

HISTORICAL ARTICLE

Scotland, Malawi and Medicine: Livingstone's Legacy, I Presume? An Historical Perspective.

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Abstract

In this personal short historical perspective I reflect on aspects of the medical history of Malawi, formerly Nyasaland, highlighting the role of Scotland and its people in the development of the Malawi medical services in both the colonial as well as the postcolonial period which began in 1964. The paper, after discussing the history of medical training in Malawi and current constraints and challenges, goes on to make some suggestions - based on historical lessons - about future role of Scottish involvement in Malawi's medical development. It would be unfortunate if, in a rush to 'help or do something' the mistakes of the past are repeated.

Introduction

The Scotland-Malawi Partnership - essentially a network of organisations in Scotland and Malawi - which arose from a Strathclyde University/Bell College Millennium project to help Malawi, became a reality in December 2005. Prior to that, the many small organisations now under the partnership ploughed their own individual furrows. A memorandum of agreement between the Scottish First Minister, Jack McConnell, and the Malawi President, Bingu wa Mutharika, was signed in December that year. Many sectors of Scottish society, not least doctors and nurses, are currently engaged with trying to help Malawi.

The past

Dr David Livingstone's arrival in present day Malawi territory, on the 1st January 1859, began the relationship between Scotland and Malawi. Although Livingstone's greatest legacy was to be his contribution to the ending of the slave trade in Malawi, his first exploratory expedition, accompanied, inter alia, by another Scot, Dr John Kirk, led to the missionary and medical efforts of others: the Church of Scotland at Bandawe, Livingstonia and Blantyre; the Anglican Universities Mission to Central Africa at Magomero and, later, Likoma Island; the Dutch Reformed missionaries at Nkhoma and the Catholic White Fathers missions, beginning in Ncheu.^{1,2}

In popular discourse, Scotland is credited with a significant role in shaping present day Malawi; this credit is usually taken to mean the positive aspects of Malawi development. The role of Scottish colonial officials, a significant part of the colonising process, is often forgotten. The role that segments of the Scottish church, academic, industry and medical establishments performed in the colonial and postcolonial history of Malawi is, similarly, also often taken to be mostly positive.

However in the medical sector, at least, closer reading of the history does not show this to be entirely accurate.^{3,4} The Scottish doyen of Malawi history, John McCracken, speaking of the period between 1859 and 1910, notes:

'One can therefore say that medical missionaries had some effect on the health of the Europeans but what was their impact on the African population? In the first period of which I have spoken about, it is probably true that it was felt only in individual cases,

*and that the health of the population as a whole was not affected ... (until 1890s when those near the hospitals began to benefit).*³

Government medical services, which followed much later than these missionary efforts, were even later in making an impact. This fact was noted by the seminal historian of the government medical services in Malawi, Colin Baker:

*'Until the early 1920s the medical service was designed primarily to care for (white) government officials and their (African) workers and 'government hospitals were located where government officials were stationed and not where the bulk of the population lived'.*⁴

Thus, contrary to most of the 'missionary' efforts, the initial emphasis of the colonial government, in which Scots played a significant role, was on 'law and order' as McCracken has shown.⁵ As late as 1911, there were only 3 African hospitals and 2 dispensaries, although the number of dispensaries had risen to 44 by 1922.⁶ In that same year, missionaries, sympathetic to Africans, were complaining that 'Africans were getting little medical attention for the taxes they were paying'.⁶ So neglected was the African population that as late as 1938, the Nyasaland government confessed that much of the time of its qualified medical staff was devoted to

*'the care of the small and scattered European population'... 'the degree of attention which can be given to the Africans is limited accordingly.'*⁴

One of the most interesting things about the early colonial medical pioneers is the fact that, typical of the era, most were also part-time 'collectors' (government officials able to collect taxes, administer districts or collect taxes)⁷ or amateur researchers, surveyors, demographers or zoologists.^{1,4}

Thus from David Livingstone's expedition until about 1910, when the missionary hospital network had become established (and government medical services were becoming more widely used by the

African population, with preference given to government workers), most Africans continued to rely entirely on traditional medicine.^{3,4,8} Only after the Second World War, with its labour imperatives, did matters improve significantly. In both World Wars, Malawi soldiers and carriers played a disproportionately large Southern African regional role. Some tribes like the Yao, Lomwe and Ngoni, were considered good 'soldiers and carrier' material. In the First World War 169,000 Malawians were ammunitions and stores carriers.^{1,9} This heavy load carrying work (mtenga-tenga), with its high mortality rates and often compared to the slave trade itself, became a metaphor for the 'labour-providing colonial and postcolonial Malawi territory'.^{2,10} And during the Second World War 'ten out of eighteen Government doctors were transferred to the army'.¹ Furthermore Colonial Malawi only saw its first specialist surgeon in 1942.¹ And in terms of patients actually seen the slow improvement in medical services translated as 'one case for every 62 members of the family in 1921 to one for every 2.2' in 1937.⁴

A number of factors delayed the onset of universal medical provision in Malawi and have left a legacy that still haunts Malawi today.

First, as we have noted, initially the missionary and government doctors were busy attending to the health needs of the European missionaries and settlers. The majority of indigenous Malawians were not exposed to western medicine until after the Second World War and economic and administrative imperatives continued to direct bigger shares of hospital resources towards the European group.^{1,4,8} Indeed, given Dr Banda's deferential attitude to Europeans, the two hospitals built at higher altitude and catering for 'whites only', called Top Hospital (as opposed to bottom hospitals for Africans), remained in place, in both Zomba and Lilongwe, until the 1970s. This continued a disproportionate use of resources by one minority group.¹¹ The relic of this discriminatory practice, the Lilongwe Bottom Hospital, was later to be made famous by Jack McConnell during his 2005 visit to Malawi.

Second, '... in the early days... the services on offer were largely curative' rather than preventative.⁴ Third, the rurality and poor infrastructure of Malawi, kept much of Malawi closed to direct, as opposed to secondary, missionary influence.⁸

Fourth, the limited educational opportunities and constrained – for racial reasons - roles of Africans retarded the early development of a significant African elite and western medical tradition.^{10,12,13} Secondary education was only introduced to Malawi in 1940.^{11,14} This 'officially' limited education available to Africans was a significant limiting factor. The Nyasaland (Malawi) colonial Chief Secretary wrote (of a request for secondary school funding for an African to attend a school in South Africa) in 1934

*... fortunately I think, since the slower the progress – in the direction of higher education for the African – the better.*¹⁰

Also, although missionaries provided the early basic paramedical medical training in Malawi, government training only commenced in 1930.¹

Fifth, even when this training began, the colonial government was reluctant to train African doctors. Up to the establishment of Federal Government in 1953, no single African doctor, nursing sister, health inspector or other senior professional cadres had been trained or employed by the colonial government. Indeed, the Nyasaland Protectorate Development Programme (NPDP) for 1948 only finds it 'necessary to train Africans in increasing numbers as health assistants, medical assistants, midwives, sanitary assistants...'¹⁵ At the same time more European doctors were being recruited. Further, there was the 1926 Ordinance - a ruling that was to change Malawi history by helping to prevent Dr Hastings Banda from returning to Malawi – which specified that non-Europeans and Asian doctors were to be registered in the Sub-Register of the Medical Register, along with hospital assistants.¹¹

The Federation of Rhodesia and Nyasaland made some improvements to Malawi's health sectors. But, as King and King point out: 'Malawi (Nyasaland) always remained a poor relation' to the white dominated Rhodesia: with the same population Malawi was given less than 50% of the doctors, less than 10% of the nurses and 20% of the budget

assigned to Rhodesia.¹ However, the Federation also offered scholarships to two of the doctors who were later quite influential: Dick Chilemba, later the first Malawian chief medical officer and John Chiphangwi, the pioneer of the College of Medicine.¹⁶

The honour of being the first Malawi 'western trained medicine man', albeit only as the equivalent of a modern clinical officer, must go to John Gray Kufa who was trained by the Scots dominated Blantyre Presbyterian Synod back in 1898. But such was his dissatisfaction with his racially-constrained role that he joined John Chilembwe's African rebellion against the colonial government in 1915.¹³ He was captured, tried and executed for his part in the rebellion.

Dr Daniel Malekebu, the first Malawian medical doctor graduated from Meharry College, USA in 1917. He was not sent for training by the colonial government but was the product of the sponsorship and efforts of Afro-American missionaries. In a major precedent, Malekebu's first return to Malawi was to be aborted in 1920, in the wake of the 1915 Chilembwe rising, after the colonial Governor turned him back at Port Herald; the governor was wary of an educated African working in a recently troubled territory. Malekebu was exiled to Liberia until he was allowed back into Malawi in 1925.⁸

The second Malawian to qualify as a doctor, Hastings Kamuzu Banda, later president of Malawi, was also trained via the Afro-American network. In 1925 he travelled to America and also graduated from Meharry Medical College, Tennessee, in 1937. That year, he sailed for Scotland to obtain British licentiates, required for work in the colonial medical service. But Banda's dream of returning home a 'full doctor' was thwarted by racism. In 1941 a group of nurses at Livingstonia wrote to the Church's headquarters in Edinburgh to say they would not be prepared to serve under an African doctor. Banda received the next rejection from the Nyasaland colonial government: 'there was an argument over whether he should be paid as much as a European, whether he should treat white patients, use the newly built Zomba swimming pool or have social contacts with white doctors'.^{8,17} He entered British general

practice, practicing in Liverpool and London, after both the colonial government and Scottish missionaries made it impossible for the proud Banda to return home 'as a full doctor'. Mkandawire has written of the discrimination within the Nyasaland (Malawi) colonial medical services at this time.¹¹

The postcolonial period

Despite his medical background, Scottish heritage and experiences, after becoming president in 1964, Dr Banda did not show any particular inclination for improving the Malawi health services or the working conditions of indigenous Malawi doctors. Indeed, his rule is associated with the establishment of a tradition of medical brain drain.¹⁸ Banda's achievements in developing the medical services were so limited that Jack Mapanje, a Malawian writer, once quipped 'strange that a medical doctor should build more prisons than hospitals'.¹⁹

A number of independently trained doctors trickled into Malawi, beginning with the first 'third wave' Malawi doctor, SV Bhima, in 1952, after training at Makerere; the fourth wave of returning doctors, in 1960-61 comprised Harry Bwanausi, Anne Ascroft and Vidah Ngwira, and the fifth generation included John Chiphangwi.¹¹ It was only the fifth generation of indigenous doctors that the government, in the case of Chiphangwi, the Federal government, supplied scholarships to study abroad. Prior to that most of the doctors had been funded independently. Partly because of this the medical profession had come to be seen as the preserve of the rich and elite and clever.

The colonial legacy was such that there were only three Malawian doctors in government service in 1962; by 1964 two others Y.H. Misomali and D. Chilemba had returned. Only five doctors were in post at independence in 1964; with two, Ngwira and Bwanausi, leaving the country by 1964 after disagreements with Dr Banda.¹¹ This postcolonial marginalisation of African doctors continued a trend that saw some doctors use professional medicine as a tool of self-improvement and empowerment rather than vocation.

A number of observers, including the present writer, have, variously, blamed the medical brain drain from Malawi on colonial and postcolonial paternalism or dictatorship, expatriate-led and fed initiatives, the lack of a working (in contrast to East and West Africa) indigenous medical personnel tradition, elitist education divorced from social realities in Malawi, poor remuneration, restrictive political climate, Dr Banda's style of governance and his successors' inability to tackle the human resources problem.^{1,8,11,16.}

The Cabinet Crisis of 1964 removed nationalist 'radicals', as well as some of those doctors who could have offered indigenous medical leadership, from Dr Banda's government. Thereafter, Dr Banda came to prefer and rely on expatriate technocratic leadership in various ministries, including the health ministry.¹⁷ In the health sector, the conjunction of the expatriate technocratic leadership preferred by Dr Banda, the absence of a significant indigenous medical leadership, and the existence of cabinet ministers who could not initiate policy for fear of falling out with Dr Banda, led to expatriate led developmental initiatives and the expatriate dependency in the medical field which persists today.

The Malawi medical service thus came to rely on expatriate doctors from the UK, USA, India, Holland, Germany, Pakistan, and other African countries. In the face of racial (colonial) and political (postcolonial) repression, qualifications like medicine (which ensured either some status and relative immunity from Dr Banda's autocracy or world/regional exportable skills) became desirable and attractive to secondary school students who dreamed of and went on to become academics or medical doctors or engineers. Many never returned to the constrained atmosphere of Malawi.

Paradoxically, even as he did little for medical training, Banda professed an abiding need to have an excellent education in Malawi. This was to lead him to build the Kamuzu Academy, dubbed the 'Eton in the bush', an elitist and meritocratic academy which took about 30% of the national educational budget and where – significantly as we

see later - the cream of indigenous Malawians were educated into the finest things of the west, including Greek classics, by Scottish and English teachers.²⁰ Some social commentators consider this a contributory factor leading some Malawi medical students to eschew aspects of their country in favour of global settings.²¹

In the 1980s, despite his earlier rejection by Scottish missionaries, Banda still preferred things Scottish, including Scottish advice on the medical school project. The project was duly delayed in order to get Edinburgh input and reports from Sir James Fraser and Professor AW Wilkinson (1983) and Professor Whitby (1984) were fed into the project.¹⁶ And, even as Malawi struggled to cope without a medical school, Banda was able to make generous 'personal' donations to the Royal College of Surgeons of Edinburgh, Meharry Medical School and other institutions.²² Banda and his international consultants and expatriates' solutions to the Malawi medical brain drain were mostly situated in the terrain of patriotism: Malawi doctors were expected to return, whatever the 'push' or 'pull' factors relative to Malawi. In 1992, only 25 of the 175 doctors working in Malawi were Malawian. Mulwafu and Muula estimated that only 25% of doctors sent abroad for training between 1964 and 1992 returned home.¹⁶ Among the expatriates - and some in post-Banda Malawi - analyses and solutions, the tyrannical environment of the Banda regime was, and has now almost been completely forgotten. The fact that hundreds of intelligent students and doctors perhaps, sometimes reluctantly, chose freedom is often ignored. A good proportion of the medical exiles of my generation left Malawi because of the lack of personal freedom and autonomy in Malawi, and not because of economic motives.

A more pragmatic solution was the creation of a large corps of clinical officers, diploma graduates trained at the Lilongwe of Lilongwe School of Health Sciences and the Adventist Malamulo School of Health Sciences, the use of nurses and, as already stated, expatriates. Christian missions, who provided and still provide about 45% of medical services through its 38 hospital and clinics, also depended on expatriate medical staff. The apparent

preference for the 'more likely to remain at home' clinical officer grade by some donors has been criticised, from an ideological and historical point of view in the Malawi context, as suggesting that - even in the postcolony - Malawians, just as they did in the colonial era, deserve second rate medical treatment.²³

Establishing the College Of Medicine (COM)

It took from 1979 until 1986 before Dr Banda, the Malawi president, was persuaded of the need to have a Malawi medical school. The reasons for Banda's reluctance have been given by a number of observers and vary from cost, preference for expatriates, through fear of educated independent-minded Malawians, to the suggestion that he wanted a first class medical school or none at all.¹⁶ A number of commissions culminated in the Tripartite Commission (German, British and Malawian) of 1986, which finally persuaded Dr Banda of the wisdom of establishing a 'community based' medical school, the College of Medicine (COM).

While the infrastructure for the college was being built, the United Kingdom agreed to sponsor 100 Malawian medical students for their preclinical studies in the UK, Australia and South Africa. Some of the Malawi students who came to the UK studied at St. Andrew's. After this temporary measure, the COM began training its own doctors in house in 1994. The first fully home trained COM graduates received their degrees in 1999. Initially, education at the COM was free. Over the years however tuition fees have been introduced. A proportion receives funding from the Malawi Government, the Global Fund, the National Aids Commission and other bodies. In 2007 the annual cost of tuition was K300,000 (GBP 1,070) for local students and \$5,000 for foreign students.²⁴ The female to male ratio of the 2007 figures was 19 (female) to 51 (male).²⁴

Ironically most of the post-school entrants to the COM were graduates from the better 'national government and primary secondary' schools as well as the elite Kamuzu Academy, referred to above, the

St Andrews International High School in Blantyre which caters for sons and daughters of expatriates and elite Malawians who can afford the international school fees. Some sociologists have drawn a connection between the 'Scottish/English' elite secondary education and subsequent reluctance of many to work in district hospitals or to prefer working in the global environments for which their secondary school had prepared them. They argue that these tendencies towards preferring global, in preference to Malawian, lifestyles can be ameliorated by appropriate education.

The present

The evangelical optimism that COM graduates would remain in Malawi has not been realised; the global 'pull' factors and the local 'push' factors leading to a brain drain have been, in the freer political environment of late 1990s and 21st century Malawi, much greater than in the 1970s and 1980s. In recent times, the COM's sister institution, the Kamuzu College of Nursing, has also seen its, hitherto, more loyal, graduates succumb to global forces. According to Muula and Broadhead, by 2001 the COM had graduated 134 doctors. Of these 57 had, to that date been sent abroad for post-graduate training, with 19 returning (a 33% return rate). Of the remaining 77, four had emigrated for 'marital reasons', four had died, 20 were in their intern year locally, 18 were in district or mission hospital and the remainder were employed by the college, government or NGOs.²⁵ These figures were greeted with considerable optimism.

With reference to specialisation, 2000, of the COM's 169 graduates 63.3% were in post-graduate training in either the UK or USA, 16.7% were in South Africa, 8.0% in Kenya, 5.0% were in Taiwan and 3.3% were in Uganda.²⁶ These figures are reminiscent of the Malawi medical undergraduate and postgraduates global spread from the 1970s and 1980s. As the majority of these students are funded by USA and UK originated scholarships – and have to compete for training posts in the UK and USA there is an inherent conflict between aid and the medical man power needs of the USA and UK.

The earlier positive optimism by Muula and Broadhead has unravelled slightly since 2001. By the summer of 2006, the principal of the COM was visiting his former students, who had moved to the UK, in an attempt at persuading more of them to return home.

The Malawi medical service needs help with its infrastructure, human resources and financial and material resources. The problems in Malawi have been contributed to by both local and foreign experts, albeit in varying proportions. Those who argue that countries like Malawi are basket cases or 'failed states' forget that many failed states arose from failed colonies. And a strong case for Malawi having been a failed colony, the 'positive efforts' of Scottish and English colonial efforts notwithstanding, can be made.^{27,28} Vail points out that by 1935, the Malawi economy was already crippled by a five million pound debt incurred in building the uneconomic Malawi Railways.²⁹

In their haste at looking at the present state of the Malawi medical service, Scottish and other experts should not be seduced by the 'do something now' imperative, forgetting the considerable Scottish role in the colonial and postcolonial development of Malawi. The present initiative is already in danger of marginalising indigenous Malawians. As with other donor-initiated and donor-funded projects there is a tendency, via consultancy, towards paternalism.

In 2006, Malawi remains a 'tea, tobacco and migrant labour' dependent economy of 12 million people with high prevalence of HIV, TB, malaria and other infectious diseases and needs as many of its indigenous and indigenously trained doctors as possible. Clearly in a free market, globalised world doctors cannot be forced to work for poor wages. But even the argument about poor wages is in itself spurious in that between 1964 and the present, incomer non-Malawian expatriates still managed to work in Malawi with most earning international salaries or remuneration that permitted international level schooling for their children. Muula, himself a COM graduate, has recently observed that out of 252 medical doctors in Malawi, 51.2% were Malawian and 48.8% non-Malawian. However of the 72 specialists, only 23 were Malawian and the rest

non-Malawian. As if alluding to the complicated system that enables 49 medical specialists to work in Malawi on international salaries not available to their local counterparts he writes

*'while the brain drain of doctors from developing nations to developed nations has attracted interest, there is need to explore the migration of doctors into resource poor countries like Malawi.'*³⁰

These salaries were, and in most cases, still are, not available to indigenous non-researcher Malawian doctors.³¹ There is an inequity in wages between incomer expatriate doctors and most of the locals. As Muula and Maseko's paper puts it

*Respondents noted that they could understand 'reasonable differences in remuneration between national and expatriate staff 'up to a degree but not to a level where one is tempted to think that nationality matters'.*³²

Researchers are usually exceptions here in that they can obtain access to international research funds. Malawi hosts a number of research institutions, including two of the most prestigious: the Wellcome Trust and Johns Hopkins Bloomberg School of Public Health tropical research outposts. Part of the post-Banda problem is the establishment of a tradition where only the research oriented doctors or those who prefer private practice can thrive in Malawi. Those of an entirely government or missionary clinical service orientation have no means of augmenting their low wages. The price is the sacrifice of their children's education; a feat of which few elite humans, including missionaries are capable. The manpower problems of Malawi medicine cannot therefore be built on research money alone.

There needs to be greater balance between resources poured into research and researchers, expatriate and indigenous salaries and those poured into clinical medicine. Well-motivated clinical personnel are required to implement the scores of research findings produced in Malawi each year. Also collaborative, rather than 'colonial outpost' research institutions may be a more positive way

forward, giving Malawians more ownership of research funds and research carried out in their land. Without this, the research outposts thereafter become reminiscent of Patton's description of the rise of the London and Liverpool schools of tropical medicine where he compares the docks to living laboratories:

*The Royal Victoria and Albert docks, and the London and Liverpool docks served as laboratories for medical students, because arriving ships were laden with the sick, the convalescing and the dead.*³³

If powerful external research outposts are 'politically active' to the detriment of indigenous needs then Patton's description may apply: the research establishments become more about the 'laboratory needs of donor institutions than Malawi'.

In the many solutions currently suggested by the Scottish and other voices one hears, a repetition of colonial and 1960s solutions is seen. These include: training clinical officers rather than doctors; sending expatriates to Malawi; high level dealings between donors like Scottish institutions and politically 'transient' government ministers, marginalising grass roots and clinically-oriented doctors and the inherent acceptance of low wages for indigenous Malawi doctors. There is a leveraging of Scottish and other foreign consultancies, including those with little knowledge of Malawi, over local voices; and a host of other measures more likely to increase rather than reduce Malawi dependency on foreign medical personnel. For example, while the developed nations absorb Africa's medical graduates:

There is this international mentality, which promotes the thinking that developing nations with inadequate supply of medicines, and crumbling health delivery systems, will benefit more from lower level health practitioners... Little thought is spared to consider whether the physician, who is better trained than the other lower cadre health professionals, would be the right person to contribute to solving the enormous health problems...^{23,34}

A common failing of elements of the donor community is their tendency to re-invent the wheel.

Most analyses lack a historical perspective. The role of Dr Banda in scattering his doctors abroad is now glossed over and doctors who left Malawi are held to have left 'for money'. The related government policy of encouraging 'remittances from abroad (and hence emigration) is also often ignored. In this regard, four points need to be reiterated. First, Malawi has always been dependent to a certain extent on migrant labour. Up to the mid 1980s this migration was to the mines and farms of Zimbabwe, South Africa and Zambia. Second, economists look at the current brain drain from a financial perspective.

*There is concern about the negative impacts of the medical 'brain-drain'. However a closer look at the evidence for and against the medical 'brain drain' in Malawi suggests that there are potential gains in managing medical migration to produce outcomes that are beneficial to individuals, households and the country.*³⁵

This economic view is subverted by the third point: successive Malawi governments have used migrants as a useful source of foreign exchange. The fourth point – which differentiates the older migration from Malawi from the new - is the fact that both donors and the Malawi governments tend to be interested in the 'training doctors' paradigm but not in facilitating the return of its émigré doctors. This neglect of the 'return option' trains and yet reduces Malawi medical manpower while, despite the Commission for Africa rhetoric, sucking medical manpower to developed countries. The majority of the older migrants returned home after periods of working abroad. If only the training track is pursued Malawi will end up being a 'producer' of doctors. The Scottish Office document neither sees the hundreds of Malawian doctors in the Diaspora as a resource nor as of potential to alleviate Malawi manpower needs.³⁶

I suggest that Malawi needs:

- A more historically grounded aid policy that takes into account all the roots and current determinants of the brain drain in Malawi.
- Collaborative programmes that train, teach and enable more Malawi doctors, nurses and clinical officers to ultimately remain in Malawi.
- Programmes that reduce the 'push and pull' factors – for example the 'global' medical phenomenon that enables researcher-oriented doctors to be well funded in the third world, sometimes at the expense of clinical ones. The money poured into Malawi under the various agencies and institutions is often only available to non-Malawian expatriates.³⁷
- Ring-fenced postgraduate schemes in Scotland that enable young Malawi doctors to spend as little time as possible (two to three years) – akin to MSc or PhD students – thus enabling them to return home before they settle in the UK as the inevitable complications of family life take over. Current free market brain drain postgraduate courses often see bright students from Africa, instead of getting into good training posts, ending up in jobs with little training components, prolonging their stay for as much as six years or more by which time their family have put down roots. These roots, particularly for those with children of school-going age, patriotism notwithstanding, can be very difficult to cut.
- The Scottish Executive can help the situation by working in close harmony with the Overseas Development ministry to improve the economy, governance and fiscal probity in Malawi to ensure that Malawi has enough resources for health. The amount of optimism generated by the Scottish initiative, for example, is far out of proportion to the ability of Scotland to deliver.³⁸ In this regard the dividend from debt cancellation needs to be consolidated and not replaced by new debt. Working to improve the governance of Malawi would, ultimately, reap more dividends than all the palliative aid schemes.
- Ultimately the health manpower needs of Malawi will be solved by the Malawi government, despite all its economic problems, improving the working conditions of its staff.

In this personal perspective paper I have pointed out some of Scotland's considerable colonial and postcolonial agency in the Malawi project. It would be unfortunate if, in a rush to 'help or do something' the same mistakes of the past are repeated.

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