁴ Personal Interview with former President Quett Masire, Gaborone, Botswana.

¹⁵ Atsushi Iimi, “Escaping from the Resource Curse: Evidence from Botswana and the Rest of the World,” *IMF Staff Papers*, 663-699, 54, no. 4 (2007). Page 675. Also see “The Changing Wealth of Nations: Measuring Sustainable Development for the New Millennium” (Washington, DC: The World Bank, 2011), <http://data.worldbank.org/news/the-changing-wealth-of-nations>.

government's fiscal priorities. In fiscal year 1969/1970, in the middle of the grant-in-aid period, health accounted for 7.2 of total recurrent government expenditure.¹⁶ Fifteen years later, with the country benefiting from growing mineral revenues and mostly free of influence over its budget process, health still accounted for 7.2 percent of total recurrent expenditure.¹⁷ In his 2008 autobiography, Masire lamented that his administration's delayed response to AIDS might have facilitated the epidemic's spread into one of the world's worst.¹⁸ UNAIDS estimated that by 2005, the prevalence of HIV infection among adults aged 15-49 had reached to 25.4 percent, second only to Swaziland (26.2 percent).¹⁹ Since 2003 Botswana's government has mounted an aggressive response to AIDS. Today every citizen with AIDS has free access to antiretroviral treatment. These life-saving drugs have been supplied with support from the US President's Emergency Plan for AIDS Relief.

¹⁶ Recurrent health expenditure in 1969/1970 was 1.003 million rand. Total recurrent expenditure during that year was 14.012 million rand. See "Memorandum on Recent Economic Development and Prospects of Botswana," Eastern Africa Department (International Bank for Reconstruction and Development and International Development Association, June 16, 1971), Documents and Reports Website, WBGA, <file:///Users/lukemessac/Desktop/1971%20memorandum%20on%20recent%20economic%20development%20and%20prospects%20of%20botswana.pdf>. Table 16.

¹⁷ Using 1985/1986 prices, recurrent expenditure on health in fiscal year 1984/1985 was 24.489 million pula, while total recurrent expenditure was 338.794 million pula. See "Public Expenditure and Development in Botswana," Country Programs I: Eastern and Southern African Region, (June 3, 1986), Documents and Reports Website, WBGA, http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/1986/06/03/000009265_3960925235906/Rendered/PDF/multi_page.pdf. Pages 17, 78.

¹⁸ Masire admits: "Our failure to deal with HIV/AIDS in an effective way" was "perhaps my greatest regret." Still, he continued, "the disease is indicative of a lack of morality in the nation." Masire, *Masire*. Page 237-239.

¹⁹ "The Gap Report: Beginning the End of the AIDS Epidemic" (UNAIDS, 2014), http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf. Annex: Table 1.

Still, other parts of the health sector remain wanting. Access to care is not universal. Non-citizens living in Botswana (including many thousands of Zimbabwean migrants) must pay the full cost of their drugs, diagnostics and consultation fees upfront at government clinics. Many cannot afford these costs and forgo treatment altogether. The quality of care is also less than one might expect from so wealthy a country. In 2015, long after Botswana had “graduated” to middle-income country status, doctors in some of the nation’s government hospitals struggled to care for inpatients without functional X-ray machines or reliable stocks of the reagents needed to run basic metabolic panels.

Botswana, like Malawi and many other former British colonies, devoted rather small portions of government budgets to health in the decades following independence. The tone was set early on, in late 1960s, when almost all of the advice they received from donors and advisers was to focus spending elsewhere. The practice continued, even in Botswana, which challenged the categorization of health as “consumption” rather than “investment.” Botswana provides yet another instance where discourses of economic development (even a discourse, like Botswana’s, that is hospitable to health) cannot fully explain patterns of spending on health care.

But there is another factor in Botswana’s history that could explain the surprising inattention to health. The nation’s transition to independence was bloodless, and it has

enjoyed prolonged internal peace in the years since then.²⁰ As the coming chapters will demonstrate using the example of Malawi, placidity has its costs, and unrest its benefits.

I. Introduction: historiography of Banda's post-independence health policy: neglect from the good doctor?

The historiography of medicine in post-independence Malawi is much thinner than that of its colonial precursor, Nyasaland. Probably the most widely read history of medicine in Malawi is Megan Vaughan's *Curing Their Ills*, but this book focuses on the period 1890-1950. John McCracken's history of Malawi—titled, aptly enough, *A History of Malawi*—ends its narrative in 1966. Colin Baker's "The government medical service in Malawi: an administrative history, 1891-1974" published as an article in *Medical History* in 1975, contains only two pages on the health sector since independence. Malawi-born physician John Lwanda has two works (*Politics, culture and medicine in Malawi* (2005), and *Color, class and culture: a preliminary communication into the creation of doctors in Malawi* (2008)) containing helpful discussions of post-colonial medicine, but even he calls these works "preliminary" in recognition of the dearth of original research.²¹ Public health and medical journals contain countless studies of the AIDS epidemic, but the period between 1964 and 1980 is rarely mentioned.

²⁰ Acemoglu, Johnson, and Robinson, "An African Success Story."

²¹ The discrepancy between pre- and post-independence historiography may be attributable in part to the fact that post-colonial records in Malawi's National Archives (which maintains a 30-year embargo before files can be opened) are poorly funded compared to colonial-era records. The European Union has provided funding to catalogue and maintain the Malawi National Archives' colonial-era records. Many colonial-era documents pertaining to Nyasaland can also be found in the UK National Archives at Kew. The dearth of research is also partly a function of Banda's effective ban on critical ethnographic and historical research in Malawi during his rule.

Much of the history that is written of the post-1964 period stresses continued neglect of government medical services for the new nation's black population during the long reign of Kamuzu Banda (1964-1993). In one of the few studies of post-independence medical services, Eric de Winter notes that between 1964 and 1971, the Government completed only two new hospitals (at Rumpi and Kasungu).²² Lwanda argued that "the colonial, Banda, and post-Banda regimes did not...prioritise the health sector."²³ Another Malawian physician, Austin Mkandawire, observed that as late as 1975, the Government of Malawi retained the colonial-era system of segregated hospitals. In Zomba the hospital for whites, commonly known as "Top Hospital" (ostensibly because of its location above the main city center), received better funding than the "Bottom Hospital" (lower on the hill) attended by black Malawians.²⁴ In 1975, Kathryn Morton concluded "there has been little expansion of government health facilities since independence."²⁵ In his study of the Banda regime, Malawian theologian and author Harvey Sindima referred to the government health sector as an "area where attention was not as high as it should have been."²⁶ Poet and Banda-era political prisoner Jack Mapanje remarked, "Dr. Banda built more prisons than hospitals—rather strange for a medical doctor."²⁷

It is quite true that during the Banda regime health was not a top priority. But together these authors paint a picture of abject political neglect that must be complicated in light

²² Winter, *Health Services of a District Hospital in Malawi*, 85.

²³ Lwanda, *Colour, Class and Culture*. Page 10.

²⁴ Mkandawire, *Living My Destiny*. Pages 114-115.

²⁵ Morton, *Aid and Dependence*. Page 45.

²⁶ *Malawi's First Republic: An Economic and Political Analysis* (Lanham, Md: UPA, 2002). Page 127.

²⁷ John Lwanda, "Hastings Kamuzu Banda & Middot; Lambert Ulrich ('Bertie') Camm · Reginald Sydney ('Reggie') Murley," *BMJ* 316, no. 7134 (March 14, 1998): 868.

of other facts. For instance, as Baker notes (in his uniquely sanguine appraisal of the health sector in this period), recurrent expenditure nearly doubled in the decade after independence, from £987,000 in 1964 to £1,906,000 in 1974. Spending on medical stores and equipment—where shortages during the Federation period were (as this chapter has shown) a constant source of aggravation for providers and poor outcomes for patients—more than doubled during this decade, from £219,000 in 1964 to £505,000 in 1974.²⁸ Further still, since the ticky fee episode in 1964 Malawi remained one of very few African countries to provide government healthcare without fees at the point of care (save for the obstetric fees).²⁹

How do we reconcile these seemingly contradictory sets of facts? Malawi's health sector expanded in the fifteen years after independence, but not nearly as much as it might have given the nation's impressive growth record during this period. At the same time, neither Banda nor Malawi's international donors considered healthcare a key priority in the years following independence. But the political backlash to the ticky fee and Banda's need to retain legitimacy among the country's impoverished rural masses did not permit him to ignore the sector entirely. Even while he remained devoted to weaning Malawi from British aid, Banda used domestic revenues and what assistance he could find abroad to build hospitals and recruit medical personnel.

II. The freedom we had told the people to die for? User fees in Malawi

a) Malawi's brief experiment with health care user fees, 1964

²⁸ Baker, "The Government Medical Service in Malawi," 308.

²⁹ Messac, "Moral Hazards and Moral Economies."

The budgetary decision that would prove most controversial came on Malawi's first day as an independent nation (July 6, 1964) when outpatients attending government hospitals and rural health centers began to be charged a fee. Throughout the colonial era, Africans had not been charged fees at the point of care at government at (segregated and inferior) government hospitals and rural dispensaries.³⁰ Glyn Jones, Nyasaland's last colonial governor, looked back on these fees as a wise policy aimed to restrain expenditure: "I regarded [Banda] as being a very honourable man in that he did his best to fulfill the conditions that the British Government tried to attach to the secession...you wouldn't have blamed him for playing for popularity—and my God, he didn't, he brought in those...charges for the health services."³¹ The fees were not much publicized; the announcement came in a notice, authored by Secretary for Health Dr. Robert Park, published in the first issue of Malawi's government gazette. Outpatients were to be charged three pence (3d), an amount known in much of British southern Africa as a "ticky" (the name for the three-pence coin).

³⁰ Colin Baker suggests, rather vaguely, that Nyasaland's colonial government medical services were "not necessarily free." He does not explain whether he is referring to fees for non-official Europeans or specialty services. But other sources are clear that African inpatients and outpatients received care free at the point of service in segregated facilities maintained by the colonial government. Baker, "The Government Medical Service in Malawi." Page 309. In 1906, Sir Hector Livingston Duff, who worked in the administration of British Central Africa (the name of Nyasaland between 1891 and 1907), wrote that the British had "erected free hospitals for the treatment of the sick." HL Duff, *Nyasaland under the Foreign Office* (London: George Bell, 1906). Page 361. While decrying the imposition of user fees after independence in the September 1964 debate in Malawi's Parliament, Paliani Gomani Chinguwo claimed that the "ordinary African...had been receiving free medical attention all along under the colonial government." Paliani Gomani Chinguwo, in *In the Parliament of Malawi, Official Report of the Proceedings, First Session-Second Meeting, 1964*, <http://www.kanyamachiume.com/docs/CABINETCRISIS1964.pdf>.

³¹ Jones et al., Colloquium on Nyasaland Finance. Pages 64-65.

Park's notice stated a number of exemptions from the fee: "children at school, adult men enjoying tax exemption for reasons of age or debility; adult women who are old or otherwise enfeebled; in-patients *after* admittance; those *who can prove* they are indigent" [emphasis in original]. Also exempted were patients found to be suffering from bilharziasis [schistosomiasis], venereal disease, tuberculosis, smallpox, and leprosy.³² Even with the exemptions, the fee marked a drastic departure from the policy, maintained during the colonial period (with one exception, to be mentioned below), of treatment for Africans at government health facilities without fees at the point of care.

But the new policy did not come from thin air. For decades, a number of commentators and colonial administrators had called for fees. In the first edition of his *African Survey*, published in 1938, Malcolm Hailey had weighed the advantages and disadvantages of medical fees for African subjects in British colonies, but he did not make any firm recommendation either way.³³ For their part, in recognition of the political significance of medical care, the medical directors of in most British East African colonies had rejected suggestions to impose fees; Dr. RR Scott, director of medical and sanitary

³² Robert Park, "General Notice No. 3: Ministry of Health: Out-Patient and Maternity Fees," in *Malawi Government Gazette*, vol. 1, 1, 1964.

³³ Lord Malcolm Hailey, *An African Survey: a study of the problems arising in Africa South of the Sahara* (London: Oxford University Press, 1938), 1201-1202. Hailey noted: "In the French colonies no payment is asked in return for medical attention save in exceptional cases where patients can obviously afford it." In the Belgian Congo, he observed that "infectious diseases, including sleeping sickness and all epidemic and endemic diseases, are treated free," while "in the case of other diseases and of accidents and most surgical cases, some payment is expected from patients who can afford it." In the colonies of British Africa, on the other hand, "it is usual for natives to receive free attention, but in many cases those who can afford to do so are required, both by government and mission institutions, to make small payments for treatment or medicines... In support of the view that treatment should be gratuitous it is said that in many parts of Africa medical attention is one of the few obvious returns which the African sees for payment of tax... On the other hand, it is held that Africans are more likely to appreciate medical aid and come for treatment with greater readiness if the service is not taken entirely for granted."

services of Tanganyika, explained medical services were one of the benefits Africans had been led to expect in return for taxes.³⁴

Late in the Federation period, calls for fees reemerged. To these observers, the existing system of healthcare financing was guilty either of hindering social progress or of advancing a revolutionary socialist agenda.³⁵ For those who thought it halted the march of civilization, the system of free care perpetuated atavistic tribal laziness and colonial paternalism. Speaking to a branch of the British Medical Association in Northern Rhodesia in 1960, Federal Prime Minister Roy Welensky said it was time for an end to the days of “something for nothing.”³⁶ Others thought “free” medical care was a foretaste of socialism, a policy that seemed too close to those concocted in the Eastern Bloc. Dr. Harry Gear, a consultant to the Federal Ministry of Health, worried both Northern Rhodesia and Nyasaland were on path toward a “socialized medical service which in a relatively few years will be irreversible...It is a phenomenon,” he continued, “not entirely reassuring to those nervous of over-organization and excessive officialdom.”³⁷ This warning may have been intended for audiences in the United States, where private sector

³⁴ Beck, *A History of the British Medical Administration of East Africa, 1900-1950*. Page 130.

³⁵ “Free” healthcare was not the only social phenomenon that inspired contradictory critiques in colonial Nyasaland. Officials also articulated two mutually incompatible explanations for the seemingly high prevalence of venereal disease. To some observers these diseases were evidence of African’s primordial promiscuity, while to others they were a symptom of social breakdown with the arrival of city life and more modern sensibilities. See Vaughan, *Curing Their Ills*.

³⁶ ““Something for Nothing Days’ over,” *Nyasaland Times*, November 25, 1960, MNA.

³⁷ Gear, “Some Problems of the Medical Services of the Federation of Rhodesia and Nyasaland.” Page 530.

provision dominated, rather than in the United Kingdom, where the NHS provided health care without user fees.³⁸

UK Minister of Home Affairs Rab Butler, who had been tasked by Prime Minister Harold MacMillan with Central African affairs in March 1962, raised the issue of fees in negotiations with Banda over Nyasaland's secession from the Federation. During a December 1962 meeting in London, Butler told Nyasaland Governor Glyn Jones that he had made it clear to Banda that he would have to cut the government budget and raise revenues to pay for education and health services.³⁹ In a visit to Nyasaland in late January 1963, Butler clarified how revenues would be raised and costs cut. At some point "in the future," Africans would be made to pay fees at government health facilities.⁴⁰

Banda would later claim to have no knowledge of the new government fees, but his own history indicates he had little aversion to them. In November 1960, an official in the Federation intelligence service in Salisbury had sought unflattering stories about Banda from his years as a doctor in Ghana (until 1957, the British Gold Coast) between 1953

³⁸ For another call for fees, this one on the basis of cost alone, see a 1961 annual report on health in the Federation: "It seems pretty obvious that a country whose population increases at the rate experienced in the Federation cannot continue to provide a completely free service to over eight million people and a very sub-economic paid service to the remainder, without adopting a system under which a larger proportion of the cost is met directly by those patients making use of the public service who are able to pay." DM Blair, "Annual Report on the Public Health of the Federation of Rhodesia and Nyasaland for the Year 1961" (Salisbury: Government Printer, 1962), 3. There were also contrary voices in Southern Rhodesia. In the November 1963 issue of the *Central African Medical Journal*, WJ Crabb wrote in favor of a single-payer health system in Southern Rhodesia, and against user fees. See WJ Crabb, "Towards a State Medical Service?," *CAJM* 9, no. 11 (November 1963): 442–45.

³⁹ Wood, *The Welensky Papers: A History of the Federation of Rhodesia and Nyasaland*. Pages 1107–1108.

⁴⁰ *Ibid.* Pages 1140–41.

and 1958. The Federation official reported hearing from a former Gold Coast officer that Banda had set up an unlicensed network of 22 dispensaries in a rural region of north Ashanti. There, the story went, Banda had his attendants—trained in a “week-end course”—charge patients 10 shillings 6 pence per consultation. Banda, who kept 90 percent of the fees even as he stocked the dispensaries with government supplies and drugs, would earn £1,000 each month from this network for years.⁴¹ Shortly after independence, Ghana’s Ministry of Health suspended his medical license for six months.⁴² Biographies of Banda have noted that he maintained a private practice in Kumasi, and that he briefly had his license suspended, but none have yet offered a convincing reason for the punishment. Given that the provenance of this account was a Federation official, it may be exaggerated or even fabricated. But Ghanaian officers were unsurprised by the story; “similar practices are common among Ghanaian doctors in Government service.”⁴³ Banda himself was likely no stranger to—or opponent of—fees for patients when Butler made his demand.

The first fees, introduced before independence, were aimed at pregnant women.

Throughout the colonial period, “non-official” Europeans and Asians were charged for care at European government hospitals in Lilongwe, Blantyre and Zomba.⁴⁴ Then, in

⁴¹ “From Security Liaison Officer, Salisbury, to Special Branch, Nyasaland Police, Zomba, re: ‘Dr. Banda’s Previous History,’” 13 November 1960, KV 2/4075, UKNA.

⁴² “From AF Hewlett, Security Liaison Officer, Ghana, to SLO Central Africa,” 6 December 1960, KV2/4075, File No 498a, UKNA.

⁴³ “Letter to Security Liaison Officer, Central Africa,” 5 December 1960, KV2/4075, File No 497a, UKNA.

⁴⁴ DM Blair, “Annual Report on the Public Health of the Federation of Rhodesia and Nyasaland for the Year 1961” (Salisbury: Government Printer, 1962).; H.B. Wilson, Barrister at law, Bentley & Broomhall. Letter to KL Hall, Chief Secretary to the Government, Zomba, Nyasaland,

April 1963, seeking to save on expenditures at the close of Federation and no longer worried about currying favor with the general African population, the Ministry of Health took what the *Central African Journal of Medicine*—published by pro-Federation doctors in Salisbury—hailed as “the first step towards charging Africans for medical services.”⁴⁵ The fee, of £1 10s, would cover “ante-natal attention, the confinement and any attendant medical or surgical care and also post-natal attention if necessary.” It was to be charged only at the African hospitals in Blantyre (Queen Elizabeth), Lilongwe, and Zomba. Hubbard, the visiting British nurse, described the effects on the maternity ward in Zomba:

Where anyone thought the women would be able to get the money from was a mystery. The maternity ward emptied overnight and the fear spread to other wards where the patients thought they would also be charged. Suddenly every patient had a bed as most had absconded.⁴⁶

In Hubbard’s reminiscence the maternity fees were cancelled, but Park’s notice in July 1964 stated, “The charge is at present and will remain 30s.” Park’s 1964 notice also instituted a 10s fee for maternity cases at Malawi’s other hospitals and rural health centres.

The notion that maternity patients would be the first to be charged fees would have been unthinkable to colonial medical administrators during the interwar years, when under-population and insufficient fertility were considered major problems and health officials

10 March 1938, MNA.

⁴⁵ “Medical Events: Territorial Government Takes over Hospitals in Nyasaland,” *CAJM*, April 1963, 159.

⁴⁶ Sally Hubbard, *Nursing in Nyasaland, Expatriate experience of life and work in Nyasaland*, vol 3, page 308.

encouraged clinic-based births (see Chapters 1 and 3).⁴⁷ But by the 1960s, the pendulum had swung and the concern had become *overpopulation*. In *The Story of an African Famine*, Megan Vaughan describes how Nyasaland officials laid the blame for a deadly 1949 famine on neo-Malthusian claims about population growth and resulting pressure on land.⁴⁸ The discursive shift helped move health policy away from de Boer's late 1930s focus on maternal and child health and skilled attendance for all births (see Chapter 3). As Eric de Winter, a Dutch physician who had worked at the Nkhata Bay District Hospital in the late 1960s, explained, "It is often considered acceptable in developing countries not to let all pregnant women deliver in a hospital, but only to select high-risk patients."⁴⁹

But if the empty maternity wards that followed the 1963 fees were disquieting to Hubbard and others, these sights paled in comparison to the far more dramatic effects of outpatient charges that came the following year. Three-pence was, at the time, considered a standard hourly wage for unskilled urban laborers.⁵⁰ But particularly for rural Malawians (and that, of course, was the vast majority of the population) rarely had cash readily available. For them, the fee would prove a significant deterrent. In June 1964, the last month before the fee was instituted, 308,381 outpatients attended government

⁴⁷ Megan Vaughan, "Maternal Mortality in Malawi: History and Moral Responsibility," in Walima T. Kalusa and Megan Vaughan, *Death, Belief and Politics in Central African History* (Lusaka, Zambia: The Lembani Trust, 2013), 303. Also see Vaughan, "Health and Hegemony: Representation of Disease and the Creation of the Colonial Subject in Nyasaland." Page 193.

⁴⁸ Vaughan, *The Story of an African Famine*. Vaughan notes that commenters who wrote about the deadly effects of overpopulation elided the fact that in the years before the famine, settlers had expropriated vast tracts of arable land

⁴⁹ Winter, *Health Services of a District Hospital in Malawi*. Page 122.

⁵⁰ Stevenson, "The Health Services of Malawi."

facilities. In July 1964, outpatient attendance fell to 126,559 (fees were instituted on July 6). In August 1964, the first (and as it turned out, the only) full month of the outpatient fee, attendances fell still further, to 122,996. Figure 9.1, a graph drawing upon a 1965 Ministry of Health report that analyzed the effects of the fees, shows this precipitous decrease in attendance.

Most of this decrease is attributable to the fee itself. Yet there is another factor at work: the seasonal variations in attendance. February, March, and April, the months following the onset of rains, were long known as the annual period of the most widespread illness; many went hungry before the harvest (which began in May), while the rains brought diarrheal disease and malaria. In any given year, then, one would expect to see attendances increase to a peak in March or April, then fall as the dry season set in and the harvest began in May or June. The 1964 figures do follow this pattern; monthly outpatient attendance peaked in 439,675 in March, and fell to a nadir in August. But the 1964 fall in attendance was *far* more precipitous than the previous year's; 295,300 outpatients attended government facilities in July 1963, more than twice as many as in July 1964.⁵¹

As the fees led fewer outpatients to present for treatment, fewer inpatients were admitted.

⁵¹A report written by the Ministry of Health in 1965 shared this analysis: "This analyses closely a period which shows annually little variation. It shows, in fact, a steep increase in attendances upon the takeover of the Ministry of Health, interrupted by a normal seasonal decline. Thereafter the 3d charge is anticipated in June and causes a remarkable plunge in July less than one third of the March total. Thereafter as the charge falls into desuetude, there is a steady recovery." Table VII. Outpatient Attendances, 1954-1964, Malawi Ministry of Health, in "A Conspectus Including the Development Plan for 1965-69."

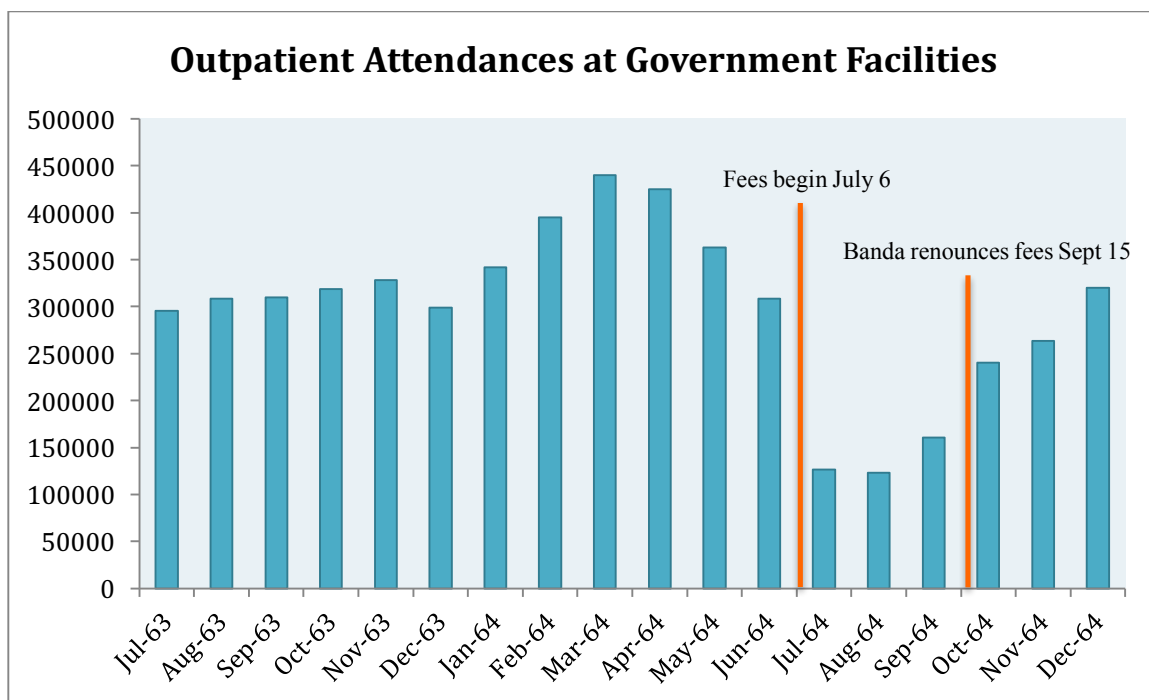


Figure 9.1: Outpatient attendances at government facilities, 1963-64, from *A Conspectus including the Development Plan for 1965-69*, Malawi Ministry of Health.⁵²

The number of inpatient days in government facilities fell from 106,702 in June 1964 to 84,916 in July and 84,317 in August, before rebounding to 91,727 in September and 95,727 in October. The fall in inpatient days is less marked than the fall in outpatient attendances; this is predictable, as “a number of chronically ill patients remained to occupy their beds while fewer new patients were admitted.”⁵³

In the weeks after the fees were begun, prominent Members of Parliament heard

⁵² Curiously, the 1964 outpatient attendance figures printed in the *Conspectus*, a Ministry of Health report, differ significantly from those given in the 1964 Annual Ministry of Health Report. In the *Conspectus*, the total outpatient attendance in 1964 was 3,506,851. In the 1964 annual report, the total outpatient attendance (including hospitals and rural health centers) was 7,717,732. It seems likely that the monthly attendance figures in the *Conspectus* include only outpatient attendances at government hospitals (central, regional, and district). In the 1964 annual report, outpatient attendances at government hospitals totaled 3,481,516. Though not identical to the *Conspectus* report, this figure is far closer to it.

⁵³ “Table Va. Inpatient Days, 1963-65. Malawi Ministry of Health, in *Ibid.*”

complaints from their constituencies. Kanyama Chiume claimed Banda (who had retained the Ministry of Health portfolio for himself) had instituted the fees without consulting his Cabinet: “All of us were pre-occupied with the independence celebrations at this time and so we hardly realized that this charge had been levied.” But soon enough, Chiume remembered, no Cabinet members could ignore the fees:

Wherever we went, we were bombarded with questions as to whether this was the freedom we had told people to die for. One old man in Usisya, my home, showed me a wound caused by an axe which was becoming septic because he could not afford the new fees. ‘How do you expect us to be enthusiastic about self-help schemes?’ he asked me, ‘when if we hurt ourselves in the process, you ask us to produce money to be treated in a country where you cannot give us jobs from which to earn our living?’⁵⁴

This question invoked politically powerful obligations, namely to provide remunerative employment and medical care in exchange for both labor and legitimacy from the people (for more on these obligations, see the conclusion to this chapter).

Cabinet members who opposed the fees would invoke these notions of obligation ever more vocally in the months to come, as the fees became one among many issues that alienated Banda from his erstwhile allies in the party. In September 1964, Chiume and other members of Banda’s Cabinet confronted the Prime Minister over the fees as well as low pay for civil servants and slow pace of “Africanization” of government posts, as well as Banda’s budding alliances with Mozambique, southern Rhodesia and South Africa, white-ruled regimes considered pariahs by other independent African states. After a conversation with Glyn Jones over whether he should resign (where Jones advised him not to), Banda scheduled a vote of confidence in Parliament. During the debate, Banda’s

⁵⁴ M. W. Kanyama Chiume, *Kwacha: An Autobiography* (East African Publishing House, 1975). Page 211.

opponents decried the fees. Henry Chipembere, a young minister who had been among those who invited Banda to return to Nyasaland six years earlier, said the three-pence fee was “a heavy burden which prevented many people from taking their fever-stricken children to the dispensary.” He lamented the government’s attempt to limit expenditure using such charges, a tactic he called “economizing at the expense of the people’s health.”⁵⁵ At a rally near his home in Fort Johnston later that week, Chipembere said the fees demonstrated that “The present Malawi government is worse than Welensky’s Federal government.”⁵⁶

During the parliamentary debate, Banda’s supporters tried to justify the fees. One Member claimed, “People don’t complain.” After all, he noted, the three pence charge was less than the fees patients had long paid at mission hospitals. “You refuse to pay...yet expect Ngwazi Kamuzu to tell medicine manufacturers to send them millions of drugs without sending them a cheque, eh?” he asked. “No,” answered other supporters of the Prime Minister.⁵⁷

Banda won the vote of confidence. But for months, Banda’s hold on power remained uncertain. Through late 1964 and early 1965, Chipembere and a few hundred followers hid in the Namizimu Forest north of Fort Johnston. Banda put a price on Chipembere’s

⁵⁵ “In the Parliament of Malawi: Official Report of the Proceedings (Unrevised Edition)” (Zomba Malawi: Government Printer, September 9, 1964), MNA. Page 98. Also see Henry B. M. (Henry Blasius Masauko) Chipembere, *Hero of the Nation : Chipembere of Malawi : An Autobiography* (Blantyre [Malawi]: Christian Literature Association of Malawi, 2001).

⁵⁶ “Chipembere Addresses Rally at Fort Johnston,” *The Times (of Malawi)*, September 15, 1964. Page 1.

⁵⁷ Bundaunda, in *In the Parliament of Malawi, Official Report of the Proceedings, First Session-Second Meeting, Second Day* (Zomba, Malawi: Government Printer, 1964), 67. Page 67.

head, but either out of fear or loyalty, locals would not reveal his whereabouts. In February 1965 his forces briefly captured Fort Johnston, but they dispersed along the road to Zomba after finding that the ferry needed to cross the Shire River at Liwonde was tethered at the opposite bank.⁵⁸ In late April 1965, Chipembere fled to the United States. Ironically, part of the reason for his departure was that he sought treatment for his Type II diabetes not available to him in Malawi.⁵⁹ Banda's regime was saved, in part, by the government's poor health system.⁶⁰

This entire episode, which came to be known as the Cabinet Crisis, marked the greatest threat to his rule until he was finally forced from power in the early 1990s. Banda did not change his foreign policy, or increase pay for civil servants, but he rather quickly distanced himself from the fee policy. A newspaper reported Banda's speech at a rally in Palombe a week after the Parliamentary debate in which he claimed that his rebellious ministers "had bribed medical aides in the hospitals to refuse treatment to poor people so that there would be resentment." The article continued: "The Prime Minister promised the people that no one would be refused medical treatment because he had not got a 'tickee.' He said the doctors and medical assistants should have made that clear from the

⁵⁸ C. A. (Colin A.) Baker, *Revolt of the Ministers : The Malawi Cabinet Crisis, 1964-1965* (New York: I.B. Tauris Publishers, 2001). Pages 212-215.

⁵⁹ Harry Franklin, "Malawi: Dr Banda Faces the Rebels," *The Spectator*, April 1, 1965.

⁶⁰ By the 1960s, Chipembere retained little direct involvement in Malawian politics. After studying for a PhD (though never completing one) in History at the University of California, Los Angeles, Chipembere worked for some years as Assistant Professor of History at California State University. He died in the United States in 1975 at age 45 of complications from diabetes. Earl H. Phillips, "HBM Chipembere, 1930-1975, Malawi Patriot," *Ufahamu: A Journal of African Studies* 7, no. 1 (1976): 5-18.

beginning.”⁶¹ Though there is no documentation of any official repeal of the fee, the Ministry of Health reported in 1965 that the outpatient fee “fell into desuetude.”⁶² The maternity fees, on the other hand, continued to be collected at most hospitals.⁶³

b) Reasserting legitimacy through displays of care: Banda’s symbolic health agenda, 1964

In addition to turning the blame for the fees back onto his rivals, Prime Minister Banda sought to reassert legitimacy through acts of generosity. Three days after his Palombe speech, Banda ordered that an earlier donation he had made to hospitals—a gift of more than 2000 chickens and over 250,000 eggs—was to be used “only to feed poor African patients.” Banda’s clarification that his gift was to go directly to the destitute sick demonstrated his need to respond to the uproar over the fees. The need to demonstrate concern for the poor after the battle over fees showed that biomedicine had become a powerful political symbol and even a weapon capable of inflicting lasting harm.⁶⁴ This was a lesson that Banda would not forget.

⁶¹ “Premier Addresses Rally at Palombe: Dr. Banda: ‘Man of Honour’: Repeats Charges against Some of the Ministers,” *The Times (of Malawi)*, September 15, 1964, MNA.

⁶² Outpatient attendances, 1963-64. In “A Conspectus Including the Development Plan for 1965-69.”

⁶³ In 1967 a midwife at a government dispensary in Monkey Bay told a touring official that average monthly deliveries had dropped from 27 in the late Federation era to 12 because “the people are not anxious to pay the fee.” See “Tour of the Fort Johnston Area Commencing on Sunday, 25th June, 1967 at Monkey Bay.” File 195, Folder 6835 (“Monkey Bay Dispensary”), MNA. Also see “Annual Report on the Work of the Nyasaland/Malawi Ministry of Health for the Year 1964.” Page 5.

⁶⁴ “Banda Gift for Poor African Patients,” *The Times (of Malawi)*, September 18, 1964. Before he donated them to hospitals, the chickens and eggs had actually been given to Banda at public meetings in Blantyre, Zomba, and Fort Johnston.

A week later the nation's largest daily newspaper, by that point solidly pro-Banda, featured a number of health-related items on its front page. The first was the announcement of a "£100,000 leper scheme" to be funded by the Brown Memorial Trust and the British Leprosy Relief Association and directed by the Ministry of Health.⁶⁵ The second item announced the arrival of 41 laboratory technicians and nurses from the United States to work on a tuberculosis control campaign under the auspices of the US Peace Corps.⁶⁶ The third was a photograph of Dr. Banda, wearing a dark three-piece suit and tinted glasses, leaning over the bed of a female patient during a visit to the Queen Elizabeth Hospital (Figure 9.2). His left arm is outstretched but his hand is obscured from view; he appears to be examining the patient. The reminder of his career as a doctor is none too subtle. Sunlight streams in from a window, illuminating a soft smile on Banda's lips. In the background other patients look over, seemingly waiting their turn. The article accompanying the photo explained that in Banda's speech on the grounds of the hospital, before "several thousands," he reminded the audience that this visit was his third to the hospital in his official capacity. The article also noted that he had given £5 10s of his own money to individual patients in the wards.⁶⁷ In the midst of the greatest threat to his political career to date, Banda centered his publicity campaign shows of solicitude to the plight of the sick.

⁶⁵ "£100,000 Leper Scheme: Malawi to Spearhead World Campaign," *The Times (of Malawi)*, September 25, 1964. Page 1.

⁶⁶ "Peace Corps to Aid TB," *The Times (of Malawi)*, September 25, 1964. Page 1.

⁶⁷ "Dr. Banda at Queen Elizabeth Hospital," *The Times*, September 25, 1964, pages 1 and 5.



Figure 9.2: Prime Minister Banda at Queen Elizabeth Hospital. From The Nyasaland Times, September 25, 1964, page 1.

b) Politics of healthcare fees in the former British Africa, 1964-1968

Malawi was not the only newly independent African nation for which healthcare user fees became a major issue during the 1960s. Following the rise of the Rhodesian Front and the end of the Federation, leading settler politicians in Southern Rhodesia were far less concerned than their forebears about British or African opinion. Their desire to appear beneficent toward their African subjects had dissolved along with the Federation. In November 1965, Southern Rhodesian Prime Minister Ian Smith would issue a Unilateral Declaration of Independence (UDI) from the United Kingdom. Without the fiscal subsidy it had garnered from Northern Rhodesia's copper mines, Southern Rhodesia also sought to find ways to cut government spending and raise revenues. So in October 1964, shortly after Banda reneged on the ticky fee, Southern Rhodesia instituted

fees at African hospitals and dispensaries. The fees were much higher than Malawi's 3-pence charge. In Southern Rhodesia, the outpatient fee for men was 1 shilling 6 pence, and for women and children the fee was 1 shilling. For inpatients, the charges were even higher: £2 for men, £1 for women, and 10 shillings for children per admission at Bulawayo and Salisbury African Hospitals, and 10 shillings for adults and 5 shillings for children at general and district hospitals. Thus the end of the Federation spelled far higher healthcare fees for Southern Rhodesia's Africans than it ever did for Malawians.⁶⁸

In other former British colonies, where independence brought majority rule, the politics of medical financing were similar to Malawi's. In 1957, the colonial government of Kenya introduced fees for Africans for many dispensary and hospital services. The administration increased these fees in 1961.⁶⁹ Yet the charges proved so unpopular that Kenya's major nationalist party (the Kenya African National Union, or KANU) promised free medical care in its party platform for the 1963 elections.⁷⁰ KANU won the election handily, securing 83 of 124 seats. In 1965, Prime Minister Jomo Kenyatta honored his

⁶⁸ Stevenson, "The Health Services of Malawi." Page 120. Mossop, *History of Western Medicine in Zimbabwe*.

⁶⁹ Edmond H. Leavey, "The Economic Development of Kenya: Report of a Mission Organized by The International Bank for Reconstruction and Development at the Request of the Government of Kenya and the United Kingdom" (Baltimore: The Johns Hopkins Press, 1963). Page 248.

⁷⁰ Messac, "Moral Hazards and Moral Economies." Also see Iliffe, *East African Doctors*. Page 130.

promise and abolished most of the fees.⁷¹ Immediately thereafter, outpatient attendances quadrupled.⁷²

In Uganda, popular opposition to the healthcare fees prevented the government from imposing them in immediate postcolonial era. Africans had been provided treatment without charge in all Government medical units since 1938.⁷³ In 1956, a Colonial Office commission on medical and health services in Uganda chaired by Birmingham University Professor AC Frazer had recommended for both outpatients and inpatients in government facilities.⁷⁴ In 1962, the same year Uganda became an independent nation, a World Bank Mission echoed this advice, proposing that the Ministry of Health impose outpatient fees of at least 1s per attendance and inpatient fees of at least 3s per admission.⁷⁵ But

⁷¹ Charles Hornsby, *Kenya: A History Since Independence*, Reprint edition (London; New York: I. B. Tauris, 2013). Page 201.

⁷² Neville Rex Edwards Fendall, "Diary: Malawi," September 1965, MSS.Afr.s990, BLOU, Fendall Papers. Fendall was the Director of Medical Services in Kenya's Ministry of Health and Housing. He toured the health facilities of Malawi and Tanzania in 1965.

⁷³ AC Frazer, "Report of the Committee Appointed by His Excellency the Governor to Examine Medical and Health Services in Uganda" (Entebbe: Government Printer, December 1955). Page 107.

⁷⁴ The Frazer Committee's report said: "We consider that there is a need for some slight restraining factor applicable to the individual provided that it can be removed in the case of certain people, such as the genuinely indigent, the emergency case or for certain groups such as young children. A small fixed charge of, say, one shilling for entry into a peripheral medical unit or out-patient department would provide this effect...A similar system of charging in-patients in hospitals might also be considered...the sum should be sufficiently small not to deter sick people from seeking medical aid." AC Frazer, "Report of the Committee Appointed by His Excellency the Governor to Examine Medical and Health Services in Uganda" (Entebbe: Government Printer, December 1955). Page 107. Also see Iliffe, *East African Doctors*. Page 130.

⁷⁵ The mission recommended that the fees be "revised upward as the economy expands," and "might be higher in the more prosperous parts of the country." The Mission did advise "certain classes of exemptions, such as prenatal care, child welfare and indigent patients." Edward S. Mason, *The Economic Development of Uganda: Report of a Mission Organized by the International Bank for Reconstruction and Development at the Request of the Government of Uganda* (Baltimore: The Johns Hopkins University Press, 1962). Pages 391-392.

Uganda's postcolonial government did not heed this counsel. The state would not impose user fees at government health facilities until 1993.⁷⁶

VI. Post-ticky politics: the dueling imperatives of health and fiscal restraint

a) Failed self-help and paltry foreign aid: forced scarcity for health in the post-independence economic boom, 1965-1975

Expansion of the health sector was limited during the post-independence decade.

Malawi's economy grew rapidly during this period, buoyed by high global prices for the cash crops produced by a burgeoning estate agricultural sector (see Chapters 1 and 2).

The health sector grew as well, but it did not claim a greater share of resources (relative the size of the economy) than it had during the late colonial era. Total health spending (public and private) as a percentage of GDP barely budged between 1964 (1.5 percent) and 1973 (1.4 percent).⁷⁷ And while recurrent expenditure for health increased, scarcely more than one percent of the government's development budget went toward health services.⁷⁸ Most of this expenditure went to "maintenance of existing facilities."⁷⁹ This

⁷⁶ GM Burnham et al., "Discontinuation of Cost Sharing in Uganda," *Bulletin of the World Health Organization* 82, no. 3 (2004): 187–95.

⁷⁷ Morton, *Aid and Dependence*, 29.

⁷⁸ This level of spending was far less than was foreseen in the development plan publicized by *The Times* of Nyasaland on 2 June 1964, four days before independence. It "gave some details of a five year development plan for Malawi, announced by the government. £32,837,000 was to be spent, in the period 1964-1969, under the plan. Of this, £2,331,000 was to be spent on health, including an increase of hospital beds by 75% by 1969 and the opening of a nurses' training school in Blantyre-Limbe to train to S.R.N level. The plan incorporates a sewerage scheme for Blantyre-Limbe. £75,000 was to be spent on a census, £38,000 on market surveys and £126,000 on Blantyre airport. (Overall, 7.1% of development spending would go to health, and a further 2.9 percent to water and sanitation)..." *The Times'* Independence souvenir, July 1964, gave the total cost of the plan as £44 million again with £2,331,000 for health." See Stevenson, "The Health Services of Malawi." Page 176.

⁷⁹ *Developing Malawi: Office of the President and Cabinet, Economic Planning Division* (Zomba, Malawi: Government Press, 1971).

stasis occurred in a country with few facilities even compared to the rest of the generally impoverished southern African region.⁸⁰

Under Banda, the government's response to the many requests from local leaders for new facilities was to require the localities to undertake construction on their own using voluntary "self-help."⁸¹ Supporters of the government tended to paint an image of vibrant grassroots efforts involving enthusiastic villagers. A doctor writing in the Salisbury-based *Central African Medical Journal* in 1966 extolled Banda for having "inspired the rural population to self-help schemes. Schools, roads, hospital wards, rural medical units were built all over the country by voluntary efforts."⁸² A 1974 Malawi government publication declared "a remarkable spirit of self-help has achieved magnificent results in the rural areas...Malawians have freely given their labour to build a better future for themselves and their children. Permanent school buildings, postal agencies, clinics and dispensaries, bridges, roads and dipping tanks are only some of the many projects tackled willingly and effectively by local communities."⁸³

Unsurprisingly, the perspective from the villages was far less rosy. Local administrators found it exceedingly difficult to convince poor peasant farmers to contribute funds (over

⁸⁰ N. D. McGlashan, "The Distribution of Population and Medical Facilities in Malawi," *CAJM* 14, no. 11 (November 1968): 249–52.

⁸¹ Writing of her time in the Gold Coast just before it secured independence in 1957, Joan Wicken said self-help programs there met with great success. Hastings Kamuzu Banda, who lived in Kumasi from 1953 to 1958, might have gained interest in self-help during this time. See Wicken, "African Contrasts." Page 65-66.

⁸² Henry Mowschenson, "Dr. H Kamuzu Banda: President of the Republic of Malawi," *CAJM*, August 1966, 152–53.

⁸³ *Building the Nation: Malawi, 1964-1974. Issued to Commemorate the Tenth Anniversary of Malawi's Independence* (Blantyre, Malawi: Department of Information, 1974).

and above already burdensome taxes) and time to what were often poorly coordinated construction projects. In 1968 the Government of Malawi secured funding from the Beit Trust Fund—a charitable donation using funds bequeathed by an early investor in the British South Africa Company—to replace a dispensary located 50 miles from Fort Johnston District Hospital. While the Government had used the Beit funds to build a new dispensary by the year’s end, officials in Zomba stipulated that the unit’s staff housing must be built by self-help. Two years later the new unit it had still yet to receive any patients because, as the Secretary for Health reported, “the spirit of self-help was not coming forth in order to get the staff homes constructed.”⁸⁴ Ministry of Health officials had made a request in 1969 to the Development Division (an office in the Executive that held the purse-strings for all development expenditures) to use savings from other projects to in order to complete the staff housing, but the Division refused. One official suggested sending field staff “to encourage the growth of local initiative which, it would appear, is lacking among the people in the area.”⁸⁵ By 1971 there was still no staff housing, and the roof of the still-unused unit had been blown off.⁸⁶

⁸⁴ WP Junde, “Letter from Secretary for Health and Community Development to the District Commissioner, Fort Johnston, Re: Nankumba Health Unit - Construction of Staff Housing, 15 July 1970,” n.d., 22-20-8F, Box 53423, No 43, MNA.

⁸⁵ WJ Kazima, “Letter from Acting Commissioner for Community Development, Zomba to Acting Regional Community Development Officer, Blantyre, Re: Support for Self-Help Schemes in Fort Johnston,” September 19, 1969, 22-20-8F, Box 53423, No 27, MNA.

⁸⁶ “Notes on Meeting Held on 25th October, 1971, to Discuss Progress on Ministry of Health and Community Development 1971/72 Development Projects,” n.d., 22-20-8F, Box 53423, No 61, MNA. Colonial officials in Nyasaland had also lamented the lack of enthusiasm of villagers for “self-help.” After using imprisoned tax defaulters to build a football field next to the Karonga District Hospital, Walter Gopsill observed that a “kindly European offered to coach them, and the game became very popular, but such is the African reasoning that they requested how much money would they be paid if they played.” But he did not consider that the request for payment, and the general lack of enthusiasm for additional unpaid activities at Europeans’ behest, might be related to Africans’ experience with forced and unpaid labor, including hut taxation, *thangata*, the

Not everyone was asked to sacrifice as much as the rural denizens made to pay for their own clinics. The post-colonial Ministry of Health operated “private wards” for outpatients and inpatients in government hospitals. These facilities promised prompt attention and the most expert care for paying patients. Most of these patients came from the few thousand “Europeans” and “Asians” who continued to dominate the commercial and professional classes of Malawi’s towns and cities. But the most troublesome patients in the private wards—according to the Ministry of Health—were “VIPs.” Members of Parliament, Cabinet Ministers and their families were supposed to pay for care in private wards, but a number of them built up substantial debts to the Ministry of Health after using these facilities. The Ministry’s accountants were frustrated, but impotent, when the officials ignored their plaintive letters asking for payment. As of March 31, 1973, prominent political figures with long-standing unpaid debts included: President Banda’s private secretary Cecilia Kadzamira; Minister of Finance Aleke K. Banda; and Reserve Bank of Malawi Governor John Z. Tembo.⁸⁷ While other patients in private wards who refused to pay could eventually face legal action and wage garnishments, the Ministry of Health accountant was instructed that “accounts relating to prominent figures are not to

impressment of carrier labor during the Great War. Gopsill, “A Few Notes on My Life in Zanzibar and Nyasaland from 1926 to 1945.” Pages 26, 35.

⁸⁷ CG Kumwembe, “V.I.P. Debtors Accounts Referred to Ministry Headquarters as at 31st March, 1973, from Auditor-General to Secretary for Health,” October 22, 1973, Folder C2/90, 9.12.3F, Box 34105, MNA. As of March 31 1973, Cecelia Kadzamira owed 2 kwacha, 60 tambala (cents); Aleke Banda owed 493 kwacha, 67 tambala; John Tembo owed 447 kwacha, 97 tambala. (between 1964 and 1973, the kwacha was pegged to the value of one-half a British pound sterling.

be referred to the State Counsel without the prior authority of the Principal Secretary.”⁸⁸

Lessons about responsibility and self-help, it appeared, were only meant for the poor. The politically well-connected, on the other hand, received superior medical care without any obligation to pay.

b) “When considered in light of the funds available”: overcrowded hospitals and drug shortages, 1965-1969

For doctors and medical assistants in Malawi’s public sector, independence did not bring an end to their struggles to provide decent care. After the brief dip during the three-month-long ticky fee period, outpatient attendance at public facilities continued to rise, climbing from 8.7 million in 1965 to 11.1 million in 1969.⁸⁹ Decrepit facilities struggled to keep up with the influx of sick bodies. “Many rural health units are old, dilapidated, and ill equipped, even for the provision of the most rudimentary outpatient services and elementary medication,” wrote Maurice King, an eminence in international health who had been invited to write a development plan for Malawi’s health sector, in 1970.⁹⁰ Even at the nation’s flagship hospital, Queen Elizabeth in Blantyre, staff felt overwhelmed. In 1967 the Hospital Secretary wrote the Secretary for Health to explain that his hospital urgently needed an inpatient intensive care unit for critical cases, as well as a completely

⁸⁸ “Letter from SFO to US, Re: Mr JZU Tembo,” March 19, 1971, C2/90, Folio 145, MNA. This forbearance towards the rich proved quite costly. In April 1971, total unpaid debts of private ward patients had reached 48,643 kwacha (or £24,321). By April 1973, this figure had nearly tripled, to 132,102 kwacha (or £66,051). See “From the Accountant General, Zomba, to Secretary for Health, Blantyre, Re: Hospital Accounts: Invoicing and Collection of Accounts Outstanding,” November 12, 1973, C2/90, Folio 302, MNA.

⁸⁹ King, “Development Plan for Health Services, 1970-1985.” and “Annual Report of the Ministry of Health for the Year 1965” (Zomba, Malawi: Government Printer, 1968), Centre of African Studies Pamphlets, Malawi Box 3, UoELA.

⁹⁰ Maurice King, “The development of health services in Malawi, 1970-1985. Zomba: Ministry of Health and Community Development, 1970.

new outpatient and casualty block. If the rate of increased attendance continued at its current pace, by 1975 his hospital alone would be visited by 2,000 to 3,000 outpatients every day.⁹¹

Correspondence between physicians and administrators remained contentious. In a 1965 letter to the Medical Superintendent of Zomba's hospitals, Director of Medical Services Durrant wrote, "My impression is that your health units have been receiving excessive quantities—not excessive to their needs, but excessive when considered in light of the funds available for Zomba Hospital. I am sure that this matter will cure itself in time."⁹² But Durrant's condescending tone did not quiet the small but vocal cadre of physicians in district hospitals who could not accustom themselves to the practice of medicine without medicines. A Dutch doctor working at Nkhata Bay District Hospital in the late 1960s bitterly recalled the futility of his pleading letters to the Central Medical Stores. The central stores, he remembered, often ran out of such basic items as "tetracycline, ferrous sulphate, chloroquine, penicillin, Lysol, acetyl salicylate and dressings (all sizes)."⁹³ He could not intubate his surgical patients even when they were put under general anesthesia "because the proper tubes were not obtainable for a long time and because nobody was trained in this technique."⁹⁴

⁹¹ LJD Harris, Hospital Secretary, QECH to Secretary for Health Peters: "Development: Queen Elizabeth Central Hospital," 1 March 1967, Box 13380, Location 7-6-11F, MNA.

⁹² HR Durrant, Officer in Charge to Medical Superintendent, Zomba Hospital, cc Secretary for Health, Blantyre, "Medical Supplies," 3 Feb 1965, Folder 3405, 2.1.1.F, Box 12484, MNA.

⁹³ Winter, *Health Services of a District Hospital in Malawi*, 121.

⁹⁴ *Ibid*, 124.

Malawi's facilities were not only under-equipped; most were run by a few harried staff with minimal training. In 1965 there were only 27 doctors in the government service; 22 worked in the three central hospitals, and five staffed district hospitals.⁹⁵ That same year the country had 83 nurses (graduate or state-registered); 75 worked at the central hospitals, and 8 at district hospitals. In the nation's first full year of independence, auxiliaries (e.g. medical assistants, maternity assistants, midwives and health assistants) were the only staff at all 112 rural hospitals and rural health centers. These cadres required no more than seven years of elementary education and two to three years of technical training.⁹⁶ Supervision was almost entirely absent; some Medical Assistants worked alone at rural dispensaries for years without even a visit from a doctor or nurse.⁹⁷

While doctors and nurses in the central hospitals complained of deficiencies at their facilities, the auxiliaries at rural facilities toiled in far worse conditions. In the late 1960s, while serving on a Rockefeller Foundation commission, US physician John Bryant visited a hospital in the town of Port Herald. He wrote:

There is not a single doctor, not a single nurse... The outpatient service is jammed with a pressing, murmuring throng... Two medical assistants are surrounded at their desks. Some intangible feeling of sequence in the crowd tells each whose turn it is. Diagnoses are made on the basis of the first words uttered by the patient and are at the simplest possible level. Each takes one or two minutes. Cases that cannot be handled in this way may be set aside for a more thorough examination, and perhaps for a laboratory test (the lab is small, closetlike, with a microscope, a

⁹⁵ In those facilities fortunate enough to have a doctor, their salaries took up a large portion of the personnel budget. At Nkhata-Bay District Hospital, one doctor earned 20 percent of the total wage bill (in a hospital with 50 staff). Ibid, 111. De Winter notes that a study in Uganda found that 2 doctors at a hospital (with 69 staff) in Uganda together earned 20 percent of the total wage bill.

⁹⁶ John Bryant, *Health and the Developing World*, 1st Edition (Ithaca N.Y.: Cornell University Press, 1969), 58.

⁹⁷ Ibid, 112.

hand-driven centrifuge, and a few bottles of stain) and consultation with one of the more senior medical assistants. The medical assistants see about three hundred patients during the morning. A baby has ‘warmth of the body.’ The blood is examined for malaria: positive. The treatment: chloroquine. Everyone with fever is assumed to have malaria. If he has a cough, pneumonia or bronchitis is suspected and penicillin is added... The next has abdominal pain. What do you do about abdominal pain in two minutes?⁹⁸

Bryant described this scene to illustrate a conundrum facing contemporary international health experts about the value of biomedical care delivered by unsupervised medical auxiliaries in rural Africa. Was their care worse than none at all? Bryant did not put himself on either side of the debate, nor did he condemn the auxiliaries or the Ministry of Health for the low standards. But Malawi’s public sector was to no one’s eyes a model of medical provision.

c) Keeping it free: Banda’s refusal to reintroduce health care user fees

According to Kathryn Morton, at independence Banda did not consider education and medicine “investments,” but rather “consumption” items. But despite the fact that Banda, like other modernizers, thought health and education unproductive social services, he believed that Malawians should reasonably expect some such services from their new government. Banda worked to provide, in the first few years of his rule, a district hospital (staffed by a medical officer) and a secondary school in every district. As of the late 1960s, he also ensured that food was provided to inpatients free of charge in government hospitals.⁹⁹ While he was not willing to spend much of Malawi’s development or recurrent budgets on health, Banda was loath to risk further unrest by attempting to

⁹⁸ Bryant, *Health and the Developing World*, 59-60.

⁹⁹ Eric De Winter described the budget for patients’ food at the Nkhata Bay district hospital: “For patients’ food the hospital paid \$0.15 per person per day, for which amount they received about 2000 calories, 65 grams protein (23 grams of animal origin) and 50 mg Vitamin C.” Winter, *Health Services of a District Hospital in Malawi*. Page 121.

reenact health care user fees. Throughout his long rule, Banda did not reinstitute point-of-care user fees at public sector facilities.

This insistence on free care was particularly striking because there was a general move early in Banda's rule toward shifting costs of social services onto Malawi's citizens. In its 1961 election manifesto the Malawi Congress Party had pledged universal free primary education.¹⁰⁰ But by 1963, Banda instituted fees at government primary schools in order to limit public expenditure. The number of primary school graduates *decreased* in Malawi's first decade of independence.¹⁰¹

But Banda did not forget how Chipembere used the ticky fees to foster discontent against him. And through the first decades of his rule, Banda saw his hold on power as precarious. In the first year of Malawi's independence his public speeches were entirely occupied with the hunt for Chipembere.¹⁰² After Chipembere fled, Banda remained concerned about other ex-ministers in exile, particularly Yatuta Chisiza, elder brother of the late Dunduzu Chisiza and Banda's own former bodyguard. Like Chipembere, the elder Chisiza had defected from Banda's government during the 1964 Cabinet Crisis.

¹⁰⁰ "The Party's ultimate aim and object is the provision of Universal Education and towards this end the Malawi Congress Party will take immediate steps to see that all children who go to Primary Schools finish their primary education without let or hindrance." *Malawi Congress Party Manifesto for the General Election, August 1961* (Limbe, Malawi: Malawi Congress Party, n.d.), Page 7.

¹⁰¹ Morton, *Aid and Dependence*; Lwanda, *Colour, Class and Culture*.

¹⁰² In one of many speeches on Chipembere, Banda addressed "the nation" over the radio (which only a small share of Malawian households owned) in February 1965, less than a week after Chipembere's failed attempt to reach Zomba. He assured the nation that he was in control, and promising that he would "crush Chipembere and anyone pinning his hope on Chipembere." Hastings Kamuzu Banda, "Prime Minister's Speech to the Nation, Transcript, Ministry of Information, Blantyre," February 18, 1965, HK Banda's Speech Collection, MNA.

While in exile in Tanzania, he founded the Socialist League of Malawi (LESOMA). He and his followers launched small guerilla incursions into Malawi until October 1967, when he was shot by Malawian troops during a failed invasion.¹⁰³

No sooner had this threat abated than another arose, this time in the form of a rumor.

Between November 1968 and March 1970, at least 33 people died in a series of murders in the Blantyre suburb of Chilobwe. One of the most popular explanations for the spate of killings was that the government was allowing white South Africans to take Malawians' blood as repayment for loans Banda had taken out to build the new capital at Lilongwe. These rumors had a context. Malawians had long experience repaying odious debts (see Chapter 1), and vampire rumors were a well-known genre used to critique exploitation in southern and eastern Africa.¹⁰⁴

The rumors fanned unrest, particularly near estates in the South, where protesters attacked MCP officials. Banda tried to appease the discontents by making summary

¹⁰³ Baker, *Revolt of the Ministers*. Page 319.

¹⁰⁴ Paul Brietzke, "The Chilobwe Murders Trial," *African Studies Review* 17, no. 2 (September 1974): 361–79. Rumors about vampires have inspired a rich literature in Africanist anthropology. Luise White has shown that "vampire" accusations directed against police and other agents of colonial rule had political connotations. They were an articulation of a radical critique of colonial exploitation. To charge a person with taking another's substance (either blood or fertility) is to make a public political objection to something one considers evil. Luise White, *Speaking with Vampires* (Berkeley: University of California Press, 2000). The sale of blood was also not only the stuff of rumor. As early as the late 1960s, the Duvalier regime in Haiti sold, at a tremendous profit, blood and plasma from poor Haitians to hospitals and laboratories in the United States. Paul Farmer, *AIDS and Accusation: Haiti and the Geography of Blame* (Berkeley: University of California Press, 1992), pages 239-240.

arrests for the murders. He also ordered estates to surrender 14,000 acres of land, which were redistributed to the landless.¹⁰⁵

Health policy must be understood in the context of this unrest. In this uncertain political environment, Banda would not risk such an unpopular decision as the imposition of user fees. Yet to expatriate physicians and advisers, health care user fees remained a necessary policy. In a health sector development plan commissioned by the Ministry of Health in 1970, Dr. Maurice King—an eminence in international health circles—acknowledged that fees were a “highly contentious issue” but insisted that they were “only too likely to be the practical option.” His assumption was that fees would improve the quality of health services: “Services which have to be paid for,” he chided, “are better than no services at all.”¹⁰⁶ Two years later, Dutch physician Eric de Winter marveled that “about 30-40 per cent of the outpatients [at Nkhata Bay District Hospital] seemed to be without organic disease.” De Winter reckoned that auxiliaries used most of their penicillin injections on such patients in order to engender a placebo effect.¹⁰⁷ Echoing economist Mark Pauly’s claim that point-of-care fees were a defense against a rational “moral hazard” among the insured, de Winter presented fees as the answer to the overcrowding

¹⁰⁵ Simon Thomas, “Economic Developments in Malawi Since Independence,” *Journal of Southern African Studies* 2, no. 1 (October 1975): 30–51.

¹⁰⁶ King, “Development Plan for Health Services, 1970-1985.” Page 45.

¹⁰⁷ An intriguing consequence of this prescribing practice (which throughout the 1960s and 1970s, was decried as “irrational”) was suggested by a member of a leprosy control project in Malawi in 1978. Their team had documented “a steady decline in the incidence of positive results of the Kahn test...in Malawian patients during the period 1968-75...It is suggested that the downward trend in the incidence of syphilis in Africa is related to the increased and often indiscriminate use of penicillin.” F. Rampen, “Venereal Syphilis in Tropical Africa,” *The British Journal of Venereal Diseases* 54, no. 6 (December 1978): 364–68.

of hospitals by patients who were not truly sick.¹⁰⁸ “Even the raising of a minimal fee from each outpatient for each attendance would greatly reduce the number of unnecessary attendances. For political reasons,” de Winter continued, “such a measure is not likely to be taken by the Malawi government.”¹⁰⁹ As of 2015, health fees had never been reinstated in Malawi, in spite of the counsel of the World Bank (in the 1990s) as well as University of Malawi economists and prominent domestic commentators (in the 2010s).¹¹⁰

III. Fertility control vs. mortality control: the Banda-McNamara debate over population policy and a national health budget held hostage

a) Seeking international assistance for health, 1964-1969

A few bilateral aid programs continued to provide modest funding for health projects during the 1960s. Immediately after independence in 1964, with Malawi’s health sector almost devoid of doctors, Israel sent seven to work in the Ministry of Health; it also funded scholarships for nurses to train in Israel. In 1966, the West German government began to help plan and fund the renovation of the African Hospital in Zomba. Between 1965 and 1967, UNICEF provided \$114,000 for teaching equipment, drugs, vehicles, and training sessions focused on maternal and child health.¹¹¹

¹⁰⁸ See Mark Pauly, “The economics of moral hazards: comment,” *American Economic Review* 1968 58, no. 3 (1968): 531-537.

¹⁰⁹ Winter, *Health Services of a District Hospital in Malawi*.

¹¹⁰ Muluji, *Mau Anga*; Messac, “Moral Hazards and Moral Economies”; *Handbook of Micro Health Insurance in Africa*, 1 edition (Zurich: LIT Verlag, 2012).

¹¹¹ “Economic and Social Developments, Including Assistance Programmes Other than the UNDP, January-June 1966,” Quarterly Reports, United Nations Development Programme, (November 10, 1966), Item No. 1047167, WBGA.

But by the 1960s most of the largest bilateral and multilateral aid agencies counseled “patience in the face of poverty,” as Kapur summarizes the World Bank’s approach to financing (or, rather, not financing) health and education during the postwar decades. During the early 1950s the United States Agency for International Development (USAID) had funded malaria eradication programs and vaccination programs. Such funding was particularly focused on Southeast Asia, where American officials devoted funds toward rural health and agriculture for security purposes rather than more strictly economic ones; they hoped that mitigating rural poverty in this region might lessen the appeal of communist propaganda.¹¹² But in the late 1950s USAID began to cut its grant support for malaria eradication programs, and by the mid-1960s its health programming was almost entirely focused on family planning.¹¹³ At the same time, UN agencies such as the Food and Agriculture Organization also turned their attention away disease control.¹¹⁴ Malawi may have found a few donors willing to fund small initiatives or provide a few personnel, but the lack of donor support for health made it nearly impossible for the new nation to fund improvements to its medical services with external loans and grants. In the seven years following independence, health spending made up only one percent of the government’s development (capital) budget.

Between the mid-1950s and the late 1960s, then, mainstream development thought as well as bilateral and multilateral aid agencies gave less and less attention to health in poor

¹¹² Devesh Kapur, John P. Lewis, and Richard C. Webb, *The World Bank: Its First Half Century*, 2 Volume set edition (Washington, D.C: Brookings Institution Press, 1997).,Page 112

¹¹³ Packard, “Visions of Post-War Health and Development and Their Impact on Public Health Interventions in the Developing World.” Pages 107-108.

¹¹⁴ Ibid. pages 107-108.

countries. The most influential studies of development were no longer surveys conducted by nutritionists, anthropologists, botanists and agricultural experts, but econometric analyses using formal mathematical models constructed by economists. This new cadre of development experts saw little use for health programs; their impact was difficult to measure and appeared to have a long and uncertain gestation. The World Bank, USAID, the UK Treasury, UN agencies and other donors echoed the economists' counsel. In this intellectual and financial environment, the holders of budgetary purse-strings in late-colonial Nyasaland and post-colonial Malawi found little support for efforts to undertake new health interventions, or even to maintain existing programs in public health and curative medicine.

b) Coolness to health at the World Bank, 1946-1968

When Malawi's development planners did actively seek funding for health projects from international aid agencies, they were rebuffed. At the October 1969 annual meeting of the World Bank in Washington, DC, Malawi Minister of Finance Aleke Banda [no relation to Kamuzu] and his team of advisers met with Abdel El-Emary, Director of the Africa Department. Late in the meeting, the Minister of Finance mentioned that Malawi was planning to approach the bank for assistance in financing health. Banda argued health projects "could be justified on social and economic grounds, although he was fully aware of the difficulty of evaluating a health project economically." El-Emary's response was not promising; he said he "could not make any positive statement on Bank interest or involvement in the area of health."¹¹⁵

¹¹⁵ "Memorandum from GE Okurume, Re: Annual Meeting Departmental Discussions Held on September 29, 1969," October 17, 1969, Item No. 1860299, WBG. This was a common experience for new governments seeking health funding from the World Bank. Following

El-Emary's response was in keeping with the position maintained toward Malawi since it joined the World Bank as an independent nation in 1964. In 1967, El-Emary had written approvingly to the United Nations Development Programme about Malawi's economic policy thus far:

Although Government expenditure must be spread over the whole range of Government services, including social and security services as well as economic ones, the greatest emphasis is given to those projects which resulting an increase in the national product. Projects which result in increased exports (or a reduction of imports) find special favour.¹¹⁶

The World Bank's unwillingness to finance health care in Malawi was simply a recapitulation of its approach to all countries prior to the 1970s.¹¹⁷ The vast majority of World Bank lending to poor countries the first quarter-century after Bretton Woods was for power and transportation projects, with much of the balance going toward industry and telecommunications, industry, and a pittance for agriculture. None went toward education or health. Bank historians Mason and Asher argue this omission stemmed both from the difficulty of measuring the effect of education and health programs on aggregate production, and the concern that such financing would raise among the Wall Street

independence in 1966, Botswana's new government sought funding from the World Bank for health projects. Quett Masire, Botswana's first Minister of Finance, recalled his conversations with Bank officials during those years. "The World Bank didn't want to touch social infrastructure, because the rule of the day was expenditure should have a rate of return... We had a very difficult time to justify raising money for schools, raising money for hospitals." "Social infrastructure" was Masire's favored term for government health and education spending. While the Bank provided loans for "physical infrastructure" (e.g. roads, bridges, power plants and factories), it refused to finance social infrastructure. Personal Interview with former President Quett Masire, Gaborone, Botswana., November 6, 2015.

¹¹⁶ "AG El Emary to Mr RH Demuth, Forwarding Paper Entitled 'UNDP Assistance to Malawi,'" April 7, 1967, Item No. 1047167, WBG. Page 3.

¹¹⁷ A World Bank study of Kenya's economy in 1962 warned against increases in health spending. A 1961 World Bank report on Uganda demanded "vigorous action" to stem further expansion of the government health sector. See Iliffe, *East African Doctors*. Page 130.

financiers who held much of the Bank's debt.¹¹⁸ The tone had been set as early as 1949, when Lauchlin Currie, a former special adviser to US President Franklin Delano Roosevelt, had tried to persuade World Bank Vice President Robert Garner to finance health and education programs in Colombia. Garner recoiled: "Damn it, Lauch. We can't go messing around with education and health. We're a bank!"¹¹⁹

b) Malawi and the World Bank battle over population control, 1969

When John Adelman returned to World Bank headquarters in Washington, D.C. from a visit to Malawi in July 1969, the findings he included in his report amplified two arguments that were then gaining attention in development circles. The first was that health was not getting enough attention. "Public health," he began, "is another area where I believe present thinking in Malawi may be too cautious. A growth rate of only 4% is being allowed for in current health expenditures, most of which are for curative purposes. Malaria, tuberculosis, and malnutrition are still widespread, as are intestinal parasites and bilharzia."¹²⁰ But this claim was tempered by the second idea rising to prominence—that disease control in the absence of family planning was a waste of money. "Still," he continued, "it is difficult to press for a large scale general attack on these problems, both because of financial limitations and also because one is reluctant to encourage a major

¹¹⁸ Edward Sagendorph Mason and Robert E. Asher, *The World Bank Since Bretton Woods: The Origins, Policies, Operations, and Impact of the International Bank for Reconstruction and Development and the Other Members of the World Bank Group: The International Finance Corporation, the International Development Association [and] the International Centre for Settlement of Investment Disputes* (Brookings Institution Press, 1973), p 189-190, 151-152; Kapur, Lewis, and Webb, *The World Bank.*, 109-110.

¹¹⁹ Kapur, Lewis, and Webb, *The World Bank.*, 111. A 1952 World Bank Survey Mission report on Nicaragua recommended "expenditures to improve sanitation, education and public health should, without question, be given first priority in any program to increase the long range growth and

¹²⁰ John A Adelman, "Back-to-Office Report, Mission to Malawi. Submitted to Mr Abdel G El Emary," July 31, 1969, Item No. 1860299, WBGA. Page 15.

mortality control campaign prior to seeing some official receptivity to a fertility control campaign. The latter is definitely absent at this time.”¹²¹ These linked ideas, that health was worthy of additional funding, but only alongside population control, would help shape development experts’ writings on Malawi for the next decade.

Adelman had shared these thoughts with Malawian officials prior to his departure, prompting a critical response from President Hastings Kamuzu Banda. At the end of his October 14, 1969 meeting with Abdel El-Emary in Washington (where El-Emary had discouraged any application for health funding), Malawi Minister of Finance Aleke Banda handed him a letter from President Banda. The letter, addressed to World Bank Group President Robert McNamara, included the following passage:

One of the officials of the Bank who was here recently, among other things, mentioned the question of population explosion in this country. He said that our annual birth rate was too high and that we should do something about it. I disagreed with him. Although by African standards Malawi is relatively a small country, it is not true to say that our population is too big for the size of the country. Malawi is 45,000 square miles as against Taiwan’s 14,000 and Israel’s 8,000 square miles as of June 1967. Yet Taiwan supports a population of 14 million and Israel at least 2 million. I sincerely and honestly believe that properly developed, Malawi can support a population of even 20 million. Because although it is small in area, Malawi has very rich agricultural soil. As I am writing there are vast rich agricultural areas unoccupied...Population explosion is not a problem in Malawi for the next fifty years, if not a hundred years. The problem is development for which we need finance.¹²²

Banda could scarcely have written a passage more offensive to McNamara. An adamant proponent of population control as a prerequisite for prosperity in developing nations, McNamara believed that decreasing the fertility rate should be a central goal of Malawi’s

¹²¹ Adelman, “Back-to-Office Report, Mission to Malawi. Submitted to Mr Abdel G El Emary.” Page 15.

¹²² “Malawi President Hastings Kamuzu Banda to World Bank Group President Robert McNamara, delivered by Aleke Banda on 14 July 1969,” September 12, 1969, Item No. 1860299, WBGA. Page 2.

health policy.¹²³ He said as much when he responded to Malawi's President, less than a week after receiving the letter: "The concern I have expressed on a number of occasions is with a situation in which the rate of population increase, is outstripping, or threatens to outstrip, the rate of economic growth, with the result that economic development does not result in human development...I...firmly believe that family planning is important for all developing countries which have excessively high rates of population increase."¹²⁴

This profound disagreement on population policy, born of deeply held beliefs and political interests on both sides, would prove a sticking point in Malawi's discussions with the World Bank. The disagreement would sour personal relationships between Banda and many of the holders of the purse-strings of aid, and for a few years in the late 1960s and early 1970s seemed to threaten the possibility of external aid for health reaching Malawi. But, as this section will explain, Banda had his own reasons for his pro-natalist position, and eventually McNamara and the World Bank, and some other funders,

¹²³ As Megan Vaughan has demonstrated for Nyasaland during the 1940s, claims of population pressure have long been intimately tied contests over land between white settlers and Africans. See Vaughan, *The Story of an African Famine*. For a sense of how population policy fit into the politics of race and resources in southern Africa, compare Banda's pro-natalist position with the support for controlling the *African* population of Southern Rhodesia, which was voiced by that nation's Secretary for Health, MH Webster, in the early 1970s: "The growth of the African population, making ever increasing and clamorous demands on the services of this country while not contributing to the cost of these services in proportion, is putting an almost unbearable strain on the medical services and on other social services. Of course, the medical services of Rhodesia can to some extent be held responsible for this population growth, and in this respect they may be working towards their own self destruction. A natural increase of 3,6 percent in population per annum simply cannot be sustained. It means in terms of hospital beds, for example. 550 new hospital beds every year. Taken in conjunction with the provision of new schools, new houses, new jobs, the total cost of this mounts up to astronomical figures, which cannot be sustained by the taxpaying section of the community." MH Webster (Secretary For health): A review of the development of the health services of Rhodesia from 1923 to the Present, Part IV, *CAJM*, p.50.

¹²⁴ "World Bank Group President Robert McNamara to Malawi President Hastings Kamuzu Banda," October 20, 1969, Item No. 1860299, WBGA.

moved toward more comprehensive (though still not amply funded) support for health programming in Malawi.

c) Population control in international health, 1964-1970

The idea that per-capita economic growth in poor countries was being hindered not just by slow aggregate production increases, but by rapid population increases, became ever more prominent in international development planning during the early 1960s. Less than three decades after the Holocaust had rendered discussions of mass sterilization suspect in Western political discourse, private and public sources of international aid dollars (particularly in the United States) opened their wallets and propounded the virtues of population control. At their June 1962 annual meeting, the Board of Directors of the Ford Foundation approved \$10.7 million in funding for population projects, surpassing its support for such work over all years in the prior decade combined.¹²⁵ In April 1963, US President John F Kennedy endorsed the idea of international aid for family planning in response to a reporters' question (in an exchange choreographed by Planned Parenthood employees).¹²⁶ Kennedy's successor, President Lyndon B. Johnson, initially appeared averse to funding for population control policies; early in his tenure he even declined to meet with the (hereditarily) wealthy activists John D. Rockefeller III and William Draper to discuss the issue. But beginning in 1966, with support from Johnson and leading members of the United States Senate, USAID began receiving ever-larger appropriations

¹²⁵ Matthew Connelly, *Fatal Misconception: The Struggle to Control World Population* (Cambridge, Mass.: Belknap Press, 2010)., 206

¹²⁶ *Ibid.*, 199.

to fund intrauterine device (IUD) insertion and mass sterilization campaigns in the developing world, with a particular focus on India.¹²⁷

President Johnson's conversion from skeptic to believer on population control is another example of the political potency of economic projections that rely on heroic assumptions rather than any grounded data. The key to Johnson's persuasion was a paper written in 1965 by the economist Stephen Enke, then working at the RAND Corporation (Enke would later become deputy assistant secretary of state). Enke's projections made use of, and drove to logical extremes, Arthur Lewis' ideas about the surfeit of labor supplies in poor nations and the backwardness of the "traditional sector." He assumed that children were unproductive consumers until age 15. Then he discounted the value of consumption during childhood by 15 percent per year. Using these two priors, Enke calculated that in the average poor country the net present value of a newborn was -\$279; that is to say, for every child *not* born a nation stood to *save* a net \$279 on unproductive consumption.¹²⁸

Enke admitted that this calculation of the value of a life should consider the negative net present value of a child's 15 years of consumption alongside the positive net present value of her future production as an adult, but he did not even include a calculation the latter, as he assumed this discounted value was so negligible as not to merit inclusion in

¹²⁷ Ibid., 233.

¹²⁸ Ibid., 213. This view of children as an economic liability is diametrically opposed to the view of many African parents. As Benjamin Platt (a main character in Chapter 2) noted in 1960, only a few years before Enke's paper, "When talking to some of the older people in an African village about these questions they will say they have four children in order that two or even one may survive to take care of the parents in their old age. That is... children are an economic asset." BS Platt, "The Effects of Maternal and Child Welfare Work on Problems of Population" (1960), LSHTM Nut/07/03/11.

his equation. Instead, using the negative consumption figure alongside assumptions about fertility rates and capital/output ratios, Enke estimated that when compared to “investment for extra output...a birth control program would be 250 times more effective a means of raising per capita income per unit of resources so employed.”¹²⁹

The lack of evidence supporting Enke’s calculations did not prevent them from reaching the desks of powerful decision-makers.¹³⁰ Upon reading this study in April 1965, Robert Komer, a staffer on the U.S. National Security Council, sent it along with a note to McGeorge Bundy, Johnson’s National Security Advisor. Komer wrote that the “hard dollar and cents argument” in the paper “might just penetrate LBJ’s defenses.” Indeed, Komer’s memo did pique President Johnson’s interest, and in June 1965 he publicly called for greater investments in population control, claiming—in a downward revision of Enke’s projections that might be attributed to forgetfulness—“less than five dollars invested in population control is worth a hundred dollars invested in economic growth.”¹³¹

¹²⁹ Stephen Enke, “Lower Birth Rates: Some Economic Aspects,” 12 February 1965, National Security File, Files of Robert W Komer, Box 48, Lyndon Baines Johnson Presidential Library. Pages 10-13. Enke admitted these assumptions were not based on any empirical data. “Depending on assumptions regarding diminishing returns, death rates, consumption, productivity, and proper discount rates, hopefully appropriate to each LDC, the value of permanently preventing birth can logically be estimated for it. Obviously a great deal of empirical research to determine these parameters by country needs to be taken. At present these calculations are not being made by development planners.” Enke, “Lower Birth Rates,” Page 10. And while Enke admitted that returns on investments in health and education “may be very great,” no allowances for this possibility were included in his model. Also see Connelly, *Fatal Misconception*, Pages 211-212.

¹³⁰ For more on the politics of statistical sleights of hand, see Scott, *Two Cheers for Anarchism*, 124.

¹³¹ Connelly, *Fatal Misconception*, 213.

The focus on population control quickly migrated the few blocks from the White House to 1818 H Street NW, headquarters of the World Bank. By 1966, Komer had convinced George Woods, then the Bank's President, to condition its aid to India (including food aid) on satisfactory population control policies.¹³² In 1967, the Bank began including information on population growth and population policies in borrower nations as "one indicator of their commitment to economic growth."¹³³ Woods' successor, Robert McNamara, who had served as US Defense Secretary under Johnson, was an even more vigorous proponent of population control upon assuming the position of Bank President in 1968. McNamara joined the Board of Trustees of the Ford Foundation in the same month he began as Bank President. His speeches, including an address at the University of Notre Dame in 1969, echoed a finding of a World Bank-commissioned study led by Lester Pearson that same year, which argued that increasing fertility rates were overwhelming investments in development.¹³⁴ His dire warnings that high fertility rates were a threat to the economies of poor nations also coincided with increasing popular

¹³² Ibid., 213.

¹³³ Kapur, Lewis, and Webb, *The World Bank.*, 249.

¹³⁴ Ibid., 252-253. "No other phenomenon," Pearson, wrote, "casts a darker shadow over the prospects for international development than the staggering growth of population... When the population doubles in twenty-five years, the task of development and modernization is compounded. It may even be impossible to attain significant improvement in living conditions and independence of foreign aid... There can be no serious social and economic planning unless the ominous implications of uncontrolled population growth are understood and acted upon." See Lester B Pearson, *Partners in Development: Report of the Commission on International Development* (New York: Praeger Publishers, 1969). Pages 55-58. Pearson did not, however, go as far as McNamara and others would in calling for a halt to investments in "mortality control" until such time as fertility had been dampened. While Pearson thought that the decline in mortality in poor counties was "the underlying cause of the grave problem of population growth," he continued to argue that "this does not detract from its value. In human terms, it has been the most convincing demonstration of the power of applied science. It has lifted people's spirits and raised their sights in planning for the future. It has increased the capacity to work, and it has opened up territories for new cultivation where disease had previously been rampant." Page 40. W. Arthur Lewis also served on this Commission.

concern in Western publics, seen most notably in the rapid sales and intense media coverage of Paul and Anne Ehrlich's *The Population Bomb*, published in 1968.¹³⁵

McNamara had not abandoned the maximization of per capita output as a measure of development, but for him it was as important to keep the denominator in the measure (population) low even as other development lending strove to push up the numerator (aggregate output).

McNamara's focus on stemming rising populations was so myopic that he was unwilling to contemplate support for health care before achieving declines in borrower nations' fertility rates. His own justifications for this requirement pitted mortality control against fertility control in the same way as Adelman did in his report on Malawi. In a March 1969 response to a Bank official who had proposed financial support for preventive health services in Jamaica, McNamara said "he was reluctant to consider financing of health care unless it was very strictly related to population control, because usually health facilities contributed to the decline of the death rate, and thereby to the population explosion."¹³⁶

¹³⁵ Paul R. Ehrlich, *The Population Bomb* (Cutchogue, N.Y.: Buccaneer Books, 1968).

¹³⁶ Kapur, Lewis, and Webb, *The World Bank.*, 249-250, World Bank, minutes of president's council meeting, march 3, 1969. These neo-Malthusian arguments against health services were revived once more during the 1990s, when leading global public health journals published articles by experts who claimed that reducing child mortality would only increase populations to ecologically unsustainable levels and doom them to famine or other forms of ruin. In a 1990 article published in the *Lancet*, Maurice King counseled against "such desustaining measures as oral rehydration...since they increase the man-years of human misery," and urged the realization that "health services may not be a priority for [poor] communities." Yet healthcare provision has been nowhere shown to be a threat to demographic stability. AIDS mortality has inconsistent effects on population-level fertility rates. Meanwhile, nations that have achieved substantial fertility declines have often done so not by permitting mass die-off, but by expanding human capabilities. For instance, an analysis in India found that female literacy accounts for approximately three-quarters of fertility decline in regression models, while the relationship

d) Population control in World Bank reports on Malawi, 1971

In its reports on Malawi during the late 1960s and early 1970s, the World Bank made the new nation's rising population a much more central concern than its dearth of healthcare providers and facilities. The report of a 1971 Bank mission to Malawi included no discrete section on health services. In fact, the only mention came in the section devoted to "population pressure," which made a virtue of the country's absence of health services. "The structure of population and the high fertility ratios, in addition to the pressure of population on land, could create a serious demographic problem, particularly if there is some improvement in health services on which expenditure is at present very low."¹³⁷ The report noted per capita recurrent public expenditure on health was only about \$0.85 per year, and guessed that it "might amount to just over \$1 when accounting for the expenditures by missionaries." Between 1964 and 1971, yearly per capita development expenditure on health had declined, "and currently averages only 3 cents." The authors predicted that this situation was politically untenable, as "sooner or later, there is bound to be increased pressure for an improvement in health." But the authors did not look forward to such political pressure, as it would bring forth "a marked reduction in infant

between fertility and per-capita income was not statistically significant. See Farmer, Basilico, Messac, "After McKeown." Shane Doyle's *Before HIV*, a careful demographic study of a few selected regions in Uganda and Tanzania, finds that fertility declines followed improvements in child survival. Apparently, women had fewer children once they could expect more of them to survive to adulthood. Shane (Shane Declan) Doyle, *Before HIV: Sexuality, Fertility and Mortality in East Africa, 1900-1980*, 1st ed. (Oxford: Oxford University Press, 2013).

¹³⁷ "Recent Economic Developments: Malawi" (International Bank for Reconstruction and Development, International Development Association, Eastern Africa Department, August 27, 1971), WBGA Website. Page 5. In an annex to the report, the authors admitted that in the absence of vital registration estimates of fertility were difficult, but used the 1966 Census to estimate that "the average number of children born to a mother by the age of 55 is 7.2, while the average number of children per family would probably be only between 3 and 4." The discrepancy between the birth rate per woman and the number of children per family is not explained here, but might be due to an assumption of high infant and child mortality rates.

mortality” (from its current level of “240 deaths per 1,000 live births which makes it probably one of the highest in Africa”), and a subsequent rise in population. To the itinerant prognosticators who authored this report, astronomical rates of infant mortality were a rather useful check on overpopulation.

e) Explaining pro-natalism in Banda’s Malawi, 1965-1975

While the World Bank, USAID, the Ford Foundation and other sources of international aid focused on IUD insertion and sterilization campaigns in India and elsewhere, Banda would lend no public support to birth control measures in Malawi. He banned books on birth control, and deported a Dutch missionary who had delivered lectures on the subject. In early 1965, a Medical Officer’s request for the oral contraceptive Anovular from Malawi’s Medical Stores was cancelled on the grounds that “contraceptives are not supplied from Government Hospitals.”¹³⁸ Historians of Malawi, and Banda himself, have offered varied reasons for his opposition to birth control in particular, and population control more generally. First, he saw Malawi’s rising population not as a threat, but as a desirable trend. In public addresses he often declared Malawi was blessed with vast expanses of fertile soil, which could support many millions more.¹³⁹ Banda told his critics that he would reconsider his position on birth control only when Malawi was peopled enough to have every acre of its arable land under cultivation.¹⁴⁰ Banda may have also relished this stand against the opinion of “so-called experts,” whose counsel ran counter to the tested wisdom of “the ordinary man and woman in the village.”¹⁴¹

¹³⁸ “Letter from HR Durrant, Officer in Charge, to Medical Superintendent, Zomba Hospital, re ‘Medical Supplies,’” February 3, 1965, Folder 3405, 2.1.1.F, Box 12484, MNA.

¹³⁹ Morton, *Aid and Dependence.*, 117-118

¹⁴⁰ Philip Short, *Banda* (Boston: Routledge & Kegan Paul, 1974)., 279-280

¹⁴¹ *Ibid.*, 279

To some observers Banda's position on birth control could be attributed to his puritanical beliefs and authoritarian dealings on matters of personal conduct. Banda did not drink or smoke, and promulgated laws against drunkenness within a year of Malawi's independence. Most famously, beginning in the late 1960s he banned Malawian women from wearing mini-dresses or even trousers.¹⁴² But if in some ways Banda's cultural views fit well with the contemporary Western backlash against the sexual revolution, in other ways his stance on population drew upon views of sexual morality that cultural conservatives elsewhere would have considered scandalous.¹⁴³ In 1947, while working as a physician in North London, Banda and the Scottish missionary Cullen Young coauthored a preface to *Our African Way of Life*, a volume of essays by written by African students in Nyasaland. In the preface, Banda and Young wrote in defense of the "fertility orgy" practiced by Banda's people, the Chewa:

For some sixty years we have frowned upon and, indeed, opposed what we—Government and Mission—took to be a more or less licentious 'harvest' or 'fertility' orgy local to the Chewa and Chipeta areas. Actually, as will be seen in these pages—it is a central part of the educational technique, fundamental to the preparation of the male for adult life within the community and maintaining at the heart of the community itself a continuing reverence for the social ideal as Africa sees it.¹⁴⁴

¹⁴² Short, *Banda.*, 280.

¹⁴³ Nor do Banda's earlier years support the notion that he was either a puritan or against birth control. In the years before he returned to Malawi in 1958, he was implicated in a number of scandals. In 1953 he was cited in the divorce proceedings of his married English secretary; the charge was that he was engaged in her extramarital affair. In May 1957 the government of the Gold Coast Medical Council temporarily shut down Banda's private practice in Kumasi. Though the reason for this has never been firmly established, rumors later swirled (thanks to their frequent repetition by Federation officials) that he had been conducting abortions (which were illegal in the Gold Coast at that time). See *Ibid.* Also see Andrew C. Ross, *Colonialism to Cabinet Crisis: A Political History of Malawi* (African Books Collective, 2009). Page 133.

¹⁴⁴ John Kambalame, *Our African Way of Life*; (United Society for Christian Literature, 1946), p 24.

The logical consistency in Banda's sexual politics lies not in its adherence to cultural conservatism along the lines of some Christian churches, but in what anthropologists and historians of Africa have called "wealth in people." The idea that people—rather than money or other resources—were primary in understandings of wealth in land-rich, labor-scarce African societies has been central to tracts on equatorial and southern Africa since the 1970s.¹⁴⁵ It has been used to make sense of the rapid assimilation of the conquered and the destitute into new social groupings as well as inclusive definitions of kinship.¹⁴⁶ Even if he did not use this term, Banda's politics could scarcely have been more focused on demonstrating wealth-in-people. Metaphors of abundance and of vastly extended kinship relations were central to his rule. Wherever Banda delivered a public address, the organizers of the Malawi Congress Party made sure he was greeted not only by cheering

¹⁴⁵ "Wealth in people" was first used by Miers and Kopytoff in an edited volume entitled *Slavery in Africa* in 1977. Suzanne Miers and Igor Kopytoff, *Slavery in Africa: Historical and Anthropological Perspectives* (Univ of Wisconsin Press, 1979). Meghan Vaughan argues that "ideologies of fertility played a large role in pre-colonial political systems in this part of Africa and much effort went into securing reproduction. When this failed on a large scale, as it did in some areas as a result of the slave trade and later as a consequence of colonial capitalism, political legitimacy was often called into question." Kalusa and Vaughan, *Death, Belief and Politics in Central African History*. Page 317.

¹⁴⁶ Since Miers and Kopytoff, a number of other anthropologists and historians have used the phrase "wealth-in-people" in describing other equatorial and southern African contexts. Though Feierman did not overtly use this formulation, his *Peasant Intellectuals* outlined continuity between the pre-colonial and colonial in the chiefly practice of putting penurious subjects to work on private plantations. Such subjects were surely exploited, but they were already at the margins of society and labored for the chief in exchange for subsistence; otherwise their survival could not have been guaranteed. They were not worked in perpetuity; eventually, widows could remarry or orphans could come of age. See Steven Feierman, *Peasant Intellectuals: Anthropology and History in Tanzania* (Madison, Wis.: University of Wisconsin Press, 1990). Also see Miers and Kopytoff, *Slavery in Africa*; Jan Vansina, *Paths in the Rainforest: Toward a History of Political Tradition in Equatorial Africa* (Madison, Wis: University of Wisconsin Press, 1990); J Miller, *Way of Death: Merchant Capitalism in The Angolan Slave Trade, 1730-1830* (Madison, Wis: University of Wisconsin Press, 1988); Henrietta L. Moore and Megan Vaughan, *Cutting down Trees: Gender, Nutrition, and Agricultural Change in the Northern Province of Zambia, 1890-1990* (Lusaka: University of Zambia Press, 1994). For a discussion of the resonances of these institutions in southern Africa's present, see James Ferguson, *Give a Man a Fish: Reflections on the New Politics of Distribution* (Durham: Duke University Press, 2015).

thousands, but also by enthusiastic and well-rehearsed groups of praise-singing local women. Banda called these women his *mbumba*, which among the matrilineal Chewa refers to a group of sisters and their daughters living under the protection of a maternal uncle or eldest brother known as an *nkhoswe*. By assuming the role of *nkhoswe* to women throughout Malawi, Banda indicated he was responsible for their flourishing, and he would in turn be made ever more wealthy and powerful by the fruits of their wombs.¹⁴⁷ This political symbolism was on full display on Christmas Day, 1980, when Life President Banda came to the Queen Elizabeth Central Hospital to open a new maternity wing. The opening of the wing—which, as the Ministry of Information touted, had been built using personal funds donated by “His Excellency the Life President” himself—was a joyous celebration of this abundance, with Banda surrounded by throngs of *mbumba* clad in blue and red *zitenje* (cloths) bearing likenesses of his face (see Figure 9.3). State-directed population control measures, particularly the kind of coercive sterilizations pursued in India at the behest of the World Bank and other international agencies during the 1970s, would have run directly counter to the legitimizing ideology Banda had so carefully constructed.

IV. Conclusion

In *The Ideas in Barotse Jurisprudence*, social anthropologist Max Gluckman argued that relations resembling kinship could be established through acts of material generosity.

This materiality of obligation was especially true in relations between ruler and subject.

A Barotse maxim held that: “The good subject is the one who is generous as a child is to

¹⁴⁷ Wiseman Chijere Chirwa, Dancing towards dictatorship: political songs and popular culture in Malawi, *Nordic Journal of African Studies* 10(1): 1-27.



Figure 9.3: President Hastings Kamuzu Banda, surrounded by his mbumba, opening the Gogo Chatinkha Maternity wing at Queen Elizabeth Central Hospital, Blantyre, December 25, 1980. Source: Ministry of Information.

a parent; the good lord is the one who is generous as a parent is to a child.”¹⁴⁸ The anthropologist Meyer Fortes found much the same thing among the Tallensi in West Africa: “A kinsman of any degree is a person whose welfare one is interested in and whom one is under a moral obligation to help in difficulties, if possible.”¹⁴⁹

¹⁴⁸ *The Ideas in Barotseland Jurisprudence* (New York: Yale University Press, 1965). Page 173.

¹⁴⁹ Meyer Fortes, *The Web of Kinship among the Tallensi* (London: Oxford University Press, 1949). Page 293. Also see Harri Englund, “Extreme Poverty and Existential Obligations: Beyond Morality in the Anthropology of Africa?,” *Social Analysis: The International Journal of Social and Cultural Practice* 52, no. 3 (Winter 2008): 33–50. Page 143.

This understanding of popular expectations of kin (and those who would claim to be kin) can help explain the politics of medicine in Malawi at the dawn of independence. Since the arrival of effective antibiotics and anti-tuberculosis agents after the Second World War, government hospitals and dispensaries had grown ever more popular among the general population. Medicine's newfound capacity to protect the sick from suffering and premature death carried with it a new set of political obligations. This was particularly true for Hastings Kamuzu Banda, the doctor-cum-president who constantly portrayed himself as the benevolent *nkhoswe* of his people.

Banda learned the potency of this obligation shortly after independence, when he sought to quell the popular reaction to the imposition of user fees. Banda quickly learned the lesson and abandoned the fees. Though he did not invest heavily in medicine in the early post-independence years, he did make grand displays of any new government developments in the health sector. His annual Christmas pilgrimages to visit patients at Queen Elizabeth Central Hospital and his "personal" donations to hospitals were public demonstrations of solicitude for the destitute ill. Banda had spent much of his life outside Southern Africa. In his manner and historical sensibility, he identified more with the London bourgeoisie among whom he had lived for so long. But, as leader of Malawi, there were certain social facts that he could not afford to ignore. The obligation to provide for the sick, or to at least appear to do so, was such a fact. Even if budget figures do not demonstrate Banda's concern for health, medicine was a central component in the symbolism of his long rule.

Chapter 10

Sovereignty and citizenship in an age of aid: financing health in 1970s Malawi

Abstract

Malawi's health expenditures and policies during the early postcolonial period closely tracked perceptions of instability within the new regime. Whereas the Cabinet Crisis of the immediate post-independence years led Banda to abandon user fees, by the 1970s Banda saw few remaining threats to his rule. He turned his attention (and government resources) away from health, even as the rise of "human capital" in development discourse prompted greater tolerance for health spending among cosmopolitan economic experts. During the 1970s Banda did not increase the share of domestic revenues spent on health. Instead he relied on external donors, particularly governments facing their own crises of legitimacy, for health financing. Drawing upon the National Archives of Malawi and the World Bank Group archives this chapter demonstrates once again while changing fashions in economic development can at times coincide with changes in outlays for health, the greatest influence on health spending were political crises. This time, though, the crises took place outside Malawi, and were deliberately exploited by Malawi's president to secure financial support for (among other aims) health facilities.

Prelude: Memories of strong medicine

When, during my stay in Nyanza village, people asked me to explain my research, there frequently ensued a moment of confusion. *Ndikuphunzira mbiri ya mankhwala*, I would say. The closest literal translation of this statement is: "I am studying the history of medicine." But people often assumed, at first, that I meant "traditional" or herbal medicine. "History" is not an exact translation for the word *mbiri*, which also means "culture," so *mbiri ya mankhwala* is ambiguous. But the confusion also stemmed from the widely shared memory, among Malawians in the Nyanza, that the medicine delivered in hospitals was of recent provenance in Malawi.

In this area, my interlocutors often insisted there really were not any hospitals or clinics around until *nthawi ya Kamuzu* ("the time of Kamuzu Banda," aka post-independence). One group of women, all in their seventies, had a shared response when I asked about

government health care during the colonial era: *Panalibe!* (“There were none!”).¹ They insisted on this despite the fact that there had been a government dispensary in Sombe—which was within two hours’ walk of Nyanza—since the 1920s.² Nyanza was not in some blank space on the colonial medical map. But over his long reign, Hastings Kamuzu Banda had repeated so often that there were hardly any medical facilities before him, and that so many of those in existence were built under his rule, that these women seemed to have accepted it as the truth.³

During the colonial era, the women explained, people found medicine “in trees.” One woman, Linda, showed me the scars on the inside of her lower leg below the knee where, as a child, she had chronic pain treated with herbs poured into cuts made with a razor. The treatment worked, she remembered, for the pain was soon gone, and never returned. Yet even though Linda had lost two children to measles, and another to AIDS, she maintained that *mankhwala wa mzungu* (“white people’s medicine”) was stronger than the herbs of the past.

The popular narrative about *mankhwala wa mzungu* among the elderly in Nyanza is that medicines grew in potency during *nthawi ya Kamuzu*, but then weakened during

¹ February 24, Nyanza interviews.

² “Rural Dispensaries: Sites,” 1921, File 23, S40/1/3/2, MNA.

³ See, for instance, HK Banda’s declaration at an opening of the Dedza District Hospital in 1975: “This is why I wanted power—to improve the standard of living of my people. And not only the food and dress, no, but also education and health... When I came here in 1958, true there were some hospitals, there were some clinics and dispensaries, but very few. I wanted more.” Speech by His Excellency the Life President, Ngwazi Dr. H. Kamuzu Banda at the Official Opening of Dedza District Hospital, December 4, 1975,” in *His Excellency the Life President’s Speeches: Central Region Tour, December 2-15, 1975*, n.d., 9–25. MNA.

“multiparty” (the era of multiparty democratic elections that followed the end of Banda’s reign in 1994). Francis’s septuagenarian mother, Anna, remembers well-stocked, well-manned, well-maintained health facilities, especially early in Banda’s reign. Even long-time Malawian government employees shared some version of this narrative. On a drive home from an outreach cervical cancer-screening clinic in the rural Neno District, a veteran female nurse remembered “there were many medicines in the time of Kamuzu Banda,” and “fewer stock-outs.” Today, the narrative goes, things are much worse. *Mankhwala kulibe* (“There are no medicines”), laments Francis’s wife Edith. She recalls recent instances when nearby government facilities have been stocked out of antibiotics like chloramphenicol, and even cheap analgesics like Panadol (acetaminophen) or aspirin. The staff at the hospital, she said, have only one piece of advice: “Buy them yourself!” (“*Mugule!*”).

This story of rise and decline is similar to the one people in Nyanza village tell about agricultural production. Anna said that food was most abundant during the reign of Kamuzu Banda. She remembered receiving two bags of fertilizer for free every year. Unlike the current fertilizer subsidy program (“coupons”), these bags went to everyone. This program went away, she said, at the start of the multiparty era. Anna was remembering the large fertilizer subsidy program of the Banda era. The government had abolished the program in the late 1980s as a condition of its second World Bank

structural adjustment loan.⁴ Even though the subsidies were abolished in 1990, four years before the start of the multiparty era, in popular memory the two events are linked.⁵

Things grew even worse in the 1990s. The “multiparty” era came to be associated in the popular imagination with famines, the likes of which the country had not seen since the late 1940s. After a weak maize harvest led the government to seek advice from the Rockefeller Foundation, the Malawian government began a universal (and universally popular) “starter pack” program, in which every household received a small packet of food and fertilizer. But facing pressure from donor governments, the government drastically scaled back the scale of the program in 2001. Smallholder maize production fell precipitously, from over 2 million metric tons in 2000 to less than 1.5 million metric tons in 2001.⁶ Under Banda government had often made up for such shortfalls in production in part by selling maize from its “strategic grain reserve.” In 1979 Malawi had constructed massive concrete silos at Kanengo, outside Lilongwe. The Kanengo silos, which housed grain bought from farmers in good harvest years to be resold at reasonable prices in bad ones, had for decades been trumpeted as a symbol of Banda’s protection of

⁴ Paul Mosley, “Development Economics and the Underdevelopment of Sub-Saharan Africa,” *Journal of International Development* 7, no. 5 (1995): 685–706. Mosley notes that in the 1980s, while the World Bank’s “adjustment policy” staff advocated for the elimination of fertilizer subsidies in Malawi (in the name of closing budget deficits), the “project staff” argued (unsuccessfully) for maintaining the subsidy in order to improve outputs and living standards. The Bank, filled as it is with thousands of staff, was never a monolith, even if it seems so in the accounts of its detractors.

⁵ Anne Conroy et al., *Poverty, AIDS and Hunger: Breaking the Poverty Trap in Malawi* (New York: Palgrave MacMillan, 2006). Page 98.

⁶ *Ibid.* Pages 120-121.

his people.⁷ In 1990, near the end of Kamuzu Banda's tenure, the Bank of Malawi even introduced a 100-kwacha note with the Life President on the front (as always) and the Kanengo grain silos on the reverse.⁸ But this symbol of dictatorial beneficence would soon transform, in the public eye, into an icon of democracy's false promises. As part of its campaign to tear down the idols of the former regime, President Bakili Muluzi's government removed the grain silo from the 100-kwacha bill in 1997.⁹ Far less popular was the action the government took in 1999 when, in fulfillment of a condition of a World Bank loan, Muluzi's government privatized the grain reserve. By June 2000 all the grain in the silos had had been sold off, mostly to private speculators within Malawi.¹⁰ When the next year's harvest proved weak, the government had no stores to sell back to its people, while speculators could charge exorbitant prices. After a half-century without widespread famine, the scourge had returned.¹¹

The advent of multiparty democracy also coincided with another disaster. AIDS ravaged communities, including Nyanza, where most everyone mentioned a son, daughter, brother, sister, mother or father lost to the disease. Many would speak of the death of a young adult during this period without invoking AIDS (*edzi*), though the cause could be

⁷ The Kanengo grain silos in Malawi built by Banda in 1979, have a capacity of 130,000 metric tons. "Storage Facilities: Adequate Reserves for Malawi" (National Food Reserve Agency), accessed June 11, 2016, <http://www.nframw.com/storage-facilities/5-storage-facilities>.

⁸ Other banknotes during Banda's reign depicted peasant farmers in verdant fields.

⁹ The grain silos reappeared on a Malawi kwacha banknote in 2011. This was part of a campaign by Muluzi's successor, Bingu wa Mutharika, to refurbish the legacy of Kamuzu Banda and to associate himself with it.

¹⁰ Conroy et al., *Poverty, AIDS and Hunger: Breaking the Poverty Trap in Malawi*. Pages 121-123

¹¹ Roshni Menon, "Famine in Malawi: Causes and Consequences," Human Development Report Office Occasional Paper (United Nations Development Programme, 2007), http://hdr.undp.org/sites/default/files/menon_roshni_2007a_malawi.pdf.

inferred given the age of the decedent and the era. Almost no one had access to lifesaving antiretroviral therapy before 2005.

The result of this confluence of conflagrations is a decided distrust of the present political system. In Nyanza, this distrust is often expressed with reference to medicines and food. Anna, who lost one child to AIDS in the late 1990s, explains that medicine had the greatest *mphamvu* (strength, potency) during the time of Kamuzu Banda. She also remembers food being most abundant during his reign (she attributes this to the fertilizer subsidies). Bamusa says that rains fell at the right time and in the right amount during *nthawi atsamunda* (the colonial era) and *nthawi ya Kamuzu Banda*. But under Muluzi, he says, there was too little rain, and under the then-current president, Arthur Peter Mutharika, there was too much. Bamusa remembers the starter pack program fondly, and believes the cause of the 2002 famine was the privatization of the grain reserve. For this, he blames former President Muluzi.

Thus, Banda's legacy was burnished not only by his ideologies of protection and abundance, but also by coincidence. He returned to Malawi from a near-lifelong exile in 1958, in the midst of the marked increase in attendance at government medical facilities. Though the women of Nyanza insisted he had built all of Malawi's government hospitals and health centers, the country had almost 100 dispensaries, and over a dozen clinics, as early as the mid-1930s. But until shortly before he came the medicines *were* "weaker," even in the eyes of the colonial doctors. The doctor's return at the same time as biomedicine was growing in popularity became linked in popular memory. Decades,

later, in 1994, as the aged Banda left office, an incurable and inevitably fatal disease claimed the lives of ever-more men, women and children. Though Banda had himself had acceded to some of the Bank's demands for privatization and budget cuts in agriculture, these changes became associated in popular memory with multiparty democracy. Historians have noted that Banda pursued agricultural policies that exploited smallholder farmers. His government marketing board (ADMARC) paid maize producers far lower than prevailing global prices. He then funneled the profits realized by the marketing boards to provide aid and credit to plantations and unproductive factories, many of which he owned personally.¹² Malawians did not forget the Malawi Congress Party cards he made every single Malawian purchase yearly and carry everywhere.¹³

At tea one morning, Francis told stories of tax collection. In the time of Kamuzu Banda, he said everyone had to pay taxes in form of party card. Everyone had to have one. And this meant *everyone*: babies, old people, even unborn children still in the womb. Tax collectors would scour the country every year. If you didn't have the money ready when they came, you might hide in the forest. If you were caught without money to pay, you would be rounded up into police vans and driven to police station in Monkey Bay. One tax collector in Nankwhali was infamous for beating people to death if they didn't have the *kwacha* for the card. "He killed many people," Francis said. Buying the card was not enough. You had to keep card with you at all times. If a collector or policeman asked you to produce it while you walked down the street and you couldn't, you would be arrested

¹² Jonathan Kydd and Robert Christiansen, "Structural Change in Malawi since Independence: Consequences of a Development Strategy Based on Large-Scale Agriculture," *World Development* 10, no. 5 (1982): 355–75.

¹³ Interview with Francis, March 20, 2015.

and often beaten. If you went to hospital without your party card, you could be refused treatment. There were, Francis said, no exceptions to this system, even for the indigent (Look up this law). When ‘*multiparty*’ came, people were happy at first, as they no longer had to buy party cards. But Muluzi’s regime was marked by hunger and disease, so people associate multiparty with as much bitterness as sweetness, if not more.¹⁴

An elderly woman living in Nyanza named Dalitso remembered the beatings by tax collectors. But she did not consider the present to be a marked improvement—far from it. People may have lacked “peace” under Kamuzu Banda, but they did not starve. Now, Dalitso said, she begs her grandson for food, only to hear him respond *palibe* (“I have none.”) Her husband died a decade ago after a painful illness that she did not name. She is too frail to walk to the field or the clinic. She lives alone in a wattle-and-daub hut, with a thatch roof infested with wasps. She suffers from chronic abdominal pain, but (aside from our trip to Nankwhali together, see Chapter 7a prelude) she goes to a clinic no more than once a year. Her main sources of income are her son, who lives nearby with his large family, and the banana-leaf mats (*nkeka*) that she weaves by hand. Each one takes her two weeks to make, and sells for 1500 kwacha (about US\$5). Today in Nyanza, the hopes that attended the much-vaunted “third-wave of African democratization” are a thing of the past.

¹⁴ Interview with Francis, March 20, 2015.

I. Introduction

By the early 1970s, the unrest of Malawi's 1960s had quieted. The cabinet ministers who had rebelled against Banda were exiled and largely forgotten; a few of the most prominent were dead. Banda relished this quietude, and used the opportunity to centralize power. He extolled "obedience" and "unity" as two of the cardinal virtues for citizens in the new nation. In 1971, the Malawi Congress party named him "Life President." The following year, Banda declared "everything is my business... When people think of the government in the village, to them it's Kamuzu."¹

Indeed, everything *was* his business. By the mid-1970s, Banda came to own many of the nation's grandest agricultural estates. He also purchased much of the nation's industrial sector. Secure in his perch, Banda felt little of the disquiet that had motivated the Federation government (and his own government, in its first few years) to spend on health as a political palliative.

But Banda knew the potency of medicine as a political symbol. He also knew how to exploit crises elsewhere in order to garner financial resources. By publicly supporting foreign governments with poor reputations in Black Africa (such as apartheid South Africa, Portuguese Mozambique, or post-1973 Israel), Banda was able to secure aid for health projects. He also found aid from other international sources, including

¹ "His Excellency the Life President's Speeches: Opening of the Education Conference, Soche Hill College" (Ministry of Information and Broadcasting, April 17, 1972), MNA. Page 4.

McNamara's World Bank, which began to provide more financing for health activities outside of population control in the mid-1970s.

Banda made use of this aid for personal political gain. In grand displays, he made every new hospital and clinic a demonstration of his personal generosity. Yet, because neither international donors nor Malawi's own government were willing to significantly increase recurrent (as opposed to capital) spending on health, the nation's health facilities remained without the staff, drugs and equipment necessary to deliver decent care.

II. Human Capital and Foreign aid availability

a) Human capital: health as wealth enters development economics theory, 1964-1972

By the mid-1970s, the debate over population control did not so dominate discussions of health policy, either in transnational academic discussions of development or in Malawi. Instead, another paradigm was on the rise, one that would move health services beyond contraception, and closer to the center of development discourse. This paradigm was called "investment in man" or "human capital." The idea posited that human abilities—and not just the number of miles of road or the stock of factory equipment—might be the rate-limiting step in achieving aggregate economic growth. During the mid-1960s, economists Gary Becker and Yoram Ben-Porath had produced models in which individuals' "investment" in formal schooling or on-the-job training raised their levels of productivity, thereby yielding higher aggregate output for the economy as a whole.²

² Gary Becker, *Human Capital*, 1964; Gary Becker, *Human capital and the personal distribution of income: an analytical approach. WS Woytinsky Lecture no. 1*. Ann Arbor: University of Michigan, 1967; Yoram Ben-Porath, "The production of human capital and the life cycle of

Several prominent economists, including Victor Fuchs, suggested health might be another form of human capital.³ Yet throughout the 1960s health remained a poor relation to education in the human capital literature. Only the latter was included in the formal mathematical models that were so prized among academic economists.

This began to change in 1972, when Michael Grossman, a recently minted PhD from Columbia University who had worked with Victor Fuchs at the US National Bureau of Economic Research, published such a model in *The Journal of Political Economy*. In Grossman's model, the main effect of increasing a person's "stock" of health was not greater productivity (as was the case for a higher "stock" of education)—but rather an increase in the "total amount of time he can spend producing money earnings and commodities."⁴ A person's initial stock of health was inherited at birth and depreciated with age, but could be increased through investments in "medical care, diet, exercise, recreation, and housing," as well as in "environmental variables" such as "the level of education of the producer."⁵ Grossman became an influential voice in health economics;

earnings, *Journal of Political Economy* 75 (August 1967): 353-367. For even earlier invocations of education as a form of human capital, see TW Schultz, "Investment in human Capital," *The American Economic Review*, Vol 51, No 1, March 1961, pp 1-17, and J Mincer, "Investment in human capital and personal income distribution," *Journal of Political Economy* 66 (1958); 3: 281-302.

³ Selma Mushkin, "Health as an investment," *Journal of Political Economy* 70, no 2, suppl (October 1962): 129-57; Victor Fuchs, "The contribution of health services to the American economy," *Milbank Memorial Fund Quarterly* 44 (October 1966): 65-102; Gary Becker, *Human Capital*. New York: Columbia University Press, 1964.

⁴ Michael Grossman, "On the Concept of Health Capital and the Demand for Health," *The Journal of Political Economy* 80, no. 2 (1972): 223-55.

⁵ *Ibid.* Environmental variables were, to Grossman, outside the control of the consumer, while the other investments were choices made by individuals themselves, p. 225. For another discussion of the history of human capital arguments in the economics literature, see Muhammad Jami Husain, "Contribution of health to economic development: a survey and overview," *Economics E-journal*, September 2009.

in 1972 he was appointed head of the health economics division of the National Bureau of Economic Research, a post he retained as of 2016. His model complicated those that saw only physical capital as a productive investment.

At the same time, more prominent economic thinkers called into question the hegemony of such formalistic model-making altogether. In a massive tome titled *An Asian Drama*, the Swedish economist, sociologist and former politician Gunnar Myrdal, lamented the postwar infatuation with abstracted growth models focused on physical capital:

Models centered on the concept of a capital/output ratio have dictated the direction of economic planning in underdeveloped countries. One implication of this postwar approach is the assumption that ‘non-economic’ factors—not only institutions and attitudes but also levels of living, including health and educational facilities—can be disregarded. The primary and often exclusive importance given to investment in physical capital for economic development requires this assumption.⁶

Myrdal believed “there can be no warrant for leaving health out of the development picture,” as “ill health is a very serious deterrent to a rise in labour input and efficiency in the underdeveloped countries of South Asia.” But Myrdal did not favor a mere expansion of the definition of “capital” in capital/output models to include health. Rather, he advised development economists to abandon these hopelessly inaccurate models. Solow had demonstrated in the 1950s that capital/output models could not explain historical patterns of growth through physical capital alone (see Chapter 7). But Myrdal believed adding health and education to these capital/output models was no panacea. Health, after all, required a large number of inputs, most notably (but not exclusively) food, clothing, housing and sanitary facilities. A capital/output model that included health as an input

⁶ Chapter 29, “Investment in man,” in Gunnar Myrdal, *Asian Drama: An Inquiry into the Poverty of Nations* (New Delhi: Kalyani Publishers, 2008).

would, of necessity, include every input that affected health. This would, Myrdal claimed, result in a model that lacked the benefits of reductionism. Such a model would be “virtually empty of theoretical content”—it could offer only a “vague propaganda term for a more rational and circumspect development planning that takes into account not only physical investment but all other induced changes.” Myrdal insisted he did not oppose formal models or quantitative social science *per se* but, he insisted, “Both models and quantitative pronouncements must be logically consistent and thoroughly grounded in the facts.”

Myrdal’s book, published in 1968, came at a moment of profound uncertainty within development economics. Postwar development planning based on capital/output ratios and an overwhelming focus on physical capital had not resulted in disappointment. The implementation of five-year development plans focused on industry and agriculture in India yielded average annual GNP growth of only 3.5 percent during the 1950s and 1960s.⁷ Schematized trajectories of Western economic growth such as Rostow’s were proving difficult to recapitulate in South Asia and Africa. Lester Pearson’s 1968 World Bank report (referenced earlier for its support of population control) documented the manifold disappointments of recent decades of investment.⁸

Even the gross national product (GNP), the preeminent measure of development during the heyday of modernization, came under attack. In a November 1969 speech, Dudley

⁷ Paul Joseph Cruickshank, “The Teleology of Care: Reinventing International Health, 1968-1989” (PhD Dissertation, History of Science, Harvard, 2011).

⁸ Pearson, *Partners in Development: Report of the Commission on International Development*.

Seers, one of the founders of the Institute for Development Studies at the University of Sussex in the UK and a leading light in development thought, argued that economic growth and development had been conflated. He offered another definition of development: “Development means creating conditions for the realization of the human personality.” Seers argued that, by this definition, development meant a reduction in poverty, unemployment, and inequality. Growth was no proxy for development, as metrics of poverty, unemployment and inequality could all fall in the absence of aggregate economic growth.⁹

The more expansive definition of “capital” and “investment” began to displace the theories favored by the Lewis, Rostow and other doyens of modernization, who saw government spending on public health and medicine mainly as “consumption.” The claims in the economic literature that health was a form of “human capital,” as worthy as public investment as physical capital like roads and bridges and power plants, created a more hospitable intellectual environment for health spending in Malawi. This was particularly true in the development (capital) budget—made up almost entirely of external financing. The share of the capital budget devoted to public health and medicine projects increased from 1.1 percent in 1971 (since independence, it had hovered around 1 to 2 percent) to 6.4 percent in 1974.

⁹ Dudley Seers, “What Are We Trying to Measure?” (World Conference of the Society for International Development, New Delhi, India, 1969).and Cruickshank, “The Teleology of Care: Reinventing International Health, 1968-1989.”Cruickshank, Teleology of Care, Pages 37-38.

Still, the enabling influence of human capital arguments had a relatively muted impact on the recurrent budget for health in Malawi, which largely came from domestic revenues. The share of government recurrent expenditure going toward the Ministry of Health did increase from 6.1 percent in 1971 to 7.6 percent in 1976, but it never approached Federation-era levels. Compared to the turbulent 1950s and 1960s, this was a decade of political quietus; the still-paltry public sector health budget was, more than anything else, a reflection of this fact.

b) McNamara's World Bank expands health beyond contraception, 1971-1973

Much of Malawi's newfound health funding in the 1970s came from international aid agencies, both bilateral and multilateral. Even though a détente between Malawi and the World Bank over the population issue would prove elusive for decades, the Bank and other external agencies did begin to provide aid for health activities other than family planning in Malawi by the mid-1970s. As detailed in Chapter 9, population control aroused great controversy not only in Malawi but also in a number of developing countries. This controversy only grew with revelations that the intrauterine devices promoted by population control advocates could cause dire adverse effects.¹⁰

The inclusion of health in growth models, challenges to model-making itself, and concomitant efforts to redefine development beyond GNP growth all created an intellectual opening for international aid agencies seeking to move beyond a modernization paradigm focused on physical capital. In the early 1970s, McNamara

¹⁰ Andrea Tone, *Devices and Desires : A History of Contraceptives in America*, 1st ed. (New York: Hill and Wang, 2001). Tone details how the Dalkon Shield, an IUD promoted by international institutions in India in the 1970s caused uterine perforation and (sometimes fatal) hemorrhage.

began to expand his focus on health beyond birth control to nutrition and, to a limited extent, curative health services. McNamara appointed a biochemist as his science advisor in 1970, and listed nutrition as one of his areas of focus. In 1972, the Bank opened a Nutrition Unit devoted to research and recommendations on the problems of malnutrition. That same year, the World Bank joined an international consortium to eradicate river blindness in West Africa, and began including lending for primary health care to larger project loans primarily aimed at improving agriculture or reducing population growth.¹¹

This change in course at the Bank moved discussions with Malawi beyond the impasse over population policy. In April 1971, John Malone (of the Bank's Eastern African Department) reminded his boss that in an upcoming meeting Malawi's Minister of Finance was "almost certain" to reiterate "the Government's long-standing request" to use Bank loans to build health facilities within regions of the country already supported by agricultural loans, including Karonga, Lilongwe, and the Lower Shire.¹² Whereas in 1969 the Bank had declined to finance programs aimed at "mortality control" (see Chapter 9), Malone's 1971 memo explained that the Eastern African Department was actively considering Malawi's request and had recently hired Eric de Winter, a Dutch missionary doctor who had worked in Nkhata Bay during the late 1960s, as a consultant.¹³

¹¹ Kapur, Lewis, and Webb, *The World Bank.*, 253-254.

¹² John Malone, Jr, "Letter to Mr Michael L Lejeune, Director, Eastern Africa Department, re 'Briefing for Your Meeting with the Malawi Minister of Finance,'" April 23, 1971, Item No 1860300, WBGA.

¹³ For more on De Winter's 1972 book on Malawi, *Health Services of a District Hospital in Malawi*, see Chapter 4.

De Winter's influence was apparent immediately. Compared to the Report of a World Bank Mission to Malawi in 1969, a report that had not included a health consultant and focused only on population pressures, De Winter's team produced a report with a detailed and, for the era, ambitious plan for health services. The team evaluated a proposed "Rural Development Program" in Karonga District. The proposed loan would be provided on concessional terms to Malawi by the arm of the Bank called the International Development Association (IDA). This project aimed to increase agricultural yields through the construction of irrigation canals, feeder roads, dipping tanks for cattle, and the provision of extension services and farm credit. But the report also lamented the Malawi government's dismally low expenditure on health (though it placed the blame "financial constraints" rather than deliberate neglect), and referred to recent surveys demonstrating that that nine percent of farmers' labor time was being lost due to illness.¹⁴ The report recommended the inclusion of a bilharzia control program in newly irrigated areas (irrigation was known to provide ideal environment for the snails that carry the

¹⁴ "Appraisal of Karonga Rural Development Project" (International Bank for Reconstruction and Development, International Development Association, Agriculture Projects Department, December 30, 1971), WBGA Website., page 4: "The health situation in Malawi gives cause for concern, not because the diseases are more serious than those in surrounding countries, but because the expenditure Malawi could in the past afford on public health has been inadequate. The country spends an average US\$0.94 equivalent per capita annually on health services, which is one of the lowest rates in Africa (Sample figures drawn from various World Health Organization Reports (1968-1971, converted to US\$): Ghana 2.44, Kenya 1.76, Lesotho 1.21, Rwanda 0.32, Uganda 1.52, Zambia 9.40. Compare with Netherlands 88.31, United Kingdom 95.16, USA 105.20 (not including expenditure on water supply, sewage, refuse disposal, etc. and private health expenditure). This rate is even lower in rural areas such as Karonga where, in 1970, expenditures for health were only about US\$0.73 equivalent per capita, despite the considerable impact there of water-borne diseases (mainly bilharzia) in addition to the usual diseases found elsewhere. Health services are generally poor and understaffed. For the 1969 mission report, led by John A Edelman, see Harvey J Sindima, *Malawi's First Republic: An Economic and Political Analysis* (Lanham, Md: University Press of America, 2002).

parasites causing bilharzia), the construction and operation of five rural health outposts, and improvements to the Chilumba Rural Hospital and the Karonga District Hospital.¹⁵

Yet these line items made up only a small part of the project's budget. Furthermore, the report's authors did not even envision that the project's health-related spending would be financed by the IDA loan. Over five years, the entire project was slated to cost a total of \$7,761,000, with slightly more than half (\$4,109,000) to be financed by the IDA loan.

The remainder (\$3,652,000) would come from Malawi's own current domestic tax revenues. Of the total project spending only \$307,000 (4.0%) would be spent on health activities. Most of the health spending (\$181,000) was to be funded by Malawi's current revenues, while the remainder (\$126,000) would be financed by the IDA loan.¹⁶

Still, the Karonga project marked a departure from the Bank's earlier position of wholesale opposition to health financing. Prior to De Winter's involvement in the 1971 report, IDA loans for Rural Development Projects in Lilongwe and the Lower Shire Valley had not included any health care components.¹⁷ But in Malawi and elsewhere,

¹⁵ "Appraisal of Karonga Rural Development Project.", i.

¹⁶ Ibid. 1971, page 7.

¹⁷ "Staff Appraisal Report, Republic of Malawi Health Project" (World Bank, Population, Health and Nutrition Department, March 24, 1983), WBGA Website., page 11. The Lower Shire Project (IDA Credit 114-MAI) began in 1968, while the Lilongwe project (IDA Credit 244-MAI) commenced in 1971. When the World Bank renewed the Karonga Rural Development Project in 1976, it planned for its second round of financing to support the "construction, staffing and operation of five maternity wards, seven health posts and staff houses to provide preventive and curative medical services, health education, maternal and child care, communicable disease control and environmental hygiene, and to collect health statistics." This time health accounted for a greater percentage (8.9 percent) of the \$9.2 million budget. Still, most (59 percent) of the \$443,000 to be spent on health was to come directly from government coffers, while the remainder would be financed by an IDA loan. "Report and Recommendation of the President of the International Bank for Reconstruction and Development to the Executive Directors on a

new Bank funding for disease control and health facilities remained only a minor part of its development financing. The Bank did not provide “standalone” funding for preventive and curative health care activities (as opposed to health care components of agriculture project budgets) until 1979, the same year McNamara established a Health Department within the Bank.¹⁸

III. Exploiting foreign crises and building Banda’s image as protector

a) Health in a political economy of exploitation

By the early 1970s, Banda had secured firm political control in Malawi. Gone were the rebellious ministers who sparked the Cabinet Crisis, or the widespread fear and rumor fanned by the Chilobwe murders (see Chapter 9). Whereas the unrest of the 1960s compelled Banda restrain his pursuit of his economic vision, by the 1970s political quietus left Banda free to pursue profoundly inegalitarian policies. A number of historians have noted the systematic impoverishment of smallholder agriculture under Banda’s rule. The state-run agricultural marketing board, ADMARC, purchased tobacco from smallholder farmers at prices far below prevailing global market prices, then resold the crop on international markets. Even when international prices rose dramatically in the mid-1960s, ADMARC did not increase the price it paid smallholders for their crops. ADMARC’s burgeoning profits were invested in elite-owned agricultural estates, largely tea and tobacco estates in the south.¹⁹ Banda and other prominent members of the

Proposed Loan to the Republic of Malawi for a Karonga Rural Development Project--Phase II,” June 3, 1976, WBGA Website., page 10.

¹⁸ Kapur, Lewis, and Webb, *The World Bank.*, 265

¹⁹ Kydd and Christiansen, “Structural Change in Malawi since Independence: Consequences of a Development Strategy Based on Large-Scale Agriculture.” The estates received this investment in

Malawi Congress Party had purchased these estates for themselves after cancelling the leases of European and Indian farmers so as to obtain the land at firesale prices.²⁰ Banda also used state funds to build ornate homes for himself around the country. During the grants-in-aid period British officials criticized these “palaces” as unseemly and wasteful uses of public funds, but Banda argued that his people expected him to live in such residences.²¹

Banda’s regime faced few existential threats, either internally or externally, during the 1970s. The World Bank and bilateral donors thought Banda’s economic policies masterful.²² And without the armed rebellions that had so preoccupied him during 1960s,

the form of ADMARC the form of concessionary loans, assistance from agricultural extension agents, and inputs such as fertilizer. Also see Conroy et al., *Poverty, AIDS and Hunger: Breaking the Poverty Trap in Malawi*.

²⁰ Thomas, “Economic Developments in Malawi Since Independence.” Page 41; Geoffrey Traugh, “Quota-Busters and the Popular Economies of Tobacco in Malawi, 1960s-1980s,” Presentation to the Greater New York Area African History Workshop, Drexel University, Philadelphia, PA, April 8, 2016.

²¹ In a 1980 discussion at Oxford University, Sir Glyn Jones (Nyasaland’s final colonial Governor) and Richard Kettlewell (Nyasaland’s former Director of Agriculture) recounted the disagreement with Banda over palaces and defense spending. Jones remembered: “Well he lives dangerously—there is no question about that. And he has got plenty of moral and physical courage that I think should be mentioned, which gave Banda’s friend’s cause for some anxiety on the financial side. One was his desire to erect Presidential palaces which [cost] a tremendous amount of money, and the other was defense. Almost from the start he insisted on increasing the army forces, which also is a very expensive business...so we had to get considerable financial support from Britain for that. But the Presidential palaces were something which he said the people were forcing the point. Be that as it may, they ran away with a lot of money. The money wasn’t entirely from public funds; a lot of private subscriptions came into it, particularly from some of our Asian friends, I suspect.” Kettlewell added: “Douglas Lomax, who was up here recently, said that he advised Banda against these Presidential palaces. He thought that they were things which the people could justifiably criticize, but Banda held the view that people expected of him to have this kind of residence.” Jones et al., *Colloquium on Nyasaland Finance*. Pages 74-75.

²² In a 1976 memo, Paul Meo of the World Bank’s Program Review Division extolled Banda’s economic management since independence: “When Malawi became independent in 1964, there were distinct doubts that it would ever have a viable economy. It has no mineral resources, is land-locked, and has one person per hectare of arable land. Since then, real output growth has

Banda faced, from a cynical political perspective, less of an imperative to spend on health as a political palliative. He could, and did, resort to other ways of dealing with discontent, such as jailing, exiling or killing those who challenged his rule.²³

Still, Banda also sought to demonstrate his concern for his people, to make good on his promise to be the “*nkhoswe* number 1.”²⁴ Part of this came in his taxation policy. The colonial systems of hut taxation and *thangata* ended with independence. Still, rural Malawians were still made to buy Malawi Congress Party cards every year. And as in the colonial era, Malawians paid direct and indirect taxes on consumption, in the form of import duties and sales taxes.²⁵

averaged over 7 percent yearly, domestic savings went from virtually nothing to about 12 percent of GDP, and investment quickly rose and is now over 20 percent of GDP (public fixed investment was about 11 percent during 1937-74). Exports boomed, the import elasticity to GDP was held to less than one, rural-urban income differentials were reduced by a tough, austere urban wage policy, and public sector management (and IDA disbursements) resembles more that of a forthcoming Bank ‘graduate’ than a ‘least developed country.’ Malawi can feed itself and is even exporting surpluses of its staple food crops.” Meo also justified Banda’s estate and industrial policies that fostered inequality: “There remains a continued concern by the Bank on ‘income distribution.’ This, apparently, is more related to our concern over the enrichment of a few cabinet ministers and private sector expatriates in the estates and industrial sector. While these managers and entrepreneurs may be getting rich, they have provided employment, exports and production almost unique in the area. We now know that more than half of smallholder income stems from cash payments provided from non-farming activities; much of it from jobs provided on the estates and industries. Could Malawi have increased smallholder output (and incomes) even one-third faster than occurred if this dynamic element had not been permitted?” See Paul M Meo, “World Bank/IFC Office Memorandum to Mr IMD Little, Adviser, Development Economics Department,” April 20, 1976, Item No. 1417224, WBGA. Pages 1-2.

²³ Power, *Political Culture and Nationalism in Malawi*. Page 206. Also see Harvey J Sindima, *Malawi’s First Republic: An Economic and Political Analysis* (Lanham, Md: University Press of America, 2002). Page 204.

²⁴ “The President Speaks: Speech Made by His Excellency the President, Ngwazi Dr. Kamuzu Banda at Neno, on Sunday, December 8, 1968” (Blantyre: Department of Information, n.d.), Pam 1127, 1968, MNA. Page 3.

²⁵ “Recent Economic Development and Prospects of Malawi” (Washington, D.C: International Bank for Reconstruction and Development, January 14, 1975), WBGA Website. Pages 9-12.

Some of Banda's most ostentatious demonstrations of beneficence came in the realm of health. In a December 1975 speech at the official opening of Dedza's new District Hospital, Banda thanked District Chairman Juma for introducing him as "Jesus Christ for this country." Banda proceeded to explain how he, personally, had improved Malawi's health sector:

That is why I wanted power—to improve the standard of living of my people. And not only food and dress, no, but also education and health... When I came here in 1958, true there were some hospitals, there were some clinics and dispensaries, but very few. I wanted more... Anyone who respects the truth will admit that there are more hospitals in the country now, more clinics and more dispensaries, than there were in 1958 when I came here... Take, for example, the hospital at Kasungu. There was a hospital there when I came but I did not like it, so I built another one. At Rumphu, up North, there was no hospital at all. I had to order the building of a hospital at Rumphu. There was a hospital here, but... I did not like it... That place was too small to cope with the population, far too small, and there were not enough facilities there. That was why I decided to build a new one and began to find means of financing and building the hospital.²⁶

In a 1972 article, health economist Peter Ruderman observed, "To many presidents and prime ministers, a hospital is a more satisfactory monument than an arch of triumph."²⁷

This was certainly the case in Malawi. If this was not abundantly clear at the Dedza Hospital opening in 1975, it surely was two years later when the Banda named Lilongwe's new central hospital (financed mainly through a loan from the Danish government) after himself.²⁸

²⁶ "Speech by His Excellency the Life President, Ngwazi Dr. H. Kamuzu Banda at the Official Opening of Dedza District Hospital, December 4, 1975," in *His Excellency the Life President's Speeches: Central Region Tour, December 2-15, 1975*, n.d., 9–25.

²⁷ Ruderman, "General Economic Considerations." Page 110.

²⁸ See PS Phiri, "Letter to the Secretary for the Treasury, Re: New Lilongwe Kamuzu Central Hospital Area 33, Contract No 12/73," July 18, 1978, 20-12-3F, 52002, MNA.

At times Banda constructed narratives in which it was not the Malawian state, but rather his own personal fortune, that made improvements in the health sector possible. Officials publicized Banda's "donations" to buy food for hospital inpatients. Here the parallel between caregiving by kin and Banda's "gift" to the sick is striking. Among friends and kin, the gift of food, particularly the *ndiwo* (relish, or side dish) that accompanies the staple maize meal, is a particularly potent demonstration of generosity. LJ Chimango, Banda's Minister of Health, used one of Banda's donations to purchase "poultry products, bread, fruit, green maize and fresh fish." While the government budget covered the cost of *nsima*, the basic maize staple, Banda himself contributed the *ndiwo*. As if the parallel between caregiving by kin and Banda's role as *nkhoswe* was not clear enough, Banda's officials arranged to have this food distributed by the League of Malawi Women.²⁹

Unlike Julius Nyerere, Kenneth Kaunda and other stalwarts of African socialism, Banda did not portray himself as a common man.³⁰ He amassed great wealth and showed it.³¹

²⁹ "Address by His Excellency the Life President, Ngwazi Dr. H. Kamuzu Banda after Inspecting and Approving the Site for the Kamuzu College of Nursing, Lilongwe, 8 December 1975," in *His Excellency the Life President's Speeches: Central Region Tour, December 2-15, 1975*, n.d., 18–25; "Letter from LJ Chimango, Minister of Health, to Life President Hastings Kamuzu Banda, 'Annual Report on Gift of K160,000 to Four Hospitals,'" 1979, 9-12-1AF, MNA.

³⁰ Banda's officials were often quite direct that their priority was increasing aggregate production, and not equalizing the distribution of wealth. In a speech on March 12, 1971, Parliamentary Secretary to the Ministry of Agriculture and Natural Resources AW Mwafulelwa explained: "Our duty here is to create wealth which our children who come later will come and dispute on its share. How they are going to divide that wealth. But it is no good now for us to scramble how we should divide the wealth here which does not exist. Therefore our main task in this country is to create wealth...and later our children will come and argue how to share this wealth." Thomas, "Economic Developments in Malawi Since Independence." Page 50.

³¹ At the same time, he did not wish everyone to know the extent of his wealth. Glyn Jones remembered that part of the reason Banda opposed the Africanization of bank management at Malawian branches of the British-based Standard Bank. "I don't really think that I would like any

He often reminded the crowds at his public addresses that he was “not poor.”³² But, he continued, he used his wealth to help people. Explaining in a 1975 speech why he had paid out of his own pocket to construct student housing at the new College of Nursing in Lilongwe, Banda declared: “To me, money is of importance only for what I can do with it, not just for its own sake, not just for the sake of accumulating money, no—only for the use to which I can put it.”³³ Banda justified his personal wealth and inegalitarian policies by the good work he did through his donations. The very modesty of his regime’s accomplishments in health made these grand rhetorical, symbolic, and material demonstrations of largesse so important.

The Life President exercised a considerable measure of personal control over the health sector. Perhaps because he knew the esteem in which doctors were held, Banda personally oversaw the approval process for individual expatriate physicians, nurses, and laboratory technicians seeking temporary licenses to work in Malawi’s government and mission hospitals.³⁴ This fear of fellow professionals may also have motivated his consistent refusal to build a medical school in Malawi. As late as 1979, 100 of the 130 doctors working in Malawi (in missions and government facilities) were expatriates. A

of my chaps to be handling my account,” Banda had said, according to Jones. “Their sisters and their cousins and their aunts would know the next day what my balance was...An African woman teller—you know jolly well that her uncle will be on to her and say, ‘How much was that cheque deposited on behalf of Dr. Banda?’” Jones et al., *Colloquium on Nyasaland Finance*. Page 76.

³¹ Ibid. Pages 74-75.

³² “Speech by His Excellency the Life President, Ngwazi Dr. H. Kamuzu Banda at the Official Opening of Dedza District Hospital, December 4, 1975.” Page 17.

³³ “Address by His Excellency the Life President, Ngwazi Dr. H. Kamuzu Banda after Inspecting and Approving the Site for the Kamuzu College of Nursing, Lilongwe, 8 December 1975.” Page 23.

³⁴ LJ Chimango, “Memorandum to His Excellency the Life President re: ‘Japanese Volunteers,’” January 4, 1980, 9-12-1AF, MNA.

few Malawian-born students were sent abroad for medical training, but this number averaged only five per year.³⁵

b) Preying on crises of legitimacy: Banda's search for foreign aid among international outcasts

Much of Banda's time during his early years as Prime Minister (and, after 1967, as President) of Malawi was spent traveling the world asking foreign leaders for development aid. Banda sought funds from many nations, including the United States, Germany, Portugal, South Africa, Israel, and, of course, the UK. These pilgrimages dominated the schedules of many postcolonial African leaders, and even determined the capacities of many to remain in power.³⁶

In his requests for aid, health was not Banda's first priority. For many years Banda remained intent on grand infrastructure projects, chief among them his plan to move the capital from Zomba to Lilongwe.³⁷ But, as the last chapter detailed, before the mid-1970s even when Banda did seek funds for health projects his requests mostly fell on unreceptive ears. Walt Rostow and Arthur Lewis' characterizations of spending on healthcare as "consumption," inapposite to the goal of economic growth, was taken as gospel by the World Bank and bilateral aid agencies.

³⁵ LJ Chimango, "Letter to His Excellency the Life President re: 'Medical School - Feasibility Study,'" November 29, 1979, 9-12-1AF, MNA. A medical school finally opened in Malawi in the early 1990s, toward the end of Banda's rule. See Wendland, *A Heart for the Work*.

³⁶ Frederick Cooper, *Africa Since 1940: The Past of the Present* (New York: Cambridge University Press, 2002). Pages 156-157.

³⁷ Sindima, *Malawi's First Republic: An Economic and Political Analysis*. Page 69.

After Malawi gained independence, the UK provided budgetary support. Though substantial at first, by 1972 Banda had weaned Malawi off of this support, a year earlier than planned. Banda saw fiscal reliance on the British—and the strings that came along with it—as degrading. But he did not see other kinds of aid in the same way. The search for aid was, to Banda a demonstration of both personal skill and national sovereignty. By securing support from a variety of sources, Banda could make the claim that he had not surrendered the nation’s independence to any outside power.³⁸ So Banda made a grand show of this search, organizing large crowds to send him off at the airport and to greet him on his return.

In his public speeches, Banda made a virtue of his skills at securing aid. Addressing a crowd in Neno in 1968, Banda declared, “I, your Kamuzu, have to find money somewhere to build more roads, more bridges, more schools, more hospitals everywhere in the country.”³⁹ The following year at the Malawi Congress Party convention, Banda told the assembled delegates, “When you work hard...you make it easier for your Kamuzu to go to Britain, Germany, and the United States of America to ask for more money.”⁴⁰

³⁸ For a description of a similar political dynamic at work in post-colonial Lesotho, see John Aerni-Flessner, “Development in Lesotho, 1970-75: Authoritarianism, Aid Increases, and the Anti-Politics Machine.” Paper presented at Northeastern Workshop on Southern Africa, Burlington, VT, April 15, 2016.

³⁹ “The President Speaks: Speech Made by His Excellency the President, Ngwazi Dr. Kamuzu Banda at Neno, on Sunday, December 8, 1968.” Page 2.

⁴⁰ “The President Speaks: Malawi Congress Party Convention” (Blantyre: Department of Information, September 1969). Page 16.

As a small, impoverished nation with few mineral resources, Banda had little to offer foreign leaders in return for grants, concessional loans, or in-kind aid. But Malawi did have a seat on the UN General Assembly, and—as an African nation ruled by a black leader (rather than white settlers), some embattled governments sought out Malawi as an ally.⁴¹ Banda realized the uses to which international controversy could be put. Rather than siding with other southern African “frontline” states (e.g. Northern Rhodesia, Botswana) in opposing apartheid South Africa, Smith’s Southern Rhodesia and Portuguese Mozambique, Banda sought resources from these white-ruled governments in exchange for support in the international arena.

When Banda did succeed in securing funding for new health facilities, he often secured it from such politically besieged regimes interested in maintaining diplomatic ties to a black African government. In 1965, the Beit Trust (tied to Southern Rhodesia) offered to help purchase a radiotherapy unit for Malawi.⁴² In the mid-1970s the Gulbenkian Foundation, a private foundation based in Portugal, and the Witswatersrand Native Labour Association (WENELA), a South African agency that recruited Malawians to work in South African’s mines, funded the construction of the new district hospital in Dedza. Banda explained to the crowd at the hospital’s official opening that he had obtained the funds by proposing diplomatic deals with both Portugal (then facing armed resistance in Mozambique) and apartheid South Africa:

⁴¹ Harri Englund explains this diplomatic power in a discussion of the Republic of China (Taiwan), which Banda made an ally of Malawi in 1966. “Taiwan depended on countries like Malawi, however small and poor, in its attempt to gain recognition from the United Nations as a sovereign state vis-à-vis mainland China’s claims to the contrary.” Englund, “Extreme Poverty and Existential Obligations: Beyond Morality in the Anthropology of Africa?” Page 36.

⁴² “A Conspectus Including the Development Plan for 1965-69.”

I happened to have known this foundation called Gulbenkian...I happened to know the man who was running it. So I sent word to him saying I wanted money...I said, 'Tell your chairman I know your government says it wants friendship with us here, particularly with me. If your government wants to be friendly with me it must help me build a new hospital at Dedza. If it refuses then I will not believe it if it says it is my friend.' I was blunt... Within two or three weeks I got a letter to say, 'O, we can at least let you have K144,000'...It was after I had that word that I began to ask WENELA to add to what the others had given. I said, 'All right, WENELA, you are recruiting my people here. That is what someone away from here has promised, so what have you to offer me?'...So they were ashamed into promising me.⁴³

During the Cabinet Crisis Banda's rebellious ministers had denounced his willingness to ally Malawi with odious colonialists like the Portuguese or the white supremacists ruling South Africa. But, in this address as in others, Banda defended his policies by trying to demonstrate how they provided direct and tangible benefits to the people of Malawi.

Outside of southern Africa, Banda sought assistance from other nations who were eager for more allies. One of these nations was Israel. In 1964, Israel contributed five Medical Officers to the sorely understaffed Ministry of Health, still reeling from a raft of departures. In the first months of Malawi's independence, these Israeli doctors would run some of the nation's largest hospitals, including those in Lilongwe and Zomba. Also in 1964, the Ministry of Health signed contracts to employ Israeli physicians as Medical Superintendent and Medical Specialist at Blantyre's Queen Elizabeth Hospital.⁴⁴ The

⁴³ "Speech by His Excellency the Life President, Ngwazi Dr. H. Kamuzu Banda at the Official Opening of Dedza District Hospital, December 4, 1975."

⁴⁴ "Annual Report on the Work of the Nyasaland/Malawi Ministry of Health for the Year 1964." Page 3. In his inaugural address at the State opening of Parliament in 1966, Banda recounted how he obtained support from Israel: "It is the endeavor of my Government to ensure that health services which it provides meet the aspirations of the people of Malawi. When we took over responsibility for health three years ago, the staff of the Medical Department was seriously depleted. In anticipation of that event I had asked the Israeli Government for a medical mission, which that government immediately provided... The Israeli team enabled us to preserve the health

majority of the more than one hundred Malawian-born nurses trained between 1964 and 1972 were trained in Israel.⁴⁵

When Israel first set up an embassy in Nyasaland in 1960, it was not yet the pariah it would later become among most of the majority-rule nations in Africa. A handful of Black African states severed diplomatic relations with Israel in the years following the June 1967 Six Days' War.⁴⁶ The more decisive break between Black African states and Israel followed the October 1973 Yom Kippur War, when the vast majority broke off diplomatic relations. In November 1973, the Organization of African Unity (OAU) Council of Ministers issued a resolution denouncing Israel for its annexation of Arab Territory, likening Israeli policies to European imperialism. In the wake of this divorce, Malawi was one of only four Black African countries (the others were Swaziland, Lesotho, and Mauritius) that maintained relations with Israel.⁴⁷ Banda preferred to request aid, rather than changes in policy, from nations facing international crises.⁴⁸ Banda knew how to reap the dividends of disquiet.

services, and since then the staffing position has gradually improved both by way of normal recruitment and by technical assistance from many countries, until there are today more doctors employed by the Government in this country than ever before. They are drawn from no less than 13 countries, including Malawi itself." See Mowschenson, "Dr. H Kamuzu Banda: President of the Republic of Malawi."

⁴⁵ Colin Arthur Baker, "The Development of the Civil Service in Malawi from 1891 to 1972" (PhD Dissertation, University of London, 1981). Page 330. Crucially, Israel also provided training to Banda's paramilitary force, the Young Pioneers.

⁴⁶ These countries were: Guinea (severed relations in June 1967), Uganda (March 1972), Chad (November 1972), Congo (Brazzaville) (December 1972), Niger (January 1973), Mali (January 1973), Burundi (May 1973), and Togo (September 1973). Joel Peters, *Israel and Africa: The Problematic Friendship* (I.B. Tauris, 1992). Page 37.

⁴⁷ Ibid. Pages 37-38.

⁴⁸ This stance was similar to the one Banda had taken vis-à-vis the United States. In 1966 Banda declared that his government supported President Lyndon Johnson's policy in Vietnam

Not all of Malawi's external health funding came from sources so anathema in Black Africa as Southern Rhodesia, Mozambique and South Africa. Still, Banda entered the fray of international debates in such a way as to secure resources from wealthy donor governments. In 1965 Banda told the UN General Assembly that "history, logic, justice and fair play leave Malawi but with no choice but to recognize the government in Bonn as the legal government of Germany." Shortly thereafter, the West German Government expressed its appreciation by offering a £1 million loan to replace Zomba's General Hospital with a new teaching hospital.⁴⁹

During the 1960s and 1970s, Malawi's health sector also benefited from increased funding from a number of Western charities and bilateral and multilateral donor agencies. UNICEF continued to provide supplies of vaccines, medicines and equipment, but also funded programs in water and sanitation, primary health care, nutrition and primary education. The European Development Fund financed the replacement of two district hospitals. In 1971 the UK-based charity Oxfam provided a grant of £16,000 for the construction of new blocks at mission hospitals at Malindi and Nkope.⁵⁰ During the 1970s ten foreign governments, including Japan, The United Kingdom and the United States also provided support for health care projects.⁵¹

"150 per cent." Among other aid, the United States was, at this time, providing Peace Corps Volunteers and funds for tuberculosis treatment. Short, *Banda*. Pages 239-240.

⁴⁹ "A Conspectus Including the Development Plan for 1965-69." Also see Short, *Banda*. Pages 239-240. Also see Chitsamba, "Malawi and the Politics of Foreign Aid." Page 104.

⁵⁰ "K32,000 Work on Mangochi Hospital Ends," *The Times (of Malawi), Republic Anniversary Special*, July 1971, 0, MNA.

⁵¹ "Staff Appraisal Report, Republic of Malawi Health Project." Page 12

Though he consistently presented a pro-Western, pro-capitalist position after independence, Banda was not averse to non-Western alliances if he thought he could garner significant support.⁵² He approached the People's Republic of China shortly after independence, before siding with Taiwan after learning that Mao's regime was aiding some of the ministers who had rebelled against him.⁵³ His general approach was to support any government that would support his own.⁵⁴

c) Re-conceptualizing health as an investment in Malawi's Economic Planning

Department

⁵² Though he was a member of the Fabian Society in England during the 1940s, this membership appears to have been driven largely by his involvement in the movement to stop the formation of the Federation of Rhodesia and Nyasaland. There is no record of him espousing socialism as a philosophical or political commitment. In a speech before the Zomba Debating Society in April 1964, Banda explained that his own preference was neither Soviet Communism nor the "rigid Capitalism such as is known in America," but rather "the kind of economic and political life... which they have in Britain and the Scandinavian countries," where "the State has a great deal of power of control over business and businessmen, but without owning all the means of production and distribution and without the power of conscription over capital and labour, except in times of war... The individual still has a great deal of freedom and liberty to do what he likes. But, at the same time, the state exercises a measure of control over him and his business, in the interest of the whole community. And this to me, is the ideal system or ideal thing, in this un-ideal world." See "What Is Communism? Speech by Ngwazi Dr. Kamuzu Banda, Prime Minister of Malawi, to Zomba Debating Society" (Ministry of Information, April 1964), Pam 1127, 1963/64, MNA. Pages 17-18. Once in power he pursued a mix of economic planning and market-based policy.

⁵³ Englund, "Extreme Poverty and Existential Obligations: Beyond Morality in the Anthropology of Africa?" Page 38.

⁵⁴ Banda promised as much in April 1964, when he told the Zomba Debating Society that he would pursue a policy of "discretionary alignment." "I will be friendly to everyone, or I will be friendly to every corner of the globe, East or West, as you have heard me say so many times... In America, I spoke at Harvard and Yale Universities in 1961... In each of the lectures and at each of these universities, I said that so far as I was concerned, the policy of Nyasaland when independent, or Malawi as it was going to be called, was going to be discretionary alignment and non-alignment... And this is my policy now. Yes, discretionary alignment and neutralism. When the West is doing what I think is the right thing—what is good for Malawi—I will align myself and this country with the West. When the East is doing the right thing—what I think is good for Malawi—I will align myself and this country with the East." "What Is Communism? Speech by Ngwazi Dr. Kamuzu Banda, Prime Minister of Malawi, to Zomba Debating Society." Pages 19-20.

By the mid-1970s, as international aid for health became increasingly available and as prominent development economists challenged the “health-as-consumption” consensus, economists within Malawi’s own Economic Planning Department began to reframe health care as a productive investment. During the late 1960s and early 1970s, health was mentioned but briefly in the Economic Planning Division’s annual *Economic Report*, and even only to explain that health spending had been limited in order to cut the budget deficit.⁵⁵ But the 1974 *Economic Report* marked a shift. “Established policy is to maintain existing services and concentrate improvements on those areas where the greatest economic return is to be expected from better health—e.g. agricultural project areas, where under-employment is at a minimum.”⁵⁶ Though the idea that health could bring a substantial “economic return” was circumscribed to certain areas (and was articulated in order to justify the domestic revenues that would have to be spent on health on the World Bank agricultural projects), this language was nevertheless a departure from the view that health care was unproductive consumption. The 1974 report was also the first in which health secured its own place in the table of contents.

That same year, the Ministry of Finance began to allow more rapid increases in the Ministry of Health budget. In the Finance Ministry’s announcement of planned annual

⁵⁵ See the 1969 *Economic Report*: “Because of constraints imposed by the need to reduce the budgetary deficit, it is not possible to undertake any significant expansion of health services and attention is therefore being concentrated on finding means of making the best possible use of existing facilities and personnel.” “Economic Report 1969, Prepared by the Office of the President and Cabinet, Economic Planning Division and the Ministry of Finance” (Zomba, Malawi: Government Printer, 1970), Box 3, No 4, SoMA. Page 72

⁵⁶ “Economic Report 1974, Office of the President and Cabinet, Economic Planning Division” (Zomba, Malawi: Government Printer, 1975), Centre for African Studies Pamphlets, Malawi Box 16, UoELA. Page 55.

“ceilings” on increases in recurrent expenditure in the coming three-year period, the Ministries of Works and Agriculture were each allotted a 10 percent increase, while the Ministries of Education and Health were allowed to increase spending by 7.5 percent. Other departments secured less: the University of Malawi, once such a priority of President Banda, was allowed only a 5 percent annual increase; and most other Ministries and Departments were given a ceiling of 4 percent.⁵⁷

As external funding became more available in the coming years, the authors of subsequent reports indicated a commitment to health for the general population (and not just those working in specified “agricultural project areas”). While reiterating the general principle that health spending should be focused where “the greatest economic return is to be expected,” the 1976 Report added: “But the inheritance at independence by the Malawi Government of a health system which was inadequate and contained many ill-equipped and outdated hospitals has meant that a considerable part of the development budget must be spent on maintaining and improving existing facilities.”⁵⁸ Whereas in the 1960s health was not included among Banda’s budgetary priorities (which included a new capital at Lilongwe, new roads and railways, and the University of Malawi), the Ministry of Health came, by the mid-1970s, to occupy a more privileged place in budgetary discussions.

⁵⁷ “Recent Economic Development and Prospects of Malawi” (International Bank for Reconstruction and Development, International Development Association, Eastern Africa Region, January 14, 1975), WBGA Website., page 11.

⁵⁸ “Economic Report 1976, Office of the President and Cabinet Economic Planning Division” (Zomba Malawi: Government Printer, 1977), Centre for African Studies Pamphlets, Malawi Box 16, UoELA. Page 56

Still, these shifts in the priority accorded to health were relatively minor. Ministry of Health expenditure (including recurrent and capital expenditures) rose 25 percent in real terms between fiscal years 1975/76 and 1980/81, but did not keep pace with the rise in overall government spending.⁵⁹ During the fiscal years 1976/77 through 1980/81, the Ministry of Health claimed an average of only 6.8 percent of the Malawi government's recurrent budget and 1.8 percent of the development budget.⁶⁰ Memos flew back and forth within the Bank's East Africa Department debating whether its reports should attribute Malawi's low level of government health spending to "neglect" or to "the paucity of funds available" to fill the "bottomless pits" of need.⁶¹ Despite suggestions from some Bank officials and other agencies that the government might spend more on health, health as a share of government expenditure remained far below the Federation-era peak.

d) Health in the political ideology of Banda's rule, 1975-1977

Banda recognized the political significance of access to biomedicine. The numbers of patients in hospitals and clinics continued to rise after independence, though at a slower rate than during the Federation era. Between 1966 and 1974, outpatient attendances at government facilities increased by 26 percent.⁶²

⁵⁹ "Staff Appraisal Report, Republic of Malawi Health Project."

⁶⁰ "Malawi Growth and Structural Change: A Basic Economic Report" (World Bank, East Africa Regional Office, February 8, 1982), WBGA Website. Page 183

⁶¹ "JR Peberdy, Acting Chief, EAPSA, to Ms Kasuko Hashimoto, EA1DB, Re: First Draft Issues Paper for Malawi Basic Economic Report," July 26, 1978, Item No. 1417224, WBGA; "Peter Hansen, Economist, East Africa Region, to Mr AA Upindi, Secretary to the Treasury, Ministry of Finance," June 23, 1978, Item No. 1417224, WBGA.

⁶² Baker, "The Development of the Civil Service in Malawi from 1891 to 1972." Page 332.

In his public addresses and in his administration's propaganda, Banda stressed his dedication to improving health care. The *Times* faithfully covered Banda's annual pilgrimages to Queen Elizabeth Hospital to visit the sick on Christmas Day. The first stanza of Malawi's national anthem, *Mlungu dalitsani Malawi* ("God bless Malawi"), adopted in 1964, made the fight against disease one of the primary goals for the new nation:

Mlungu dalitsani Malawi, (O God bless our land of Malawi)
Mumsunge m'mtendere. (Keep it a land of peace.)
Gonjetsani adani onse, (Put down each and every enemy,)
Njala, ntenda, nsanje, (Hunger, disease, envy,)
Lunzitsani mitima yathu (Join together all our hearts as one,)
Kuti tisaope (That we be free from fear.)
Mdalitse Mtsogoleri nafe (Bless our leader, each and every one,)
Ndi Mayi Malawi (And Mother Malawi.)

In speeches, Banda declared his commitment to improving access to medicine. During his inaugural address as President [following a change in Malawi's constitution] in 1966, Banda said, "It is the endeavor of my Government to ensure that health services which it provides meet the aspirations of the people of Malawi." He pointed to his recruitment of staff from Israel and other countries as evidence of his commitment. He also pointed to the National School of Nursing, opened in 1965. He touted a 400-bed hospital to be built in Zomba with the £1 million loan from West Germany.

Banda was not deterred by slow progress. In 1971, speaking once more before Parliament, he acknowledged the modesty of his government's achievements in the health sector: "Of course... we have not achieved everything we want to achieve, but everyone must admit that we have achieved far more than anyone ever hoped or expected

us to achieve.” New hospitals at Rumpi and Kasungu had been completed, though many of the planned renovations to existing hospitals had not been carried out yet.⁶³

By 1974 the tone was more confident. A Government-issued booklet that surveyed the “expanding health services” since 1964 claimed: 3 new hospitals and 21 new dispensaries had been built; visits at under-5 clinics (including government and mission facilities) surpassed one million per year; government health assistants had improved access to safe water in rural areas; smallpox and leprosy eradication programs had been launched; a major new hospital in Lilongwe—with a new training school for medical auxiliaries—was scheduled to be opened in 1975; and 20 Malawian doctors (trained abroad) practiced in the country.⁶⁴

Banda also touted his own status as a biomedical doctor, while simultaneously claiming powers as an indigenous healer. At most every event, Banda carried a flywhisk, a gift from Kenyan President Jomo Kenyatta. Among the Kikuyu, the flywhisk was said to confer defense against witchcraft. Many groups in Malawi, including the Yao, had similar ritual objects.⁶⁵ Banda had built a popular reputation for immense healing powers during the first few months after his return from exile. A top-secret January 1959 report by an analyst in the UK’s Special Branch explained, “Banda’s personal reputation

⁶³ President Hastings Kamuzu Banda, *His Excellency the President’s Speeches: State Opening of Parliament, 2 July 1971*, n.d. Page 20.

⁶⁴ *Building the Nation: Malawi, 1964-1974. Issued to Commemorate the Tenth Anniversary of Malawi’s Independence*. Page 32.

⁶⁵ John Lwanda explains that the “the flywhisk symbolized Banda’s potent *kukhwima* [skill in magic]...Banda’s unambiguous nod to traditional culture was clear...Banda was held to be both a western and African doctor.” Lwanda, *Colour, Class and Culture*, 32.

amongst the illiterate masses has been enhanced by a belief, now becoming evident in the urban areas of the southern province, that he has powers of faith healing, as even the most sickly patients walk out of his surgery claiming to have been completely cured after five minutes.”⁶⁶ Even Banda was initially surprised by the power of his medical persona. A few weeks after his release from Gwelo in April 1960, Banda expressed his surprise in a letter to friends in London: “Poor patients! I do not know what to do about them...the size of the crowd of patients is growing each day.”⁶⁷

But after independence, the Life President’s most potent symbols of power were the throngs of women who surrounded him. At the opening of Dedza District Hospital in 1975, Banda’s *mbumba* sang songs and danced during Banda’s speech. The songs, often written by the women, were particularly important, as they were delivered in Chichewa. Banda, on the other hand always delivered his speeches in English (even Banda’s closest confidants admitted that after decades abroad he didn’t have much facility with Chichewa or any other indigenous language). At the Dedza rally the *mbumba*’s first song was as follows:

Ife ndife amayi (We are mothers)
Ochokera ku Dedza (The poor of Dedza)
Tangomvani mawu a Ngwazi (We are here to hear the words of our Hero)
Chitukuko m’Malawi (On the development of Malawi)⁶⁸

⁶⁶ “Banda, Dr. Hastings Walter Kamuzu,” January 7, 1959, KV2/4075, File 498a, UKNA.

⁶⁷ “From Dr H Kamuzu Banda to the Micklems,” 9 May 1960, KV2/4075, File 453a, UKNA.

⁶⁸ “Speech by His Excellency the Life President, Ngwazi Dr. H. Kamuzu Banda at the Official Opening of Dedza District Hospital, December 4, 1975.”, page 12. For more on these singers, see Wiseman C. Chirwa, “Dancing Towards Dictatorship: Political Songs and Popular Culture in Malawi,” *Nordic Journal of African Studies* 10, no. 1 (2001): 1–27; Lisa Gilman, *The Dance of Politics: Gender, Performance, and Democratization in Malawi* (Temple University Press, 2009).

After Banda, speaking from the dais, thanked them for their “sense of gratitude,” the women continued:

Taomboledwa a Malawi, (We are the redeemed of Malawi)
Taomboledwa mu ukapolo, (We are the redeemed from slavery)
Kubwera kwake kwa Ngwazi Kamuzu, (The coming of our Hero Kamuzu)
Nyimbo Zinamveka m’mwambam’mwamba, (The sounds of loud music could be heard)
Oyitanidwa kudaona Kamuzu (When those who came to see Kamuzu)
Anasonkhana pa Chileka (Gathered at Chileka)⁶⁹

“Chileka” is a reference to the airport outside Blantyre where Banda landed in Malawi in 1958 when he returned, to great fanfare, for the first time after decades living outside the country. The women’s final song made clear that they were thanking Banda personally for the new hospital. He was not a representative of the state, but rather its personification:

Ife ndife amayi (“We are mothers”)
Tinyadira chipatala (“We are proud of the hospital”)
Tangoona a Ngwazi amangitsa chipatala. (“We see that our Hero has built a hospital”)

The centrality of women to Banda’s political symbolism (also discussed in Chapter 9) had been demonstrated early in his tenure. A prime example is an article from the *Malawi News*, the mouthpiece of the Malawi Congress Party, which in January 1961 reported on Banda’s speech to a crowd in Limbe with the headline: “Kamuzu Speaks to his Amazon Army.” The article consistently referred to the women in the crowd as “his women.”⁷⁰ This attribution of all women to Banda persisted well into his reign as Life President, and motivated much of the imagery surrounding his appearances at hospitals and clinics. The

⁶⁹ Speech by His Excellency the Life President, Ngwazi Dr H Kamuzu Banda at the official opening of Dedza District Hospital, 4 December 1975, page 13.

⁷⁰ “Kamuzu Speaks to His Amazon Army, by Our Staff Reporter,” *Malawi News: The Voice of the Congress Party*, January 21, 1961, MNA.

presence of so many singing women was evidence of Banda's greatest source of wealth—his wealth in people.

IV. Counterintuitive, once more: health spending at the dawn of the neoliberal era

a) Limits of human capital and basic needs rhetoric at the World Bank

The brief opening for international aid for health services ended quite rapidly at the start of the 1980s. Though McNamara had tried to champion new approaches to development financing during his tenure at the Bank, he did not fundamentally change the institution's lending practices. In 1976, McNamara called for the Bank to focus not only on increasing GDP growth, but to aim its attention and resources toward the universal provision of "basic needs," which to his mind included nutrition, health, clothing, and shelter.

McNamara insisted that there existed no tradeoff between equity and efficiency; the focus on growth could continue alongside concern for basic needs. But his ambitions ran aground against skeptical economists making everyday lending decisions and writing the reports that shaped understandings of economic reality. Skeptics of health financing maintained that no one could muster sufficient evidence to convince them that spending on "basic needs" would yield as much growth as the earlier focus on physical capital such as roads, telephone wiring and power plants. Critical observers (including the Bank's own staff) pilloried the "basic needs" approach as "a mistake," a "superfluous new idea," a "slogan," and a "populist" program that obscured the unavoidable trade-off between consumption and investment.⁷¹

⁷¹ Kapur, Lewis, and Webb, *The World Bank*., 267.

By the early 1980s, profound global economic shifts made budget cuts for health appear, to many in Ministries of Finance and international development agencies, a necessity. Around the world rising oil prices increased the cost of imports, while poor harvests (due, in part, to *El Niño*) depressed primary-product export revenue. At the same time, interest rates on sovereign debt increased markedly. Following the elections of Margaret Thatcher (1979) and Ronald Reagan (1980), economic thought in the US and UK shifted away from the Keynesian consensus. When McNamara departed from the Bank in 1981, Reagan named as his replacement the former Bank of America CEO Alden Clausen. Clausen and his Chief Economist, Anne Krueger, scrapped the rhetoric of basic needs. The Bank's 1981 World Development Report, authored by Elliot Berg, proposed on stabilization of inflation through cuts in public expenditure, the liberalization of financial markets, and the privatization of government services. Following Mexico's default on its sovereign debt in 1982, the Bank insisted on the prompt repayment of loans by other nations. In this new environment of austerity, health spending was deemed contrary to the central aim—the timely servicing of rising debt burdens.

b) Health spending in Malawi at the dawn of the neoliberal era, 1980-1983

But, once more, international development discourse and even economic crisis proved insufficient to predict all of Malawi's health policies during the dawn of neoliberalism. Malawi's health budgets did fall precipitously during this period. While the Ministry of Health claimed 7.2 percent of total expenditure on the revenue account in 1980, it secured

only 4.6 percent in 1982/1983.⁷² In absolute terms, this was a decline (in current Malawian Kwacha) from 14.98 million to 12.64 million. The 1982/1983 figure marked the smallest share of the revenue account that the Ministry of Health had claimed since the Second World War (see Figure 0.2). Still, in the face of constant advice from Bank staffers that Malawi should stop providing free food at hospitals and institute user fees, public sector health facilities remained free at the point of care (with the notable exception of obstetric services) and patients were fed at hospitals.⁷³ Chakakala Chaziya, Malawi's Minister of Finance, wrote to McNamara on May 22, 1981 (during his final week as World Bank President) to explain that due to the nation's interest-rate-fueled debt burden and falling export revenues, "low priority items" would be dropped from the development budget. Yet there were, Chaziya continued, "key sectors" that would remain priorities: agriculture, transport, education and health.⁷⁴ The inclusion of investments in human capital, as well as physical capital, on this list ran counter to contemporary trends in development thinking. Banda sought to avoid a reenactment of the popular discontent that had followed the ticky fees and budget cuts of 1964.

V. Conclusion: politically important but sparse on the ground, health under Banda's reign

Through the first two decades of Banda's iron rule medicine was not a central priority, but nor was it entirely forgotten. In the colonial era, officials in London had used medicine to try to tamp down labor unrest. During the Federation years, officials in

⁷² "Staff Appraisal Report, Republic of Malawi Health Project." Page 73.

⁷³ Ibid. page 11.

⁷⁴ L Chakakala Chaziya, "Letter to Robert McNamara, Re : 'Letter of Development Policies,'" May 22, 1981, Item No 1158183, WBGA. Page 3.

Salisbury had increased medical spending to try to demonstrate the beneficence of Federation rule. After independence, Banda used government medical services much as he used his ubiquitous flywhisk—to ward off the bad omens threatening his own regime.

Yet in the midst of all Banda's grand displays of concern, Malawians continued to suffer for want of decent curative and preventive health services. Measles vaccination, for instance, was fairly universal in children in the United States by the mid-1950s. But in 1979, measles remained the leading cause of inpatient pediatric deaths in Malawi's government hospitals.⁷⁵ The other two leading causes of pediatric inpatient deaths, pneumonia and malaria, were readily treatable conditions.⁷⁶ And, for all his talk of protecting women, Banda's ban on birth control and poor funding for antenatal and perinatal care helped Malawi secure one of the world's highest maternal mortality rates.⁷⁷ Banda's rhetoric about health may have helped to secure his regime, but the lack of

⁷⁵ Until the late 1970s Malawi's government received external financial support for smallpox, measles and DPT (diphtheria-pertussis-tetanus) vaccines. Still, by 1978, BCG coverage stood at 65 percent, and only 30 percent of children had received their 3rd dose of DPT. Prior to 1978, the government had to purchase polio and measles vaccine using its own domestic revenues, and these were often out of stock. In 1978, with funding from the UNFPA and WHO, the Ministry undertook its first nationwide measles vaccination campaign. In the following years, UNICEF also provided funding for measles vaccination campaigns. In 1980, the Ministry also received support from Save the Children UK for a polio vaccination campaign, as well as refrigerators to store cold chain vaccines. See WJ Chikakuda, "The Expanded Programme on Immunization in Malawi," *Malawi Epidemiological Quarterly* 2 (April 1983): 3–12.

⁷⁶ "Malawi Growth and Structural Change: A Basic Economic Report." Page 180.

⁷⁷ According to the World Bank, in 1994, the final year of HK Banda's long tenure in office, the maternal mortality ratio stood at 956 deaths per 100,000 live births. This was 164th out of 183 countries for which the World Bank collected statistics. See "Maternal Mortality Ratio (Modeled Estimate, per 100,000 Live Births)," World Bank Data, accessed June 10, 2016, http://data.worldbank.org/indicator/SH.STA.MMRT?order=wbapi_data_value_1994+wbapi_data_value&sort=asc&page=4. For a critical analysis of the methodology by which maternal mortality is estimated, see Claire Wendland, "Estimating Death: A Close Reading of Maternal Mortality Metrics in Malawi," in *Metrics: What Counts in Global Health* (Durham, NC: Duke University Press, 2016), 57–81.

attention to health in his budgets helped Malawi maintain its position toward the bottom of international health indices.

Nevertheless, many Malawians today remember Banda as a protector who successfully brought a modicum of material security to most Malawians. In the three decades that followed 1980, an era marked by AIDS, famine, and chronic want, government health facilities again became a focal point of popular politics. The idealization of this less-than-ideal past is the focus of the conclusion.

Conclusion

I. Conflict as the Bridge Between High and Low Politics

During the summer of 2006, I was a congressional intern in Washington, D.C., working in the office of a Democratic representative with a liberal voting record and an interest in global health. His most senior legislative aide, “Susan,” was a woman in her early 50s. She had the seen-it-all, done-it-all grizzled habitus shared by many long-time staffers on Capitol Hill. Whenever I became too excited about a new piece of proposed legislation, or a seeming breakthrough in budget negotiations, Susan would laugh a bit and warn me not to get my hopes up.

One day, Susan explained the hierarchy of policy areas in congressional deliberations. Health policy was, she explained, a “chick issue.” As health was part of her portfolio in the congressman’s office, I thought at first this might be a declaration of feminist pride. After all, the preparations for the next push for universal health insurance were one of the few topics Democratic staffers would discuss without a hint of cynicism. Yet I could not help but notice that Susan spoke of “chick issues” in a tone of bitterness. She went on to explain that health and other “caring” issues (such as children’s policy and old-age policy) were often delegated to female staffers because they were commonly viewed as both more feminine *and* less important than economic policy and defense. Health was, she explained, an afterthought in the halls of power, one that the male-dominated legislative body felt comfortable relegating to a second tier.

Susan was not alone in noticing this hierarchy. One need look no further than the field of international relations, which draws a distinction between “high politics”—those issues, namely defense, that are vital to the survival of the state, and “low politics”—issues that are not so essential. But in this dissertation I have argued that this distinction between high and low politics obscures a more complex history. Health policy has long been a tool wielded by regimes seeking to maintain power. In Malawian history, the political ideology of health was often gendered (see Chapters 7 and 8), but neither Banda nor the (almost entirely male) British officials of the colonial era saw health as an issue that they could simply ignore.

The unrest to which colonial and postcolonial officials felt compelled to respond with health spending was not “health activism.” The labor militants of East and West Africa of the 1930s and 1940s did not demand health spending, but rather higher wages and better working conditions. Still, the UK Government responded with the Colonial Development and Welfare Act of 1940, as it sought to answer concerns that the “colonial question” was hurting its international standing. The Malawi Congress Party of the 1950s did not call for hospitals and clinics, but rather for the dissolution of the Federation of Rhodesia and Nyasaland. The one exception to this was the “ticky fee” in 1964 and the ensuing Cabinet Crisis, in which access to care was an explicitly stated concern of agents of unrest. Yet, for the most part, officials offered health care to restive publics demanding more fundamental social changes.

Africanists have long recognized the *lack* of a separation between what Aristotle termed the *oikos* (the home) and the *polis* (the public sphere).¹ Indeed, in Malawi there is no clear distinction between these two spheres. Insofar as two spheres can be said to exist at all, it must be recognized that the *oikos* shapes the *polis*. The logic of judgments about local moral worlds informs those that citizens and subjects make about distant politicians and institutions. They are not divided spheres with separate logics. In both, the ability to subsist and the continuation of social solidarity are central concerns. The fluidity between these two spheres—divided in Western self-understandings—is evident in the work of “public healers,” as Steven Feierman has demonstrated.² Dunduza Chisiza, the foremost economic thinker in Malawi’s nationalist vanguard, recognized the influence of domestic life on national politics when he argued that while “charity begins at home,” obligations to the vulnerable extended beyond the family to “the clan, the tribe, the nation, and to humanity as a whole.”³

The blurring of *oikos* and *polis* in European welfare states has long concerned social theorists. Jürgen Habermas argues that a citizenry beholden to public benefits is no longer well-placed to engage in “rational-critical” debate about the proper extent of state action.⁴

With the rise of the welfare state, particularly in postwar Europe, Habermas sees a state

¹ For a discussion of the separation of these spheres in classical philosophy, see Giorgio Agamben, *Homo Sacer: Sovereign Power and Bare Life* (Palo Alto: Stanford University Press, 1998). Page 4.

² Steven Feierman, “Colonizers, Scholars and the Creation of Invisible Histories,” in *Beyond the Cultural Turn: New Directions in the Study of Society and Culture* (Berkeley, Calif.: University of California Press, 1999). Pages 186-187.

³ Amartya Sen, *Development as Freedom* (New York: Anchor, 2000). p 11. Also see Chapter 5.

⁴ Jürgen Habermas, *The Structural Transformation of the Public Sphere: An Inquiry into a Category of Bourgeois Society* (Cambridge, MA: MIT press, 1991). p. 232.

no longer opposed by a critical public sphere. Instead, he laments that the public sphere, “once invested in the institutions of the bourgeois constitutional state,” has become “an element in the political realm.” Once defined by negative rights guaranteeing certain liberties to propertied bourgeois citizens, the public sphere has been transformed with the rise of positive social rights. The state is now called upon to interfere constantly in realms previously off limits.

In Malawian history, political leaders have indeed sought to use spending on social services to maintain power and consolidate support. The white settlers who ran the Federation Government from Salisbury touted health spending as a demonstration of concern for Africans and proof of its mantra of “partnership.” President Hastings Kamuzu Banda fostered the connection between *oikos* and *polis* whenever he spoke of “his *mbumba*” or when he called himself “*nkhoswe no. 1*” at openings of new government hospital wings. This practice endures. In 2012, President Joyce Banda (no relation to Hastings Kamuzu Banda) had her likeness emblazoned on sacks of corn purchased with USAID funds and distributed to drought victims.⁵ With such a personalized, intimate discourse of political legitimacy, it is unsurprising that health spending would be a central tool of leaders in times of imperiled legitimacy.

While Habermas might interpret these acts as nefarious attempts to foreclose critical debate, many Africanists believe that postcolonial citizenries would benefit from *more* robust state involvement in the lives of citizens. Achille Mbembe has argued that

⁵ Personal communication with Anna West, July 13, 2013.

postcolonial African states have only rarely concerned themselves with the productive capacities of their citizenries. By contrast, it was a continuation of colonial sovereignty, which was “the exact opposite of the liberal model of debate and discussion.” Colonial sovereignty did not fit Foucault’s description of biopolitics.⁶ Rather, like Foucault’s classical sovereignty, it rested on violence, much of it “designed to ensure this authority’s maintenance, spread and permanence” through numerous banal acts “falling well short of what is properly called war.”⁷

When compared to such violence (seen in Malawi in the form of forced labor, hut taxation, and coercive and ineffective public health campaigns), spending on voluntary medical care seems more benign than Habermas’ dystopian portrayal. Anthropologist Jean Comaroff echoes this point in her discussion of South African AIDS activists, who have forged a “moral politics” that “insists on making death sacrificial once more.”⁸ These activists make productive use of the “salience of health in the reciprocal engagement of rulers and subjects across the world.”⁹ There is, in this telling, life-saving potential in the welfarist response to civil (and uncivil) disobedience.

The idea that social spending is a product of agitation is not entirely new. It has been more than three decades since the economist Amartya Sen argued that famine is rarely

⁶ P. Wenzel Geissler, Richard Rottenburg, and Julia Zenker, “21st Century African Biopolitics: Fuzzy Fringes, Cracks and Undersides, Neglected Backwaters, and Returning Politics,” in *Rethinking Biomedicine and Governance in Africa: Contributions from Anthropology* (Bielefeld, Germany: Transcript, 2012), 7–22. p. 11.

⁷ Mbembé, *On the Postcolony*. P. 25.

⁸ Comaroff, “Beyond Bare Life.” Page 207.

⁹ *Ibid.* Page 210.

the result of a decline in available food, but always occurs in the setting of an unequal distribution of “entitlements.”¹⁰ The distribution of entitlements—the means by which people acquire food, through cash wages or food distribution programs or any other means—is an outcome, Sen argues, of political decisions. Scarcity is a political construction used to justify a distribution of resources that leaves some with an abundance of food while others starve and die. Sen places great faith in the ability of democratic political discourse to prevent famines. He has gone so far as to argue “there has *never* been a famine in a functioning multiparty democracy.”¹¹

The importance of politics to social protection is evident in Malawian history as well. By the 1960s, Chisiza would argue that ignoring popular expectations of social protection “would be a dangerous political omission for the ruling parties.”¹² Later politicians heeded this counsel. In the years leading up to Malawi’s 2004 general election, President Bakili Muluzi presided over an increase in public expenditure on health, which rose from 2.9 percent of GDP in 2002 to 5.7 percent in 2004. Muluzi’s handpicked successor, Bingu wa Mutharika, won the election and maintained this level of health spending as a percentage of GDP even as Malawi entered a period of rapid economic growth.¹³

But during the period covered by this dissertation, Malawi’s 1961 election was its only one with multiple parties and a large African franchise. What kinds of political action

¹⁰ Amartya Sen, *Poverty and Famines: An Essay on Entitlement and Deprivation* (Oxford: Oxford University Press, 1983).

¹¹ Amartya Sen, *Development as Freedom* (New York: Anchor, 2000). p 178. Emphasis added.

¹² Chisiza, *Realities of African Independence*. p 17.

¹³ “World Development Indicators: Health Expenditure, Total (% of GDP)” (World Bank), accessed May 25, 2016.

could shift the distribution of entitlements colonial Nyasaland, or Malawi under Banda's one-party rule? Neither British colonial officials nor Banda's censors allowed for the flourishing of critical discourse so valued by Sen. Colonialism and dictatorship foreclosed to the populace certain options for registering discontent. Instead of strongly worded newspaper editorials and orderly demonstrations, subject peoples had to resort to other tactics. As the political scientist James Scott has argued, "Much of the politics that has historically mattered has taken the form of unruly defiance." Particularly in places where a vocal civil society is outlawed (but even, as Scott argues, where it is allowed) profound structural change usually only occurs after "massive, non-institutionalized disruption in the form of riots, attacks, on property, unruly demonstrations, theft, arson, and open defiance threatens established institutions."¹⁴

Throughout the era covered in this dissertation, Malawi was not a place where votes mattered.¹⁵ But even here, the demands of a marginalized African populace could not be entirely ignored. Particularly after the antibiotic revolution, colonial and postcolonial regimes could not miss the popularity of government health services. Even without opinion polling or free elections, the long queues at outpatient departments made it impossible to ignore the demand for government medical facilities. Rulers thought it wise to oblige African publics with some measure of health spending, even if health spending was not thought to contribute to economic growth. Cosmopolitan technical experts and

¹⁴ Scott, *Two Cheers for Anarchism: Six Easy Pieces on Autonomy, Dignity, and Meaningful Work and Play*. P. xvii.

¹⁵ The only election that approached openness and fairness during this era came in 1961. Not coincidentally, the Malawi Congress Party, which won that election handily, promised free education and healthcare for the populace in their party platform. See Chapter 6.

repressive rulers did have to make some concessions to local demands if they were to remain in power.

This line of inquiry reveals new insights about postcolonial global health. International aid has been a crucial part of the recent response to AIDS, malaria, tuberculosis, maternal mortality and other major health problems in Africa. While the nature of this assistance differs in many ways from colonial development funding, there are similarities. The Colonial Development Act was, in part, a response to a political crisis of unemployment. So, too, was the US President's Emergency Plan For AIDS Relief (PEPFAR), a 5-year, \$15 billion contribution to the international AIDS response. US President George W. Bush announced this plan—which he called “a work of mercy” in his 2003 State of the Union. In this same speech, the President issued an ultimatum to Iraqi President Saddam Hussein, threatening that if he did not “fully disarm” (of his alleged weapons of mass destruction), “we will lead a coalition to disarm him.” In juxtaposing the threat of war with AIDS relief, Bush seemed to try to soften his image.¹⁶ There were, of course, many other motivations behind President Bush's PEPFAR proposal—particularly the pleas of powerful members of the evangelical Christian Right. I have written about these motivations elsewhere.¹⁷ I mention the Iraq War connection only to show that the confluence of crisis politics and health spending persists.

¹⁶ Greg Behrman, *The Invisible People: How the U.S. Has Slept Through the Global AIDS Pandemic, the Greatest Humanitarian Catastrophe of Our Time* (New York: Free Press, 2004); Messac and Prabhu, “Redefining the Possible: The Global AIDS Response.”

¹⁷ Messac and Prabhu, “Redefining the Possible: The Global AIDS Response.”

More recently, health activists have used the power of what Martin Luther King Jr. called “productive tension” to awaken politicians to the urgency of their demands. In 2000, activists in the United States persisted in disrupting the campaign rallies of Vice President Al Gore until the Clinton Administration stopped threatening Mandela’s government in South Africa with trade embargoes for importing low-cost generic AIDS drugs.¹⁸ Three years later, activist Zackie Achmat’s refusal to take antiretrovirals to treat his own infection until low-income citizens were guaranteed access to the same drugs helped compel the South African government to declare the right of universal access.¹⁹ During Bingu wa Mutharika’s presidency, protestors held marches and rallies to draw attention to stock-outs of drugs and supplies in public hospitals.²⁰

These actions are much more consciously directed toward the health sector than, say, the Copperbelt strikes of the 1930s, or the anti-Federation protests of the 1950s. But this recent activism, which makes claims upon what Adriana Petryna has called “biological citizenship,” aims to recreate the same atmospheric of political tension that has often impelled officials to direct public resources toward the needs of the masses.²¹ Indeed, the share of government spending devoted to health reached its historical zenith after the anti-stock-out protests, rising briefly to 21 percent in 2009.²² Health activism itself can

¹⁸ Messac and Prabhu, “Redefining the Possible: The Global AIDS Response.”

¹⁹ Comaroff, “Beyond Bare Life.” p.210.

²⁰ “Missing Medicines in Malawi: Campaigning against ‘Stock-Outs’ of Essential Drugs,” Oxford Programme Insights (Oxfam, 2011), file:///Users/lukemessac/Downloads/pi-local-governance-malawi-25052012-en.pdf. p 1.

²¹ Adriana Petryna, *Life Exposed: Biological Citizens after Chernobyl*, With a New introduction by the author edition (Princeton, NJ: Princeton University Press, 2013).

²² “Missing Medicines in Malawi: Campaigning against ‘Stock-Outs’ of Essential Drugs.” p 7.

then, in certain circumstances, open the purse-strings of government budgets just as effectively as widespread social unrest.

II. Does health spending matter?

To advocates of a certain strain of social medicine, the kind of politically driven health spending—largely on curative medicine—this dissertation has chronicled does little to improve the public’s health. The architects of the 1978 Alma-Ata Declaration promoted the concept of “appropriate technology,” which sought to prioritize scientifically proven and financially feasible interventions over expensive and sophisticated technological interventions, which would, in the words of historian Marcos Cueto, draw away a “substantial share of scarce funds and manpower.”²³ The following year, Julia Walsh and Kenneth Warren’s proposal for “selective primary health care” helped convince many of the largest international health agencies to focus on small menu of simple health interventions in order to achieve the maximum benefits for public health. Over the next two decades, UNICEF, the World Bank, USAID and the Rockefeller Foundation promoted and funded a set of interventions known by the acronym GOBI-FFF: Growth monitoring, Oral rehydration therapy, Breastfeeding, Immunization, Family planning, Female education, and Food supplementation.²⁴

Proponents of “appropriate technology” and “selective primary health care” were especially critical of the high shares of health budgets going toward urban hospitals. Such

²³ Marcos Cueto, “The Origins of Primary Health Care and Selective Primary Health Care,” *American Journal of Public Health* 94, no. 11 (November 2004): 1864–74.

²⁴ Kelley Lee, *The World Health Organization* (New York: Routledge, 2009). p. 80-81.

hospitals were, they said, costly distractions from the high-impact interventions in nutrition, water and sanitation, maternal and child health care, immunization, and essential drugs.²⁵ Such hospitals rarely benefited the poor, and only served to bolster the egos of out-of-touch politicians. As the economist Peter Ruderman had observed in a 1972 article, “To many presidents and prime ministers, a hospital is a more satisfactory monument than an arch of triumph.”²⁶ According to these critics, such monuments were not an appropriate use of limited resources if the intent was to provide the greatest benefit for the greatest number.

This strand of criticism also tended to criticize the focus in poor countries on curative chemotherapeutic interventions. Steeped in 1970s debate about the “medicalization” of U.S. and Western European societies, some cosmopolitan international health experts viewed budgets as zero-sum contests between individual-level measures such as drugs and surgeries and more upstream preventive interventions like clean water. Ivan Illich, the most prominent proponent of the “medicalization” thesis, went so far as to argue that medical provision was so harmful that “less access to the present health system would, contrary to popular rhetoric, benefit the poor.”²⁷ In a 1979 book, British political economist Lesley Doyal used less strident language, but remained critical of the trend in which postcolonial governments continued to spend on “individual curative” measures instead of focusing on “fundamental social and environmental” transformations. She explained, “While the application of western medical treatment under third world

²⁵ Ibid. p. 76-80.

²⁶ Ruderman, “General Economic Considerations.” p 110.

²⁷ Ivan Illich, *Medical Nemesis: The Expropriation of Health* (London: Calder & Boyars, 1975). p. 73. Emphasis added.

conditions may have extremely beneficial short-term consequences for the individual patient, it cannot reduce the high incidence of disease, or raise the general level of health.”²⁸

Since the 1990s, similar critiques have often been couched in the language of cost-effectiveness. Health economists, ethicists, and policymakers have argued against spending “limited” international aid and domestic health resources in poor countries on “high-tech” interventions such as antiretroviral AIDS treatment,²⁹ multi-drug resistant tuberculosis treatment,³⁰ and cancer chemotherapy.³¹ These analyses tended to assume costs were fixed, though as the steep fall in the prices of AIDS drugs would demonstrate they are anything but.³² Many of these studies also made assumptions about efficacy of preventive measures such as educational campaigns focused on behavior change that lacked evidence. Still, cost-benefit analyses have been highly influential in shaping the priorities of international agencies and national health ministries.³³

²⁸ Lesley Doyal, *The Political Economy of Health* (London: Pluto Press Limited, 1979). p. 256.

²⁹ Andrew Creese et al., “Cost-Effectiveness of HIV/AIDS Interventions in Africa: A Systematic Review of the Evidence,” *Lancet* 359, no. 9318 (2002): 1635–42; Elliot Marseille, Paul B. Hofmann, and James G. Kahn, “HIV Prevention before HAART in Sub-Saharan Africa,” *Lancet* 359, no. 9320 (2002): 1851–56.

³⁰ John Donnelly, “Emanuel on TB: ‘The Challenge in Enormous,’” *Science Speaks: Global ID News*, October 28, 2010.

³¹ I Magrath and J Litvak, “Cancer in Developing Countries: Opportunity and Challenge,” *Journal of the National Cancer Institute* 85, no. 11 (1993): 863; TA Ngoma, “World Health Organization Cancer Priorities in Developing Countries,” *Annals of Oncology* 17, no. suppl 8 (July 2006): viii9-viii14.

³² Messac and Prabhu, “Redefining the Possible: The Global AIDS Response.”

³³ Paul Farmer, *Infections and Inequalities: The Modern Plagues* (University of California Press, 2001).

This line of argumentation contains many important truths. For instance, the lack of access to health services in rural areas is a well-documented problem with deadly consequences.³⁴ Yet this perspective also elides other realities. First, pace Doyal, individual-level medical care *can* “reduce the high incidence of disease” and “improve the general level of health.” The most notable recent demonstration of this is a randomized-controlled trial, published in 2011, which demonstrated that early initiation of combined antiretroviral treatment for HIV/AIDS not only improves the health of the person taking the medicines, but also reduces the risk of transmitting the virus to uninfected sexual partners by 96 percent.³⁵ Thus, while the value of many preventive interventions, such as behavior change campaigns, remains relatively unproven, treating an individual patient is one of the most effective ways to prevent new infections and stem the tide of the AIDS pandemic. The global scale-up in antiretroviral treatment helped effect a 42 percent decline in global deaths from AIDS between 2004 and 2014. It also contributed to the 35 percent decline in new infections between 2000 and 2015.³⁶ There exists, then, no bright line between individual-level treatment interventions and population-level prevention measures.

There is also growing evidence that, at least since the antibiotic revolution of the mid-twentieth century, individual-level medical care has been an important part of many

³⁴ Stephen C. Joseph, “The Case for Clinical Services” (Good Health at Low Cost, Bellagio, Italy: Rockefeller Foundation, 1985), 221–27.

³⁵ Myron S Cohen, Ying Q Chen, and Marybeth McCauley, “Prevention of HIV-1 Infection with Early Antiretroviral Therapy,” *New England Journal of Medicine* 365, no. 6 (July 18, 2011): 493–505.

³⁶ “The Global HIV/AIDS Epidemic,” Global Health Policy Fact Sheet (Kaiser Family Foundation, November 30, 2015).

population-level mortality declines. For instance, demographer Olukunle Adegbola argued that the deployment of biomedicine in Nigeria helped increase life expectancy by fourteen years between 1963 and 1980.³⁷ In a presentation before the famous conference sponsored by the Rockefeller Foundation on “Good Health at Low Cost” in 1985, Stephen Joseph of UNICEF also presented a case for the population-level mortality benefits of clinical services. He joked that in making this argument, he represented a school of whose members “are usually in these circles referred to as ‘the bad guys.’” Joseph contended that in each of the four case studies being considered at the conference (Kerala, Costa Rica, China and Sri Lanka), a sizable portion of steep drops in mortality could reasonably be linked to rising government expenditures on personal-encounter medical care: “All the societies under consideration expended significant portions of their government budgets for health, and much of that was and remains in the clinical or health services sector.” Joseph did not argue *against* preventive services such as mass vaccination campaigns, but contended instead that the two were complementary—experience with clinical services “may well serve as a motivator and incentive for people to utilize/accept preventive and public health services.”³⁸ The key lesson in these case

³⁷ Olukunle Adegbola, “The Impact of Urbanization and Industrialization on Health Conditions: The Case of Nigeria,” *World Health Statistics Quarterly* 40 (1987): 74–83. This literature is not without its own immodest claims. In 1975, Orubuloye and Caldwell published a study arguing that statistically significant differences in under-five mortality between two otherwise very similar areas of rural Nigeria could be attributed almost entirely to the presence of a hospital in only one of the towns. But anthropologist Steven Feierman has pointed out that the authors “ignored several possible explanatory factors,” including higher rates of male migration and of well water contaminated with feces in the town without the hospital. See Steven Feierman, “Struggles for Control: The Social Roots of Health and Healing in Modern Africa,” *African Studies Review* 28, no. 2–3 (1985): 73–147.

³⁸ Joseph, “The Case for Clinical Services.” For more on the role of trust in public acceptance of public health interventions such as vaccines, see Robert Aronowitz, *Risky Medicine: Our Quest to Cure Fear and Uncertainty* (Chicago: University of Chicago Press, 2015). Page 214. Also see Julie Livingston, Keith Wailoo, and Barbara M. Cooper, “Vaccination as Governance: HPV

studies, Joseph maintained, was *not* the need to prioritize population-level prevention over personal-encounter medical care. None of the governments had so shifted their health budgets. Instead, these case studies revealed two much more salient factors: first, the importance of the overall size of government health budgets, for both “medical” services and “public health” interventions; and second, the need for equitable access to such services in areas rich and poor, urban and rural.³⁹

Scholars seeking to determine the causes of mortality decline face the challenge of collinearity; investments in health infrastructure often occur alongside broader social and economic changes. Yet there is now a sizable literature demonstrating that biomedicine has made a discrete and measurable contribution to population-level mortality decline.⁴⁰ A review of this literature by Harvard economist Michael Kremer in 2002 concluded that the weight of evidence favored the view that “the role of pharmaceuticals and medical technology in improving health in developing countries stands in contrast to the historical experience of the developed countries...Modern medical technologies allow tremendous improvements in health even at low income levels.”⁴¹ Medical care, then, is more than just a neo-colonialist drain on limited resources.

Skepticism in the United States and Africa, and the North-South Divide,” in *Three Shots at Prevention: The HPV Vaccine and the Politics of Medicine’s Simple Solutions* (Baltimore, Md.: The Johns Hopkins University Press, 2010), 231–53.

³⁹ Joseph, “The Case for Clinical Services.”

⁴⁰ For a review of this literature, see Farmer, Paul, Matthew Basilio, and Luke Messac. “After McKeown: The Changing Roles of Biomedicine, Public Health and Economic Growth in Mortality Declines.” In *Therapeutic Revolutions: Pharmaceuticals and Social Change in the Twentieth Century*, Eds. Jeremy Greene, Flurin Condrau, Elizabeth Watkins. Chicago: University of Chicago Press, 2016. Also see Robert Aronowitz, *Risky Medicine: Our Quest to Cure Fear and Uncertainty* (Chicago: University of Chicago Press, 2015).

⁴¹ Michael Kremer, “Pharmaceuticals and the Developing World,” *Journal of Economic Perspectives*, 2002, 67–90.

Furthermore, as this dissertation has demonstrated, after the Second World War what has been called “personal-encounter” medical care—that is, care delivered by individual medical professionals and paraprofessionals to individual patients—has increasingly been in demand among the Malawian public. During the 1950s and 1960s, Nyasaland’s Africans presented in rapidly growing numbers at government hospitals and health centers. When, in 1964, the popular hero of the anti-Federation movement, Hastings Kamuzu Banda, presided over the imposition of an outpatient user fee, he quickly encountered armed resistance. This popular demand for medicine was not false consciousness. As shown in Chapter 7, patients sought preventive and curative interventions for those conditions with proven efficacy at relieving symptoms. Patients with tuberculosis avoided palliative long-term hospitalization and surgical ablation of the phrenic nerve for tuberculosis, but flocked for treatment once streptomycin and isoniazid reached clinic shelves. Communities shunned ineffective smallpox vaccination campaigns for decades, but accepted them willingly following the use of effective vaccine and cold-chain storage. Care-seeking behavior in Malawi was highly specific and empirical. Patients appeared when there was something on offer that worked.

III. Scarcity discourse

The most troubling consequence of pitting personal-encounter medical care against population-level prevention is that it concedes the argument to those who argue that health budgets in poor countries are fated to their current low levels. This concession appears early in a 2008 commentary in the *Journal of the American Medical Association*

authored by Colleen Denny and Ezekiel Emanuel, published just before Emanuel began serving as a global health advisor to U.S. President Barack Obama. “International aid is inherently limited,” the authors argued. “Consequently, it is extremely important to consider how this finite aid is distributed.”⁴² The authors’ assumption that the size of the budget for global health is inherently limited (to its current levels) automatically limits the discussion to how existing resources should be divided amongst competing priorities. Inevitably, this calculus leaves some to die: should money go to immunize children against pertussis, or to treat adults with AIDS? But those who make this assumption discard the many possibilities that arise from the question: where are more resources to be found? Only if we accept the allocation of societal resources as given will we make expanded AIDS treatment the enemy of higher immunization rates, as Denny and Emanuel do in their commentary.

In one sense, this focus on apportioning limited resources is surprising, for it comes from many of the same people who argue for the importance of upstream, environmental factors. Yet when they discuss the political process, their temporal perspective is very limited. They take health budgets as given, rather than considering how to influence decisions about their size.

Rural Malawians, on the other hand do not accept this zero-sum formulation. Scarcity may have a hold on the elite moral imaginary, but this thrall does not cross class lines. I

⁴² Colleen C Denny and Ezekiel J. Emanuel, “US Health Aid Beyond PEPFAR: The Mother & Child Campaign,” *Journal of the American Medical Association* 300, no. 17 (November 5, 2008): 2048–51.

learned this rather quickly during my time in Nyanza. There I frequently had my clothes repaired by a paraplegic man who had survived polio. He used a hand-powered sewing machine; his young nephew aided him by turning the wheel. About a kilometer away lived a blind man who had lost his sight in the late 1970s to measles. Neither of these men would likely link their debility to the man in their village who had regained his sight following cataract surgery in Zomba's Central Hospital. The cataract surgery was more expensive than a polio or measles vaccine, but none of the men saw a necessary trade-off between immunization and ophthalmologic surgery. They did not believe resources were so scarce as to demand such a choice.

People in Nyanza knew the benefits of immunization, of better housing and more adequate food. They desperately sought each of these goods for themselves and their families. But none saw decreasing budgets for drugs and staff at hospitals as the preferable way to increase spending on these other priorities. When asked where additional funds for such programs might come from, many Malawians looked to government officials who stole from government coffers, or wealthy Malawians in the larger cities and towns, or foreign governments with historic ties to Malawi. Looking far and wide, they could see that there was plenty of money available; it just wasn't available to them. In the words of Amartya Sen, they recognized the unequal "distribution of entitlements."

Understanding where health budgets actually come from demands that we see claims of scarcity for what they usually are: an excuse. Even in Malawi, once an "imperial slum"

and in the twenty-first century still one of the world's poorest countries, scarcity is a construction that obscures unequal wealth and exploitative extraction, and by so obscuring aims to free the powerful from social obligations. During the First World War, colonial police conducted night raids to kidnap villagers and force them into the carrier service. At the same time, colonial officials claimed to lack the resources to provide better care for the thousands of African carriers who toiled and died (Chapter 1). During the 1920s, the claim of scarce resources was the preferred excuse of the UK Treasury as officials demanded repayment for the TZR loan while refusing to improve African hospitals (Chapters 2-3). During the 1940s, the Labour Party used claims of scarce resources and the myth of comprehensive "traditional social security" to place geographical bounds on its plans for social protection (Chapters 4-6). The Federation government resorted to such claims as they spent far more per-capita on health services for Europeans than they did for Africans (Chapter 8). Throughout the 1960s and 1970s, Life President Banda and World Bank administrators constantly claimed Malawi's dismal health services were actually quite impressive "in light of funds available," even while Banda built personal palaces with state funds (Chapters 9-10).

The impoverishment of Nyasaland's medical department by 1919 TZR loan guarantee also has postcolonial parallels. Multilateral and bilateral aid agencies have consistently favored large, capital-intensive projects over community health and education (see Chapters 7 and 8). Muckraking exposés and confessional memoirs have presented loans from the World Bank, USAID and other agencies to build dams, roads, and railways in poor countries as ploys to profit European, American and (more recently) Chinese

manufacturers and financiers, prop up puppet dictators, and entrap poor countries in debt.⁴³ The moral obligations invoked by advocates in the international debt relief (“Jubilee”) movement of the 1990s and 2000s find echoes in the pleas of Colonial Office officials to the Treasury to lessen the crushing burden of the TZR loan guarantee on Nyasaland’s population. Neither accepts the geographical boundaries that underpin the claims of scarcity.

While historians of colonial, postcolonial, or international health have tended (with notable exceptions) to accept claims of scarcity at face value, other scholars have begun to contest them. The clearest example of this is in studies of water and food allocation. Inspired by Sen’s studies of famine, the Institute of Development Studies at the University of Sussex convened a meeting in 2005 on “the limits of scarcity.” Their collective statement, signed by economists and sociologists specializing in the politics of food and other “scarce” resources, expresses many of the themes I have explored in a dissertation on health budgets. It is worth quoting at some length here:

Scarcity is considered to be the ubiquitous feature of the modern condition and is widely used as an explanation for social organization...Scarcity is made out to be an all-pervasive fact of our lives... We, however, believe that scarcity is not a natural condition. It is not something that is inherently in the nature of things...Detailed sociological and political attention to what is actually happening on the ground has almost always located the causes of pressing social problems such as hunger or water shortage not in an absolute scarcity but in socially generated scarcity arising from imbalances of power that deny people access to food or water...Moreover, the ‘scare’ of scarcity has led to scarcity emerging as a political strategy for powerful groups...It is also used to provide simplistic

⁴³ Burgis, *The Looting Machine*, 2015; John Perkins, *Confessions of an Economic Hit Man* (New York: Plume, 2005).; Léonce Ndikumana and James K. Boyce, *Africa’s Odious Debts: How Foreign Loans and Capital Flight Bled a Continent* (London ; New York: Zed Books, 2011).

solutions rather than focusing on the social and political reasons that cause inaccessibility and perpetrate exclusions.⁴⁴

In order to understand that money for government health services is rarely so scarce as officials claim, and to see when and how these claims of scarcity have been overcome (if momentarily), scholars must look beyond the normal confines of global health discourse. They must look to international labor history, the history of economic thought, and to the idiosyncratic details of the political histories of particular countries. In doing so, it becomes apparent that even in one of the world's most impoverished nations, health budgets have been determined not by the absolute amount of money available, but by the extent of unrest.

This is not an automatic cause-and-effect relationship. The episodes of unrest that led to increases in health spending in Malawi were not always—or even often—in Malawi proper. And though governmental responses to unrest often involved the provision of health care, the unrest itself was only seldom impelled by an explicit demand for health care. In this dissertation, health spending came in response to varied and unrelated movements, including strikes over pay and labor conditions (see the strikes of the 1930s and 1940s in the Copperbelt and the West Indies), a movement to stop an inequalitarian political system (see the anti-Federation protests of the 1950s), and rumors about foreign creditors (see the vampire rumors about South Africa in the 1960s). Furthermore, as James Scott has noted, sometimes unrest leads not to progressive social and political

⁴⁴ “Appendix: Institute of Development Studies Conference Statement on Scarcity, June 2005,” in *The Limits to Scarcity: Contesting the Politics of Allocation* (Routledge, 2010). p. 257-258.

transformation, but to repression.⁴⁵ Even unrest that accomplishes the aims of protestors can lead to great suffering. The people of Masasa have not been displaced from their homes, but Nicotine is dead and Innocent has only one leg (Chapters 3 and 4). It is difficult to predict the dividends of disquiet.

And, of course, there are limits to health spending, particularly spending coming from the domestic coffers of poor countries. Such nations cannot spend at will on anything and everything. Governments do have competing priorities. A number of these—education, agricultural supports, and social insurance—are essential for human flourishing. And government spending requires revenue, which must be raised by collecting taxes, issuing debt, or printing money. Each of these can have undesirable economic consequences, such as inflation, particularly when taken to extremes. Yet low-income countries have seldom found themselves imperiled by runaway government *health* spending. In a cross-country analysis of 80 nations between 1973 and 1990, Song Han and Casey Mulligan concluded that inflation was spurred by most often by wartime *military* expenditures rather than by expansions in social spending.⁴⁶

Since the turn of the twenty-first century, experts in development economics have reached a consensus that poor countries generally *underinvest* in health, education, and

⁴⁵ Scott, *Two Cheers for Anarchism: Six Easy Pieces on Autonomy, Dignity, and Meaningful Work and Play*.

⁴⁶ Song Han and Casey B. Mulligan, “Inflation and the Size of Government,” *Federal Reserve Bank of St. Louis Review*, June 2, 2008, 245–68.

social insurance.⁴⁷ This consensus had affected Malawi's health spending. In recent years the International Monetary Fund has warned Malawi that it must pursue "tighter fiscal and monetary policies geared toward placing inflation on a declining trend." Malawi's refusal to follow this advice could leave it without the IMF's seal of approval, a demerit that often leads other international agencies to deny poor nations access to concessional loans and grants. But even while it counsels cuts to farm input subsidies and certain parts of the civil service, the IMF has insisted that Malawi's finance ministry should "safeguard social spending," especially health, education, and cash transfers.⁴⁸ So even the foremost institutional guardian of fiscal austerity on the planet has decided that health budgets need not be subjected to the same regimes of scarcity as other public spending.

IV. Lessons

In a series of lectures first published in 1961, British historian EH Carr objected to two kinds of historical writing. The first is the kind of writing that maintains pretensions to scientific impartiality. These are chronicles of dates and events so thorough and without analysis as to numb the mind. The second form of meaninglessness is the history of

⁴⁷ Sanjeev Gupta, Benedict Clements, and Gabriela Inchauste, *Helping Countries Develop: The Role of Fiscal Policy* (Washington, DC: International Monetary Fund, 2004). See Chapters 8 and 9. Over the same period, a grand debate has persisted over the benefits and harms of international development aid. But even the critics of aid, such as Angus Deaton, generally consider health aid as more beneficial than other forms of international assistance. For anti-aid perspectives, see Angus Deaton, *The Great Escape: Health, Wealth, and the Origins of Inequality* (Princeton, NJ: Princeton University Press, 2013); Dambisa Moyo, *Dead Aid: Why Aid Is Not Working and How There Is a Better Way for Africa* (New York, NY: Farrar, Straus and Giroux, 2010); William Easterly, *The White Man's Burden: Why the West's Efforts to Aid the Rest Have Done so Much Ill and so Little Good* (New York, NY: Oxford University Press, 2006). For a pro-aid perspective, see Jeffrey D. Sachs, *The End of Poverty: Economic Possibilities for Our Time* (New York, NY: Penguin Books, 2006).

⁴⁸ "2015 Article IV Consultation--Press Release; Staff Report; and Statement by the Executive Director for Malawi," IMF Country Report (Washington, DC: International Monetary Fund, December 2015), p. 13 and 15.

accidents, which rests all historical turning points on great or evil men or unforeseeable calamities. While Carr believed that great historical shifts had multiple causes, he also believed historians can speak of causation and not just pure contingency. Only from those histories that explore relationships between actions and reactions can lessons be derived. History does not repeat itself, nor prescribe immutable laws of causation. But, as Carr suggested, it is not the historian's aim merely to produce either naively "objective" or meaningless narratives, but to glean lessons relevant to the present.⁴⁹ In this spirit, I, too, will suggest that this history has lessons for the present.

After rapid increases in international aid for health in southern Africa during the 2000s and 2010s, funding has plateaued in recent years. International development assistance flattened at a level far below of the target of 0.7 percent of GDP agreed to by the leaders of wealthy nations at the G8 summit in Gleneagles in 2005. Aid levels failed to rise even as Western economies emerged from recession that followed the 2008 financial crisis. Politicians in rich nations have justified the persistently low levels of aid by invoking familiar claims of scarcity. At the same time, wealthy nations have done little to stem the tide of illicit financial flows leaving poor nations. By some credible estimates, the amount of money leaving Africa through illicit financial flows equals the amount entering through aid.⁵⁰ Meanwhile, Malawi's recent governments have in recent years

⁴⁹ Edward Hallett Carr, *What Is History?*, 40th anniversary ed. (Houndmills, Basingstoke, Hampshire: Palgrave, 2001).

⁵⁰ The African Union defines the term "illicit financial flows" as "money illegally earned, transferred or used." The most important illicit financial flow, according to most academic analyses, involves the misattribution of profits earned in Africa to low-tax nations in Europe. See "Report of the High Level Panel on Illicit Financial Flows from Africa" (United Nations Economic Commission for Africa, 2011). National and international activists have also spoken

floated the idea of making the rural poor pay for user fees at government clinics. The Ministry of Health has claimed that the government can no longer afford to treat patients free at the point of care.⁵¹

These claims lack evidence and imagination; they are also tired. What Paul Farmer has called “the house of No” was built long ago; officials in Britain’s Colonial Office and Southern Rhodesia’s Federal Ministry of Health justified paltry health budgets with similar claims, until forced by circumstances to shift course. Claims of scarcity are a smokescreen, a simulacrum; they apply only in periods of political quiet. Health funding is not an automatic function of economic growth. Government purses have been pried open before, and they will be again. All it takes is a crisis of legitimacy. The health of the poor has mattered most to those in power when their own political fortunes hang in the balance.

If we acknowledge the role of unrest in determining health budgets, and the importance of health budgets in determining health outcomes, what are we to do? Foment uprisings? This seems a dangerous strategy, given the often-disastrous consequences of political instability, particularly in central and southern Africa. Some Malawians have seen fit to protest the dreadful state of government health services.⁵² Their protests could surely

out against licit, but still quite deleterious, avoidance of taxes by corporate actors in Malawi. The most prominent recent example is the Australian mining company Paladin, which operates a uranium mine in Malawi. See Martha Khonje, “Corporate Tax Deals Are Robbing Poor Countries of Teachers and Nurses,” *The Guardian*, July 2, 2015.

⁵¹ Luke Messac, “Malawi’s Health Care Subject of Intense Worry for Country’s Poor,” *Pulitzer Center on Crisis Reporting*, August 2, 2013.

⁵² “Missing Medicines in Malawi: Campaigning against ‘Stock-Outs’ of Essential Drugs.”

benefit from international support. But thus far, they have not secured sustained improvements in the government health system. In fact, a popular rumor holds that when 78-year-old President Bingu wa Mutharika's was rushed to Kamuzu Central Hospital with a heart attack in April 2012, the hospital did not have any epinephrine to administer to him.⁵³ Though the government never confirmed the rumor, and it is not at all certain that epinephrine would have saved the president's life, this drug is a standard component of cardiac resuscitation protocols around the world. Bingu's purported death-by-stock-out became a subject of derision among Malawians, no longer surprised by a health system so poorly funded and managed it killed even the president.

For the citizens of the wealthy nations of the Global North, different lessons emerge from the history recounted in the preceding chapters. There is an urgent need to challenge the ubiquitous claims of scarcity. Even colonial-era doctors such as John Owen Shircore and Henry De Boer realized that health budgets in Nyasaland need not be so low, and presented plans to increase them. During the Federation Era, doctors like John Goodall insisted that they did not have the tools they need to practice decent medicine in Nyasaland's African hospitals. At times their protests helped to garner greater resources, as when the Colonial Development Fund approved the majority of the proposals in Shircore's 1930 report. Yet during the last two decades of the twentieth century, with the World Bank and IMF insisting on cuts to social spending in debtor nations, practitioners

⁵³ "Editorial: Revealed: How the Malawian Cabinet Nearly Committed Treason," *The London Evening Post*, May 10, 2012.

and policymakers in international health became “socialized for scarcity.”⁵⁴ So pervasive was the habitus of defeatism in international health in 2004 that an executive at the Clinton Foundation HIV/AIDS Initiative told me he generally did *not* hire people with NGO experience because they had grown “too used to taking no for an answer.”⁵⁵

Through all of this, though, there remains a need to cultivate a “willingness to be surprised,” to question totalizing narratives with inductive histories.⁵⁶ Twenty-first century global health does not share all the sins of colonial medicine.⁵⁷ Nor were colonial doctors and officials simply handmaidens of economic exploitation. Even this study of colonial medicine, which is informed (though not dictated) by a materialist understanding of history, there are still colonial administrators who exhibit deeply held moral commitments and have made significant impacts on access to medicine and care. John Owen Shircore, Shenton Thomas, and Lord Eustace Percy are such individuals. Working within a discriminatory social and economic system, the efforts of these sons of privilege helped to funnel resources down steep gradients of inequality to ensure some modicum of medical care reached subject African populations.

⁵⁴ Paul Farmer, *Spoken Remarks, Preparatory Meeting to Support Operational Plan of Action to Eliminate Cholera on the Island of Hispaniola* (Washington, DC, 2013).

⁵⁵ Interview with Clinton HIV/AIDS Initiative executive, May 2005.

⁵⁶ Ferguson, *Give a Man a Fish*. Page 33. I refer here, too, to what Slavoj Žižek has called the “singular”; there must be space in our historical imaginations (even if we do tend toward materialism) for actors who do not conform entirely to universals. Slavoj Žižek, *First as Tragedy, Then as Farce* (London: Verso, 2009).

⁵⁷ Jeremy Greene, “Colonial Medicine and Its Legacies,” in *Reimagining Global Health: An Introduction* (Berkeley: University of California Press, 2013).

It may seem regressive to look to colonial doctors as role models, but in this case there is something worth emulating. Global health practitioners and policymakers should be at least as skeptical about claims of scarcity in our time as Shircore and De Boer were in theirs. Just as De Boer suggested that tax revenues from mining might be used to benefit Nyasaland, advocates of the present should insist on greater creativity in securing the finances necessary to improve the health of poor people in poor countries.⁵⁸ Such creativity is evident in the creation, in 2006, of the UNITAID airline tax by a number of European and Latin American nations. The revenues of this tax, which reached \$2.4 billion between 2006 and 2014, have been used to finance AIDS, tuberculosis, and malaria diagnosis and treatment activities around the globe.⁵⁹ More recently advocates have agitated for a financial transactions tax (on sales of bonds and shares) and a tax on arms sales to fund health programs in poor nations.⁶⁰

V. What it takes

⁵⁸ The historian Shula Marks has also sought to recount a progressive vein of mid-twentieth century medicine and medical officialdom in Southern Africa. In a 1997 article, she recounts the support that social medical pioneers Sidney and Ellen Kark received from secretaries of health Eustace Cluver and George Gale and deputy chief health officer Harry S. Gear. “Through the health center movement,” writes Marks, “these advocates, albeit small in number, were to contribute to some of the most notable developments in social medicine anywhere in the world. Gear, Gale and Kark all worked later for WHO, and their ideas contributed to the development of international models of community health care...They explicitly identified both the sociopolitical causes of ill health and the sociopolitical means of preventing and curing it, even if...they were ultimately powerless to implement the broader policies they believed necessary.” Shula Marks, “Public Health Then and Now: South Africa’s Early Experiment in Social Medicine: its Pioneers and Politics,” *American Journal of Public Health* 87 (1997): 452-459.

⁵⁹ “UNITAID Audited Financial Report for the Year Ended 31 December 2014,” accessed June 6, 2016. p 35.

⁶⁰ Report of the technical group on innovative financing mechanisms: action against hunger and poverty. September 2004. Also see Landau, Jean-Pierre. The Landau Report. 2004. Pp.65.

Malawi markets itself as the “warm heart of Africa,” trading on its international reputation as a friendly, peaceful oasis in the midst of a region long mired in violence and turmoil.⁶¹ As this dissertation has shown, this land is not so placid as its reputation indicates. Early in the nineteenth century it received migrants from the south fleeing the *mfecane*. By the mid-nineteenth century, its people were constantly subjected to slave raids from armed traders seeking riches in the Indian Ocean trade. The colonial era brought wars of conquest, two world wars, anti-witchcraft movements and Christian millenarianism. Mass arrests and strikes attended the anti-Federation movement of the 1950s and early 1960s. After independence, the leadership of the new nation fell into a bitter and bloody internecine battle. Popular demonstrations and labor actions heralded the end of Banda’s long reign in the 1990s. Even today, as evidenced by the Masasa incident in 2015, political violence remains a feature of life and death in Malawi.

Still, it is true that Malawi has presented few of the profound threats to foreign capital that have led, in other places, to significant increases in social spending. Nyasaland benefitted relatively little from the 1940 Colonial Development and Welfare Act, while centers of labor agitation in the West Indies and West Africa received far more aid. Malawi’s dearth of mineral resources and its geopolitical insignificance have afforded it few opportunities to enter the *realpolitik* calculus of more powerful nations. The few exceptions to this trend, such as the increase in health spending that followed the

⁶¹ Didier Fassin, ed., *A Companion to Moral Anthropology* (Hoboken, New Jersey: Wiley-Blackwell, 2012); Luke Messac, “Moral Hazards and Moral Economies: The Combustible Politics of Healthcare User Fees in Malawian History,” *South African Historical Journal* 66, no. 2 (April 3, 2014): 371–89.

agitation of the Federation era, only prove the rule. There are dividends to disquiet, but Malawian history has usually demonstrated, conversely, the perils of peace.

Just as Malawi's health services have derived relatively paltry benefits from unrest, they also have been unable to garner much funding from arguments about the economic benefits of health spending. The interwar focus on nutrition petered out without any great investments in either agriculture or medical services, while the human capital arguments of the 1970s did not spur vast new health spending by international aid agencies or by Banda's government. Those holding the purse strings of colonial and postcolonial treasuries have proven to be little moved by trends in economic thought.

The greatest recent boon to Malawi's health sector came neither from unrest nor from economic logics, but from a human rights movement for health at the dawn of the twenty-first century. Activists, humanitarians, and politicians of vastly different ideologies from the Global North and South propelled successful campaigns for debt relief and increased international aid for global health. These campaigns made it possible for Malawi's government, and those in other poor countries, to expand access to AIDS treatment while improving staffing in clinics and hospitals around the country.⁶²

In 2004 an estimated 900,000 citizens had HIV.⁶³ The next year, 98,000 Malawians became newly infected.⁶⁴ For every 10 new nurses graduating from Malawi's training

⁶² Messac and Prabhu, "Redefining the Possible: The Global AIDS Response."

⁶³ Katharina Kober and Wilm Van Damme, "Scaling up Access to Antiretroviral Treatment in Southern Africa: Who Will Do the Job?," *Lancet* 364, no. 9428 (July 3, 2004): 103–7. p 2.

institutions, four existing nurses succumbed to AIDS.⁶⁵ Only nine facilities in the public sector offered antiretroviral therapy (ART); these treated a total of 3,000 patients.⁶⁶ That year, using funding from a successful application from the first round of the Global Fund for AIDS, Tuberculosis, and Malaria, Malawi began providing free antiretroviral therapy to adult patients.⁶⁷ Within a few years, with funding from UNITAID, Malawi also began to provide pediatric patients access to ART free of charge. By March 2011, 433 clinics in Malawi treated over 264,000 patients with ART.⁶⁸ A recurring survey in Karonga District, in the north of Malawi, found that all-cause adult mortality decreased by 32 percent between 2002 and 2008.⁶⁹

During this period, Malawi also received assistance to address its dire shortage of healthcare workers. Low pay and desperate working conditions had long impelled many of Malawi's health workers to leave the public sector. The Global Fund and the UK Department for International Development inaugurated 6-year, \$272 million Emergency Human Resources Programme (EHRP) in 2005. This program provided a 52 percent salary increase for all health workers, expanded pre-service training, and recruited expatriate volunteer doctors and nurses. The EHRP also included incentives to attract

⁶⁴ "The Gap Report: Beginning the End of the AIDS Epidemic" (UNAIDS, 2014). p A39.

⁶⁵ Kober and Van Damme, "Scaling up Access to Antiretroviral Treatment in Southern Africa: Who Will Do the Job?"

⁶⁶ "Treatment of AIDS: Guidelines for the Use of Antiretroviral Therapy in Malawi" (Ministry of Health, Malawi, April 2008). p iii.

⁶⁷ Edwin Libamba et al., "Malawi's Contribution to '3 by 5': Achievements and Challenges," *Bulletin of the World Health Organization* 85, no. 2 (February 2007): 156–60.

⁶⁸ "Malawi Antiretroviral Treatment Quarterly Report" (Ministry of Health, HIV Unit, March 2011).

⁶⁹ Sian Floyd, Anna Molesworth, and Albert Dube, "Population-Level Reduction in Adult Mortality after Extension of Anti-Retroviral Therapy Provision into Rural Areas in Northern Malawi," *PLoS One*, October 19, 2010. Page 9.

healthcare workers to underserved areas.⁷⁰ Analyses found that the salary “top-ups” helped stem the flow of healthcare workers out of the public sector, while expanded pre-service training led to a more robust cadres of healthcare workers.⁷¹ The number of health professionals trained annually increased from 400 in 2004 to over 1000 by 2008.⁷²

Between 2002 and 2008, donor countries’ contributions to global AIDS programs increased by a factor of six. For millions, these investments transformed HIV from a death sentence to a manageable chronic disease. Yet in the wake of the financial crisis, the annual increases in aid stopped.⁷³ As of 2016, global health spending levels by bilateral and multilateral donors remained largely unchanged.⁷⁴ In a July 2011 interview Dorothy Ngoma, Executive Director of Malawi’s National Organization of Nurses and Midwives, expressed despair over the state of Malawi’s health sector:

⁷⁰ Mary O’Neil, Zina Jarah, and Leonard Nkosi, “Evaluation of Malawi’s Emergency Human Resources Programme” (Cambridge, MA: Management Sciences for Health, July 2, 2010), http://www.who.int/workforcealliance/media/news/2010/Malawi_MSH_MSC_EHRP_Final.pdf, p 10.

⁷¹ Ibid. p 32-30.

⁷² David McCoy, Barbara McPake, and Victor Mwapasa, “The Double Burden of Human Resource and HIV Crises: A Case Study of Malawi,” *Human Resources for Health* 6, no. 16 (2008). Also see Doug Farquhar, Jamie Greenman, Roland Li, Luke Messac, and Jennifer Cohn, “Breaking promises to the poor: the donor retreat puts Malawi’s AIDS program in peril.” (Unpublished manuscript).

⁷³ This halt in aid increases contributed to shortages and stock-outs of antiretrovirals in many parts of sub-Saharan Africa. In Uganda by 2010, for instance, physicians were once more forced to refuse to initiate patients who, by World Health Organization guidelines, should have begun treatment. See Sung-Joon Park, “Stock-outs in global health: pharmaceutical governance and uncertainties in the global supply of ARVs in Uganda”, in *Rethinking Biomedicine and Governance in Africa: Contributions from Anthropology*, eds. Paul Wenzel Geissler, Richard Rottenburg, Julia Zenker (Verlag, Bielefeld, 2012), 177-196.

⁷⁴ For US international health spending between 2006 and 2015, see “The U.S. Government and Global Health” (Kaiser Family Foundation, April 23, 2015). For an overview of multilateral and bilateral spending levels between 1990 and 2014, see “Financing Global Health 2014: Shifts in Funding as the MDG Era Closes” (Seattle, WA: Institute for Health Metrics and Evaluation, 2015)., p 18.

Don't let anyone convince you that [past efforts] have relieved the emergency. While we can see improvements in pockets, we are still in a crisis. Without money on the table, we can't make progress...Where are our partners?...Why are babies still dying? In a nation with only one-quarter of the nurses necessary to meet WHO-recommended minimums, why does tuition still cost \$2000 per student? Why are there so many people dying for want of basic needs? Why are there so many hospitals without labs?⁷⁵

While unrest and economic arguments may help put drugs on shelves and nurses in wards of public hospitals, ultimately Sen is correct. Incredibly, scholars and policymakers still need to be reminded of “the intrinsic importance we attach—and have reason to attach—to living.” Campaigns built on moral claims have, in recent years, proved capable of spurring rapid changes. Still, the provision of medical care and public health to Malawi's people remains woefully inadequate.

What is an acceptable standard of care for poor people in poor countries? How much untimely and avoidable death is morally permissible? How much action is politically possible? This dissertation has chronicled the (generally disappointing) answers that actors of the past have given to these questions in their own time. Now, we must answer them in our own.

⁷⁵ Interview with Dorothy Ngoma, July 8, 2011, Lilongwe, Malawi.

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