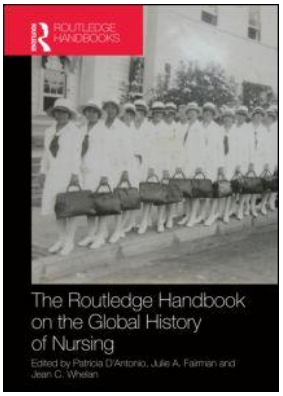

Routledge Handbook on the Global History of Nursing

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Nursing and the "Hearts and Minds" Campaign, 1948–1958

Publication details
https://www.routledgehandbooks.com/doi/10.4324/9780203488515.ch13
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Published online on: 24 May 2013

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NURSING AND THE "HEARTS AND MINDS" CAMPAIGN, 1948–1958

The Malayan Emergency

Rosemary Wall and Anne Marie Rafferty

From 1900 to 1955, British Malaya was the most common destination in the world for British colonial nurses (see Figure 13.1). The Malayan territories in South-East Asia were composed of many races including aboriginal communities, Malays who were largely rural, and various Chinese and Indian immigrant populations, in addition to the British and Eurasians.[1] This complex crucible resulted in racial and political tension. Examining nursing during the Malayan Emergency (1948–1960) highlights the role of the profession during a political crisis, and the problems faced by the Colonial Nursing Service in supplying sufficient nurses for the area. How were British nurses persuaded to travel to Malaya and how did methods compromise stringent recruitment standards? How did the Emergency attract international health organizations' attention to nursing? In particular, in what way did nursing become embroiled in the "hearts and minds" campaign to defeat communist insurgents? This chapter argues that the Malayan case illustrates an early emphasis on rural healthcare and the training of nurses within post-World War II international health policy.

For decades, racial and political tensions had been building in British Malaya. The area was a "patchwork quilt of dependencies with different political and administrative traditions" and representative institutions had not developed to the same extent as in India, Burma and Ceylon.[2] While the Straits Settlements, which included Singapore, were a Crown colony, sultans retained sovereignty of the Federated Malay States (FMS) and Unfederated Malay States (UFMS), although the sultans were compelled to follow advice from British administrators.[3] The political life of the Malayan territories was further complicated by the rapid economic development of the region and the influx of immigrant labor. By 1938, Malaya was the world's most successful producer of natural rubber, bringing huge demands for plantation labor, encouraging migration from India. The colony also mined a third of the world's tin before World

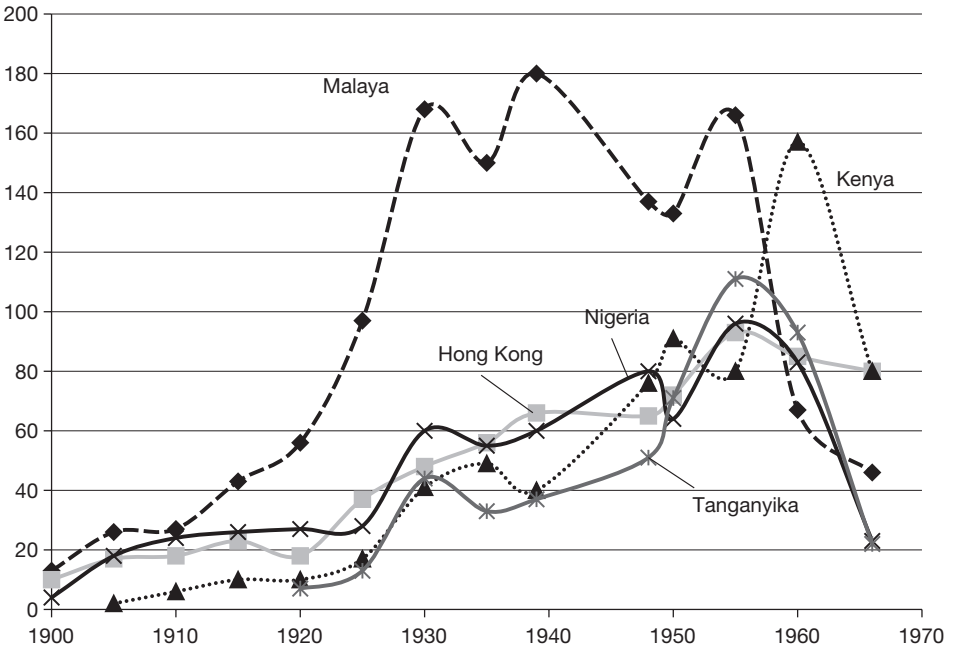

Figure 13.1 Number of British colonial nurses sent to the five most common destinations.

Source: The Bodleian Library of Commonwealth and African Studies at Rhodes House, Oxford, Overseas Nursing Association Collection, Colonial/Overseas Nursing Association, *Annual Reports*, 1897–1966, Brit Emp s400 131.

War II (WWII), an industry that attracted Chinese immigrants.[4] By 1941, although the population of British Malaya was 43 percent Chinese, 41 percent Malay and 14 percent Indian, the Chinese and Indian populations had not been granted political representation. Indeed, conscious of the effect that immigration was having on the population from the 1870s on, the British declared "Malaya for the Malays," developing this ethnic group's political and public sector roles and their education, while operating a *laissez-faire* attitude towards the recent immigrant populations.[5] This resulted in the Malayan sultans' disproportionate influence over the colonial government, which was not in sync with the shifting balance of socio-economic and demographic change.[6]

As part of the Japanese invasion of South-East Asia during WWII, between December 1941 and February 1942, the Japanese gained control of and occupied Malaya and Singapore. British civilians were imprisoned in internment camps. After regaining control in 1945, the British decided to restructure Malaya in order to work toward Malayan self-governance within the Commonwealth. The British government implemented the Malayan Union, excluding Singapore from this new state in order to appease business interests in Malaya who felt threatened by the city's hegemony, and also because the largely Chinese population of Singapore was a concern for Malays. The establishment of the Union involved coercing the sultans to sign over their sovereignty to the British, and opening up citizenship to non-Malays.[7] The

Malay protests regarding the new regime led to the abandonment of the Union, and the British declared the Federation of Malaya in 1948. The Federation gave concessions to Malays, such as making it harder for the Chinese and Indians to gain citizenship, and returning sovereignty to the sultans, with Malaya administered by a high commissioner rather than a governor. Thus, the Federation insulted the Malayan-Chinese who were an important workforce within the colony and had fought against the Japanese during the war.[8] In fact, the Malayan-Chinese communist guerrilla movement developed during WWII, in opposition to Japanese occupation.[9] Additionally, the Malayan Communist Party (MCP) aired grievances about social and economic problems among the Chinese that stemmed from the 1930s. Although many of the Chinese urban and rural populations did not support communism, they did have complaints about the British colonial government which included inadequate medical facilities and the short supply of housing and of food, resulting in high rents and prices.[10] This tension built up to the Malayan Emergency (1948–1960), a violent communist, guerrilla insurgency fought in rural areas.

The Malayan Emergency was one of the most dramatic challenges to British interests and authority in the post-war years, requiring the deployment of some 20 battalions of the British army in addition to nearly 50,000 local police and special constabulary.[11] The stakes were high since the Emergency put the production of Malayan rubber and tin at risk. These Malayan commodities were crucial for earning dollars for the Sterling Area. This bloc was officially formed at the beginning of WWII and included colonies and ex-colonies that fixed their currencies to the British pound, with Britain exchanging sterling for all of the US dollars earned within the Sterling Area. Through this policy, Britain hoped to stimulate markets for its exports and relieve its economic indebtedness to the United States. The insurgency also threatened to open the way for Chinese domination in Malaya at a time when Mao Tse Tung was establishing the People's Republic of China (1949).[12] In January 1950, three months after Mao's victory in China, the British government announced its recognition of the communist government in China, accompanied by Prime Minister Clement Atlee's reassurance that the struggle to stamp out the MCP would continue.[13] If the communists gained control of the Malayan interior, the repercussions would have been far-reaching for the British economy, the control of Singapore, and for relations with the Malayan population and with all Western countries' interests in Asia. Significantly, British policy demonstrated a determination to strengthen British control of the Malayan peninsula, in contrast to the relinquishment of India, Ceylon and Burma.[14] The consequence of this action was that Britain was drawn into a protracted and expensive counterinsurgent campaign.[15]

The "second colonial occupation" is a term used by historians to refer to the post-WWII return of the British in order to re-establish rule over the colonies with a goal to provide the mother country with much-needed raw materials and foodstuffs.[16] This movement supported the increase of British nurses in the colonies. Extra funding from the British Colonial Development and Welfare Fund, and tripartite agreements for Technical Assistance between the World Health Organization (WHO), UNICEF (United Nations International Children's Emergency Fund) and colonial governments led to British government nurses being sent into the Empire in

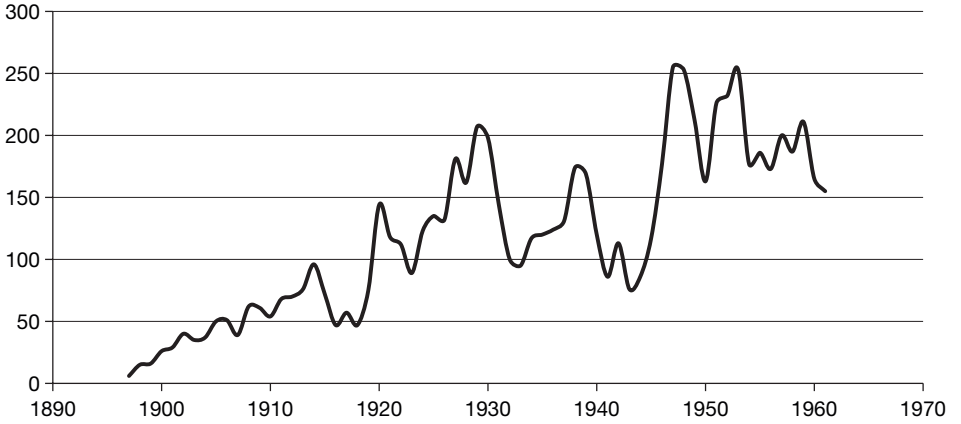

Figure 13.2 Number of Colonial/Overseas Nursing Association nurses sent overseas, 1897–1961.

Source: The Bodleian Library of Commonwealth and African Studies at Rhodes House, Oxford, Overseas Nursing Association Collection, Colonial/Overseas Nursing Association, *Annual Reports*, 1897–1966, Brit Emp s400 131.

unprecedented numbers during the late 1940s, with one of their major roles being to train the local populations in nursing (see Figure 13.2).[17]

Situating post-war Malaya in the historiography of colonial nursing

The nurses who were recruited and employed by the government or its agencies were the largest professional group of female colonial government employees. Between 1922 and 1943, 2,189 nursing sisters were recruited, compared to 83 female teachers and 72 female doctors.[18] Nurses were probably the second largest group of single women in Empire, next to teachers who were employed in Malaya by a wide variety of agencies.[19] Although they initially worked for white populations overseas, the nurses' role in caring for local populations gradually increased, culminating in the training of local nurses.[20] In Britain, colonial nursing was organized by the Colonial Nursing Association (CNA) which was established in 1896, and worked as an agency for the Colonial Office until 1940, when the relationship was formalized with the establishment of the Colonial Nursing Service.[21] In 1918, the organization was renamed the Overseas Nursing Association (ONA), reflecting the work of the nurses in locations outside the official British Empire.[22] From 1896 to 1966, the association recruited 8,450 nurses for work overseas.[23]

The historiography of government nursing in the tropical colonies is slowly building upon the more mature studies of early British nursing in the white dominions.[24] Studies of nurses in British tropical colonies have so far focused on single countries, such as Jhana Gourlay's study of Florence Nightingale's interest in India.[25] West Africa has been a focus for two historians interested in CNA nurses, with Dea Birkett's claim that it was

the venue for "by far" the largest number of colonial nurses.[26] However, our research demonstrates that, between 1920 and WWII, South-East Asia became the most common destination for nurses, after which East Africa employed the most.[27] Margaret Jones incorporates colonial nursing into her study of healthcare in Ceylon (present-day Sri Lanka) and in particular reveals the relatively early training of local nurses to higher levels than other colonies.[28] With virtual self-government in Ceylon dating from 1931, this is a rather different case to Malaya, where independence came only in 1957. She also examines the post-colonial incursion of the Rockefeller Foundation following the granting of independence in 1948, and the subsequent involvement of the WHO.[29]

Helen Calloway and Birkett's discussions of colonial nursing in West Africa are incorporated into a substantial body of work on gender and empire. In the 1980s, Calloway's work in this genre established single working British women in empire as a crucial topic. The nurses, lady medical officers and female teachers in empire had perhaps the easiest access to local people.[30] Margaret Strobel and Alison Bashford also briefly acknowledge the role of nurses.[31] Other literature on working white women includes discussions of missionaries with their ideology of religious and cultural superiority (approaches that were not widely successful among Muslims in Malaya), and groups such as teachers with their capacity to connect with local populations.[32] From the perspective of the history of medicine, Lenore Manderson mentions the role of British nurses and health visitors in women and children's health.[33] In many cases this literature reveals that women's roles in Empire enabled close contact with the local communities. As Anne McClintock reminds us, white women were "boundary makers" in Empire.[34]

Although the colonial nurse was subordinate to the male colonial officials and doctors, her lower status and her gender were advantageous for building links with local people, particularly Muslim women. In particular, the local women, whom the British nurses trained and worked with, acted as "cultural brokers," disseminating Western biomedical ideas to the local populations.[35] However, these colonial relationships were complex. The racial and gender hierarchy could be disrupted in situations where white nurses were treated as subordinate to local doctors, as Margaret Jones has illustrated for 1930s Ceylon.[36] Indeed, this was also the case according to one British nurse working in Malaya in the 1920s; Mary Culliton wrote that working with the locally trained doctors in Perak required "tact" as they did not appreciate the training of the British nurses, and offended some sisters by explaining orders in minute detail.[37] WHO male nurse tutor, John Waterer, reported the challenge of male Asian hospital assistants not accepting the authority of the female European sisters and matrons.[38]

The history of nursing in areas of South-East Asia has previously been discussed in terms of the "colonial gaze" of health visitors in Malaya.[39] Nursing auxiliaries volunteering with the St John's Ambulance Brigade in Malaya have been examined within the period during and after the WWII Japanese invasion.[40] Additionally, descriptive accounts of the history of nursing in Singapore have been produced.[41] Catherine Choy's study of Filipino nursing includes a short study of the American nurses who traveled to Asia, but mainly concentrates on the supply of Filipino nurses generated for the American nursing market, and these Filipino nurses' experiences in the USA.[42] Winifred Connerton's extensive exploration of the experiences and

influence of American nurses in the Philippines and Puerto Rico depicts the variety of ways in which nurses could travel, whether as missionaries, with the armed forces, or as colonial nurses.[43]

As shown by Figure 13.2, the largest number of nurses in the British Empire operated in the late 1940s and early 1950s. Thus far, this is a neglected period for research on the history of medicine in Malaya as, except for Phua Kai Hong's doctoral thesis on the Malayan health services, the small number of histories of healthcare in Malaya stop before WWII.[44] Yet the challenges of the Emergency and decolonization make this a compelling period for study, with competing political agendas and significant shortages in the healthcare workforce.

The nurse is increasingly a focus for studies of international health organizations. In their studies of the Rockefeller Foundation's International Health Division, John Farley and Barbara Brush have noted the important role nurses played in spreading American schemes of public health around the globe.[45] In addition to Jones' brief account of the WHO incursion into nursing in Sri Lanka, Christine Hallett and Lis Wagner have discussed the role of nurses within the WHO. Focussing on the European Office, they examine the essential role of nurses in the organization's aim to expand primary healthcare which had been articulated in 1978.[46]

Nursing and the "hearts and minds" campaign

The term "hearts and minds" – a strategy of counter-guerrilla warfare – was coined by the High Commissioner for Malaya, Gerald Templer, in 1952. It referred to a "total effort" in political, economic, cultural and social policy and practice in order to gain the support of the Malayan people.[47] Contemporaries usually discussed this strategy in terms of inspiring "confidence" and building or breaking "morale."[48] The nurses who were recruited in order to assist with the hearts and minds campaign in Malaya deliberately reached previously neglected populations as part of the acceleration of "cultural colonialism."[49]

This policy was introduced nearly four years after the declaration of the Emergency as previous propaganda methods had failed in the rural areas of Malaya. Templer arrived in Malaya in 1951, following the death of his predecessor, Henry Gurney, in a guerrilla ambush.[50] Templer's morale-boosting anti-communist campaign was in contrast to Gurney's punitive strategy. Gurney's ruthless program of detention and resettlement to break up guerrilla networks was accompanied by the distribution of millions of leaflets to rural areas, film shows and radio broadcasts, and the rationing of food for the rural communities in order to reduce the supplies reaching the terrorists. His political concessions to the urban elites did not appease the economic and social concerns of the rural Chinese-Malayans.[51]

Templer decided to continue Gurney's plan to resettle Chinese squatters in order to separate them from the guerrillas, hence disrupting the MCP's supply lines. This scheme relocated the rural Chinese population in areas that were often restricted by barbed or electric wire and security guards. In total 500,000 people (10 percent of Malaya's population) were moved into what Templer renamed the "New Villages".[52] The 410

villages had main streets, village committee offices, temples, churches, playing fields, schools, police stations, markets, homes for older people, and in some cases maternity homes, assembly homes and cinemas. These villages housed not only Chinese, but also Malay, Javanese and Indian people. From a healthcare and sanitation perspective, resettlement led to problems such as the lack of adequate supplies of clean water and reliance on voluntary organizations for health clinic services, which Templer was determined to resolve.[53] The prevalence of malaria and water-borne diseases in the villages was particularly challenging for medical officials due to the lack of doctors and nurses.[54]

Most importantly for the history of nursing, the "hearts and minds" campaign included improvements in basic measures such as medical facilities, education and social welfare as part of a "mass exercise in propaganda."[55] Ramakrishna has argued that this was crucial for success in the Malayan Emergency as most Chinese in Malaya were much more concerned about the economic and social problems of their everyday lives than about political reform.[56] Additionally, the campaign included a demonstration of the intention of granting independence, in particular the Malayanization program – enabling Asians, whether Malay, Chinese or Indian, to take senior administrative roles, including those within healthcare.[57]

This type of program, utilizing healthcare to inspire newly independent countries or those on their way to independence to align with capitalist rather than communist countries, became part of international health organizations' policies. This was despite Brock Chisholm, a Canadian and the first Director General of the WHO from 1948 to 1953, being a critic of the Cold War; he hoped to exclude politics from the organization's activities. Yet conflict within the WHO led to many communist states withdrawing, including the USSR and China, because of disagreements regarding WHO administration and policy.[58] John Farley has argued that a "magic bullet" approach of quick solutions to eradicating disease was the route to winning "hearts and minds" within newly independent countries during the Cold War in order to persuade them to align with capitalist rather than communist ideologies. However, Chisholm's influence also inspired an understanding of the importance of social and economic conditions for public health.[59] Additionally, the records of the WHO reveal that there was a commitment to "Technical Health Education" in order to assist training of healthcare practitioners in countries that had been badly affected by WWII.[60]

The Malayan Emergency – a crisis in care

The increase in demand for rubber and tin, stimulated by the Korean War (1950–53), boosted the Malayan government's coffers, enabling increased expenditure on medicine and health.[61] Decisions on healthcare provision changed in 1951 with the introduction of the "member" system to the Malayan Legislative Council. Members of the Council represented commercial and state interests, and were given portfolios, including a Federal Medical Programme under the Member for Health. The Director of Medical Services, in charge of the colonial Malayan Medical Service, became responsible to the Member of Health, advising him on future plans for Malayan healthcare. Prior to 1951,

healthcare provision was administered locally and was uneven across the states, particularly in rural areas.[62] In July 1951, Lee Tiang Keng, the Member for Health, requested that medical facilities be established in the New Villages. The aim was not to give the villages any special consideration but to provide them with the same level of service as the rest of the rural population, delivered by male Asian hospital assistants.[63] However, the shortage of staff made this impossible, and existing training schools for hospital assistants were already "fully taxed."[64] Even so, the new measures provided for 32 dispensaries, a further 29 mobile dispensaries, 49 treatment and examination rooms, 25 hospital assistants, 23 hospital attendants, six health inspectors and 156 overseers and labourers for anti-malarial work.[65]

"Hospital assistants" was a term used in Malaya since the late 19th century for male dressers who had been involved in roles including administration, nursing, dispensing, laboratory work, surgery and plastering; the roles also involved serving as clinic assistants, treating minor injuries, storekeeping and radiography, with work not necessarily within hospitals despite their job title. By the 1940s and 1950s these men received the same training as nurses. For 400 villages, 25 hospital assistants were insufficient, so the staff from the existing rural settlements were also stretched over the newly settled areas.[66] Hence, these clinics led to an immediate demand for British nursing staff as a result of the lack of locally trained nurses and assistants.

In 1946, the Malayan medical report presented statistics of its public health staff who conducted much of the rural work. The Director of Medical Services considered that the 28 nursing sisters (usually British nurses in senior positions) and 90 nurses (usually Asian nurses in subordinate roles) for a population of approximately five million was small "by western standards, but it is probably higher than would be found in most of the eastern tropical territories."[67] The rural areas were particularly difficult to cover, considering 47 nursing positions remained vacant within Malaya in 1950.[68]

Despite the demand for nurses, the ONA did not supply enough recruits for rural Malaya. The Emergency deterred nurses from applying to work in the area.[69] Additionally, the deaths of 48 of the British nursing sisters who had served in Malaya during WWII dramatically depleted the post-war nursing workforce in British Malaya. Of colonial nurses working in Malaya and Singapore prior to WWII, four nurses were killed when the Japanese invaded Singapore, 40 were killed while trying to escape on ships, and four more died in the internment camps.[70] As a result of these deaths and the challenges of post-WWII recruitment, the number of British colonial nurses in Malaya and Singapore was only 137 in 1948, whereas it has been 180 in 1939.[71] Although more nurses were required, only nine nurses were appointed to go to Malaya in 1950, and in that year the total number of ONA nurses there decreased to 133.[72] This was at a time of particularly intense terrorist activity, with 4,789 incidents in 1950 and 6,082 in 1951.[73] Guerrilla warfare was nearly under control by 1954, and this led to an increase in nursing recruits. Hence, by 1955 there were 166 British colonial nursing sisters working in Malaya.[74] By March 1953 there was a total of 560 registered nurses in Malaya (including the Asian nurses), but H.M.O. Lester, the Director of Medical Services, believed that the number of nurses should be 2,000 and that a further 2,000 auxiliaries were required.[75]

This nursing shortage in Malaya was exacerbated by the increased global demand for nurses after WWII. British nurses were in high demand for the new British National Health Service and also for the United Nations Relief and Rehabilitation Administration, an organization founded by the Allied nations during WWII in order to provide relief to areas that had been occupied by Axis powers.[76] Additionally, with the second colonial occupation, ever increasing numbers of nurses were going to work across the Empire in the late 1940s (see Figure 13.2).[77]

Recruitment was even more challenging because of the careful assessment of the character of potential colonial nurses in the ONA interview. The word "character" is a chameleon term that covers a code of values, virtues and moral behavior, sometimes explicitly stated but often implicit.[78] In the case of nurses recruited by the ONA it was those behaviors deemed appropriate, combined with the exercise of leadership and authority in the colonial context, which implied a particular type of deportment, demeanor, temperament of self-control, tact, adaptability and resilience, especially important in the tropics, where climate and circumstances could be very trying. Following WWII, the ONA described the type of nurse required: "Character and vision are needed in addition to academic qualifications."[79] The ONA lamented in 1947 that although it had "a greater choice of candidates, there has not been a surplus of good nurses, because heavy demands have come from all Colonies as the Governments build up their staffs after the war and plan developments."[80] The ONA still refused to reduce its required standards of training and character even at this time of political crisis, accompanied by severe nursing shortages. Successful applicants were expected to be dually trained in nursing and midwifery, and have three years' post-qualification experience. Increasingly, particular posts required experience in teaching.[81] In 1950, 298 nurses were interviewed, but only 163 were selected; the ONA argued that "however difficult recruitment may be, it is imperative that there should be no lowering of the standard of the nursing sisters selected, and the Nursing Selection Committee can by no means accept all the nurses who apply and are interviewed."[82] The shortage of ONA nurses resulted in the Malayan government accepting help from the military and calling for assistance from the Red Cross, the St John's Ambulance Brigade and WHO.

A call for help: The military, the Red Cross, St John's Ambulance Brigade, and the World Health Organization

Following the end of the Japanese occupation, the British Military Administration governed Malaya from September 1945 to April 1946.[83] Many army nurses had been working in Malaya during the military administration and some wished to remain. However, in 1946 only seven nurses were released from military service for work in civilian duties and a mere 11 military nurses who had been seconded from elsewhere in Empire to civilian duties in Malaya were allowed to remain for a longer posting.[84] These nurses were required to attend an interview with A.C. Pender, a retired ONA nurse who volunteered to return for this task. Additionally, several other active and

retired members of the ONA, who had previously worked in Malaya, volunteered to assist the military nurses in Malaya and Hong Kong, which had also suffered badly from Japanese occupation.[85]

Although such a small number of military nurses could not meet the demand, the recruitment of these nurses was more relaxed than in the African colonies of the British Empire, where military nurses were forbidden to work within the colonial healthcare system due to their lack of midwifery training.[86] The ONA refused to accept the suggestion that military nurses should be recruited for the African colonies, which was made by the Director of Recruitment for the Colonial Service. The association was concerned that a change in standards would cause anger in the colonies as some nurses had specifically undertaken this certificate in order to qualify for colonial service.[87]

In 1950, the Malayan government asked the WHO for help, requesting the assistance of a WHO tutor in public health nursing.[88] Following discussions with the Director of Medical Services and Malaya's Principal Matron, the Member for Health asked for the tutor's contract to be extended and for four more female tutors and a male tutor to be sent by the WHO.[89] In spite of the ONA's difficulty in recruiting from Britain, the WHO decided to try to recruit a male tutor from there in 1952. However, it is not clear in the records from where the candidate, John Waterer, was recruited.[90] The WHO provided further funding in 1953: US$47,000 for a Rural Health Training School at Jitra in Kedah and for four Rural Health Centers. The Western Pacific Secretariat of the WHO claimed that, despite financial challenges, the Organization was attaching "unusual importance" to this project, which was of "very considerable potential value."[91] UNICEF matched this with $47,000 for equipment for maternal and child welfare services.[92] WHO assistance continued, and a further WHO public health tutor arrived in Penang to teach health visitors in 1956.[93]

Although there is no reference to the political challenges of communism in the WHO records in relation to rural health and nursing in Malaya, the concentration on nursing in the colony is revealing. Malaya and the states in North Borneo which were to form unified Malaysia from the 1960s onward, were the only areas of the world to have dedicated WHO nursing programs in the early years of the Organization, between 1948 and 1953, coinciding with the Malayan Emergency. However, WHO nurses took part in many programs across the world, including tuberculosis campaigns and maternal and child health projects.[94]

Assistance from the WHO did not provide an immediate solution as it took time to establish the centers and train staff. With demand for nurses still not met, 370 doctors from the Malayan branch of the British Medical Association (BMA) gathered together in April 1952. They complained about the woeful lack of health services for the New Villages, arguing that where there was a population of over a thousand, a permanent dispensary should be provided. However, the BMA doctors acknowledged that dispensaries would not be easy to provide at a time of staff shortage. It was argued that hospital assistants could run the centers, and doctors would need to volunteer their time.[95]

The colonial Malayan government was fully aware of the inadequate care in the New Villages, and in March 1952 it arranged to pay grants to the British Red Cross Society (BRCS) for supplementary staff. The government hoped that the St John's Ambulance

Brigade (SJAB) would also help to recruit staff. Ninety percent of the charities' costs were paid for by the government, amounting to $1.5 million (Malay dollars).[96] The Red Cross already had a strong presence in Malaya, providing a range of services; for example, maternity and child welfare clinics, welfare work and training in first aid and home nursing.[97] The government also offered aid to church and missionary societies in return for qualified staff.[98] However, except for the China Inland Mission, the missions were reluctant to release their staff for government service.[99]

The BRCS was well advanced in its preparations to send 50 members of staff from Britain by April 1952 – a trained nurse and a welfare worker for each of 25 mobile dispensaries.[100] It had actually anticipated the demand in January and had already written to the County Directors of the BRCS asking them to recruit trained nurses aged 25 to 45.[101] In March 1952, 25 trained nurses were required "at once" with the designation that they should be in excellent health, prepared for "rough conditions" and hopefully able to drive a car. Nursing work was of "great importance in connection with the present Emergency in Malaya, and County Directors are asked to do all they can to make it known as early as possible."[102] In May the age limit was lowered to 21 in order to draw from a "wider choice" of applicants. However, the young applicants had to have "exceptional qualifications" in order to be considered, which were generally undefined but included a "high sense of responsibility."[103] In contrast to the ONA, which produced very few recruitment materials in general, publicity gained for BRCS work in Malaya included Janet Grant speaking on the BBC radio program *Under Twenty Parade* in October 1952.[104] With lower standards, including much less post-qualification experience and without demands for a midwifery qualification, and with much more publicity, the Red Cross was more successful in recruiting nurses for Malaya than the ONA.

With funding provided by the Malayan government, the BRCS built a house for each pair of nurses and welfare workers in the New Villages. Each pair was to look after communities of 10,000 people, half of the population of the New Villages.[105] By August 1953 there were 30 BRCS teams, five from the Australian Red Cross funded by the Colombo Aid Plan for South and South-East Asia, and 25 St John teams. The Red Cross nurses undertook 12-month contracts with the opportunity to extend them for a further year.[106] These organizations covered the traditional Malay villages as well as the New Villages. The BRCS insisted on providing "equal treatment for all races," therefore not just focusing on the Chinese population.[107] Indeed, Templar had promised the sultans that this would be the case as there was religious tension regarding Christian missions in the area.[108]

The Red Cross teams were welcomed with "open arms" and "nothing had been too much trouble" for the Malayan authorities and doctors in helping them to settle in.[109] It was not only the administrative and medical officers who valued their help, but also the "New Villagers" who appreciated their role to such an extent that the guerrillas never attacked their vehicles for fear of angering the Chinese communities and losing potential supporters.[110] Indeed, Mao's directives of 1951 included the cessation of all attacks on Red Cross vehicles.[111] A newspaper report from 1953 claimed that although there had been many communist attempts to "discredit" the Red Cross, the nurses in Malaya had not experienced any violence.[112]

The range of tasks that the nurses and welfare workers were to undertake was enormous; to name a few, they included a daily clinic in their home village, home visits, taking urgent cases to hospital, visiting schools and providing health education, "organizing and promoting" the Junior Red Cross, providing courses on first-aid and home nursing, training "promising girls in the elements of nursing," and advising on health and hygiene.[113] In August 1953, the Member of Health evaluated the work of the Red Cross and SJAB teams and judged that the welfare workers had made a very limited impact and so they would not be replaced. However, the nurses were crucial for rural areas in order to provide "medical treatment facilities."[114] Therefore, the Malayan government negotiated with the BRCS and SJAB for continued provision and replacement of nurses from Britain until 1955. These qualified nurses would train apprentice assistant nurses each time that British welfare workers resigned. The local recruits would receive 12 months' training, followed by further training in hospitals, before returning to work in rural areas. These recruits would also reduce the need for interpreters.[115] This training scheme for rural nurses, coupled with the new training school in Jitra, can be seen as part of the citizenship program described by historian Timothy Harper; community development was introduced into rural areas, including education and reading rooms. This included Malay women being encouraged to take a role in social welfare where they could work and socialize with expatriate British staff employed in this area.[116]

Another tactic used in the Emergency was an earnest incentive of independence to inspire the Malayans to fight communism.[117] Part of this program was the "Malayanization" of public services – the transfer of roles from the British to the Asians, whether they were Malays, Chinese or Indian. The training and promotion of Asian nurses in Malaya had been limited by a belief in the superiority of British nurses, and by the complicated racial mix in Malaya. Muslim Malays were largely reluctant to train as it was unusual for women to work outside of the home, and they lacked formal education.[118] Following WWII, A.G.H. Smart, Medical Adviser to the Secretary of State for the Colonies, visited Malaya and complained that the British were suppressing the career progression of Asian nurses who had clearly proved their capabilities when the British were interned during the war.[119]

In 1949, 66 nurses completed their training at the Penang School and 28 Asian nurses were given posts as health or nursing sisters: positions that were previously held by Europeans.[120] By 1952, nurse-training at the Penang School was awarded reciprocity with the General Nursing Council in the United Kingdom.[121] The emphasis was on training men as nurses rather than hospital assistants from 1951, exemplified by the request for a male tutor from the WHO. Despite the long history of hospital assistants in the country, it was difficult to change their title to nurse as these men thought this meant a loss of prestige, even though the intention was to give them a professional status. Waterer noted with interest that in one state the Asians did not realize that the European sisters were nurses. This change in status was made even more challenging as the colonial government had declared a policy that the number of hospital assistants would be reduced. Despite male hospital assistants outnumbering female nurses before the war, the post-war policy was to aim for only 10 percent of the nursing workforce to be male

nurses. A recruitment drive had been aimed specifically at women, marginalizing these men who believed their livelihood was at stake.[122]

In 1955, the process of the Malayanization of the public services was accelerated.[123] The official policy was that British nurses would cease to be recruited from the mid-1950s. Sisters were only to be appointed from the local nursing service from 1955 on. This program accentuated the shortage of senior nurses in Malaya, and by 1956 there were plans to carry on recruitment from other overseas areas, including India.[124] In 1962, the Malayan government invited the WHO back in order to provide technical assistance as teaching staff were urgently needed in order to train staff for the hospitals and public health services. However, this project only required one WHO nurse, and mainly funded fellowships for study overseas.[125]

Although 21 percent of the New Villages still did not receive medical services by 1958, the number of static dispensaries in rural settlements increased from 32 in 1951 to 172 by the end of 1954.[126] In 1954, a mission of the International Bank for Reconstruction and Development reported that health in the colony was "one of the world's outstanding achievements of public health and medicine, a tribute to the British administrators and their medical and public health officers."[127] Randall Packard, a historian of medicine, has noted that healthcare facilities and campaigns increased following WWII, partly influenced by the anti-communist campaign to win hearts and minds. He has argued that except for occasional rural campaigns, these strategies focussed on techno-centric eradication campaigns for diseases such as malaria and smallpox and that until the 1970s, primary healthcare facilities continued to be located around areas of economic activity, which were usually urban.[128] Yet rural health centers were established in the British colony of the Gold Coast in West Africa (present-day Ghana) in the early 1950s, with 23 completed by 1960, so perhaps facilities such as these were not as unusual as has been portrayed.[129] The Malayan Emergency had inspired rural public health provision on a scale that was apparently unique in the British Empire, particularly with provision of such a large nursing workforce, with around 250 British Red Cross or colonial nurses in the area by the mid-1950s.

Discussion

Historian Timothy Harper argues that the Malayan Emergency was the "most major metropolitan commitment to empire in the mid-twentieth century, in terms of the people and resources absorbed"; its goal was the transfer of power to safe hands through a much quicker "civilizing mission" than previously intended, constructing a "pro-western, capitalist and clean" government.[130] The Emergency was associated with the "second colonial occupation" and demonstrates the deployment of nursing as part of a wider strategic effort that, officials perceived, could be effective in counteracting the spread of communism on the ground. One of the features of this "second colonial occupation" was the pouring in of experts with different technical backgrounds into the region to protect trade and commercial interests as well as stimulate the economy, including the health economy. Thus Malaya became a melting pot for interventions

from a range of governmental and non-governmental organizations and philanthropies. The nurse was used as a totem and tool in the propaganda war of the British government to demonstrate that it cared about the welfare of villagers. She was an important conduit into the local population and ideally placed to win their trust and confidence, thereby presenting a benevolent image of the British government.

The experiences of nursing in Malaya also reveal an awareness of the need to balance gender considerations with pragmatics in the recruitment of men and skilling and scaling up of training for indigenous workers. The mobilization of sufficient numbers of nurses at the appropriate speed meant that the government could no longer rely on its usual sources. Recruits were sought from a wider range of organizations, and it was this pluralistic world that would increasingly characterize the post-war health regime.

Nursing has much to add to the political history of Malaya. Not only has the detailed history of 1940s and 1950s health services been largely neglected by historians, but the nurse was crucial to the hearts and minds campaign. The Malayan case demonstrates the significant political role that nurses played as proponents of a particular set of values in providing "outreach" to communities on the ground. Before accelerated decolonization, the Emergency brought a second wave of colonization with publicly funded facilities extended to rural areas, and federal and state governments growing in size, assisted by specialists working on civilian projects.[131]

The history of nursing in post-WWII Malaya also has much to add to the history of colonial nursing, demonstrating why it is essential to study the post-war years in order to understand the political and practical role of the colonial nurse, especially considering that this was the period when most colonial nurses were employed. The Emergency also highlights the elitism of the ONA, with its insistence on quintessential good character and experience, and how this resulted in the colonial governments diversifying in their use of agencies for recruitment of nurses.

The use of nurses as part of a wider political strategy was not new.[132] Yet before the Malayan case, nurses had not been recruited with such an explicit recolonizing campaign in mind. Nursing was also drawn into the process of Malayanization, and this dual role during the second colonial occupation and the seriousness of the stakes for the British government put nursing at the center not only of colonial history but of the socio-political history of the region.

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