2. Missionaries and “A Better Baby Movement” in Colonial Korea

Sonja M. Kim

Binghamton University, State University of New York

Introduction

On a cold winter morning in January of 1924, American missionary and trained nurse Elma T. Rosenberger and her assistant, Korean nurse-midwife Han Singwang, knocked on doors in Seoul inviting mothers and their young children to a new infant welfare clinic at T'aehwa yŏjagwan (hereafter, T'aehwa, called the Social Evangelistic Centre by the missionaries).¹ This was a community centre for Korean women and children founded in 1921 by the Woman's Foreign Missionary Society of the Methodist Episcopal Church and the Women's Council of the Southern Methodist Church for evangelistic, education and social service purposes.² The first day, one baby came. The next, two more. Rosenberger recalled how difficult it was initially to garner Korean interest, “We literally got

1 Many of the original journals and reports used in this chapter are in limited edition, located in archives in both the United States and South Korea. Reports by individual missionaries, their institutions and stations of the American Presbyterian boards are provided by the Presbyterian Historical Society (PHS) located in Philadelphia, PA. These reports are also available in microfilm at the University of California, Los Angeles and in serial form in Seoul at the Institute for Korean Church History (*Han'guk kidokkyo yŏksa yŏn'guso*). The *Bulletin of the Nurses' Association of Korea* published in both the Korean (*Chosŏn kanhobu hoebo*) and English languages are located in the rare manuscript section of Yonsei University in Seoul, Korea. *The Korea Mission Field* was a journal of this period (1905–1941). While it has been re-published in serial and microform format, it is available primarily in libraries of seminaries or successors of mission colleges in Korea. There is currently a project to make the journal digitally available which is now searchable through 1922.

The Korean Christian newspaper, *Kidok sinbo* (Christian Messenger), Chinese medical missionary journal, *The China Medical Journal*, and annual reports of the Korea Woman's Conference (KWC) of the Methodist Episcopal Church are also available in re-published editions. The *China Medical Missionary Journal* (1887–1907) was renamed *The China Medical Journal* (1907–1932); the latter publishing research articles from the Korean Medical Missionary Association (KMMA). There are no publicly available editions of the journal from the KMMA. Not all of the annual reports of the KWC are extant. Those that have been found are in print and microform and may be obtained at certain American libraries, the United Methodist Archives at Drew University, and in Korea at Ewha Woman's University and Institute for Korean Church History.

2 *Tonga ilbo* (East Asia Daily), 27 February 1921. T'aehwa later became a union centre with the two Methodist denominations along with the Presbyterian Church of the United States of America. The fact that missionaries translated T'aehwa yŏjagwan into English as the “Social Evangelistic Center” as opposed to a literal translation as “T'aehwa Women's Center” attests to the centre's primary purpose of evangelism. It was also the predecessor to the centre known today as T'aehwa kidokkyo sahoe pokchigwan, or Taihwa Christian Community Center. For a fuller history of T'aehwa, see Yi Tŏkchu, *T'aehwa kidokkyo sahoe pokchigwan ūi yŏksa: 1921–1993* (History of Taihwa Christian Community Centre), Seoul, Korea: T'aehwa kidokkyo sahoe pokchigwan, 1993.

cold feet when we opened our work at Seoul in the Social Evangelistic Centre (T'aehwa), because people did not understand what we wanted and would not let us into their homes."³ But soon home visits to attract members were no longer needed. "Calls [were] coming to us, more than we could answer," Rosenberger reported.⁴ After one year, 462 babies were registered on the roster. By the end of the 1930s, most American Protestant mission stations throughout the peninsula offered some form of infant welfare services. They established infant health clinics, organised baby shows and mothers' meetings, offered obstetric referrals and milk feeding stations, and trained Korean nurse-midwives, public health and social welfare workers.

On one hand, this transpired as an outgrowth of global practices in the medicalisation of childbirth and childrearing. The nineteenth century in the West witnessed the solidification of obstetrics and paediatrics as specialised medical fields that demanded the professionalisation of practitioners who increasingly oversaw the pre- and post-natal care of parturient mothers and their infants in institutionalised settings of the hospital or clinic. Shifts in notions of childhood became conceptualised in campaigns to lower infant mortality rates and promote their welfare. The main agency to implement this was the infant welfare centre; its core activities being the periodic examination of babies and the instruction of mothers in the care of their children. Other welfare programs included mother-craft schools, day nurseries, baby week, milk stations, expanded obstetric and prenatal care through home visiting or lying-in accommodation, cultivation of district nurses and social service workers, child protection legislation, and state maternity benefits such as mothers' pensions and meals for expectant and/or breastfeeding mothers.⁵ Many of these were run by local governments and Christian missions, which Roger Cooter suggests may be more significant than institutionalised paediatrics in the broader history of child health and welfare of this period.⁶ Missionaries drew from maternal and infant welfare practices back home in developing similar programs in Korea.

On the other hand, missionaries in Korea as elsewhere placed heavy emphasis on persuading their converts to adopt mission "ideals of domesticity," thereby intervening directly with local habits in marriage, gender and family relations,

3 Sherwood Hall, "Pioneer missionary work in Korea," in *Within the Gate*, ed. Charles A. Sauer, Seoul, Korea: Korea Methodist News Service, 1934, pp. 94–105, p. 104.

4 Elma T. Rosenberger, "Public health work in Seoul," *Bulletin of the Nurses' Association of Korea* 1 (1925): 12–13.

5 For more on the history of childbirth and infant welfare practices in the United States and Europe, see works such as Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750–1950*, New York: Oxford University Press, 1986; Alisa Klaus, *Every Child a Lion: The Origins of Maternal and Infant Health Policy in the US and France, 1890–1920*, Ithaca and London: Cornell University Press, 1993; Richard A. Meckel, *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850–1929*, Baltimore, MD: Johns Hopkins University Press, 1990.

6 Roger Cooter, "Introduction," in *In the Name of the Child: Health and Welfare, 1880–1940*, ed. Cooter, London and New York: Routledge, 1992, pp. 1–18.

dress and living arrangements.⁷ A Christian life was to entail more than spiritual faith and theological understanding. As Hyaeweol Choi’s chapter attests, the establishment of “true Christian homes” affords “civilisation” as well as proper Christian lifestyles to new converts. In this way, missionaries’ attempts to transform Korean child-birthing and rearing practices were natural extensions of their evangelising efforts. Furthermore, infant welfare work allowed missionaries to focus on social service, a call renewed by the global mission community in the 1920s and 1930s to be linked with evangelism.

However, the emergence of infant welfare projects seemed an anomaly in the overall picture of medical missions in Korea. The 1920s coincided with retrenchment in budgets and reluctance from Mission Boards to support further medical work which was allegedly provided (however minimally) by Japan, Korea’s colonial overseer. This chapter then addresses this conundrum—why were new infant health programs started at a time when medical missions were being attenuated? What implication does this raise in regards to mission work in general? Furthermore, the emergence of mission infant welfare programs in colonial Korea dovetailed with the bio-politics of the Japanese imperial state that sought to protect its female subjects’ fertility and infant viability to increase the population with healthy bodies for industrial and military goals of imperial expansion. Efforts to promote maternal and infant welfare by the colonial state became increasingly visible by the late 1920s and were supported in general by medical missions. Yet missionaries had ambivalent at best, antagonistic at worst, relations with the colonial government in the realm of medicine. What insights into this complicated relationship between foreign missionaries and Japanese colonial authorities does an exploration of infant welfare provide?

Using infant welfare as a prism, I interrogate the ways the context, mission goals and encounters that missionaries had in Korea shaped the implementation, intentions and meanings of their medical programs. I argue that infant welfare appealed to missionaries as an area of their focus despite limited resources not merely for the real material benefits they provided to young mothers and infants but also because they believed it enabled Koreans to embody the ideal Christian family. Furthermore, missionaries’ attempts to differentiate themselves from Japanese “secular” medicine on moral grounds allowed them to carve a space in a medical world quickly closing by both their Mission Boards and the Governor-General of Korea (GGK).

7 See Mary Taylor Huber and Nancy C. Lutkehaus, “Introduction: gendered missions at home and abroad,” in *Gendered Missions: Women and Men in Missionary Discourse and Practice*, ed. Huber and Lutkehaus, Ann Arbor: University of Michigan Press, 1999, pp. 1–38. For more on the work of missionaries in Korea, see Hyaeweol Choi, *Gender and Mission Encounters in Korea: New Women, Old Ways*, Berkeley: University of California Press, 2009.

Early medical encounters in the Korean mission

One narrative in the Korean mission field is that of Horace Allen, physician and a Presbyterian missionary, who saved the life of Min Yöngik, nephew of Queen Min in the aftermath of the bloody 1884 Kapsin Coup. His surgical skills won the support of the royal family, and he was granted permission to establish *Chejungwön*, the first hospital based on Western medical therapeutics in Korea and the predecessor to today's Severance Hospital affiliated with Yonsei University. This is the "Allen myth," which according to Korean scholar Sin Tongwön, shapes much of the conventional understanding of the role of foreign missionaries in Korean medical history.⁸ What this "myth" elides, however, was the already present thirst for new knowledge and adaptation of practices associated with Western science and medicine, such as the smallpox vaccination, in self-strengthening attempts to bolster the Chosön dynasty's "wealth and power" in a rapidly changing world.⁹ *Chejungwön* then was an expansion of Korean self-strengthening reform platforms already in place. The fact that Allen was a missionary was secondary as the Chosön court explicitly prohibited proselytisation of the Christian faith on Korean soil and Allen's recognised status in Korea was medical officer of the American Legation, not missionary. Moreover, the name of the hospital itself, which literally means "House of Succouring the People" was translated into English by Allen as "His Majesty's Hospital," which attests that medical services provided there were to remain firmly on Korean terms and to augment the King's benevolence to his subjects by providing them with health services.¹⁰

What Allen accomplished was to open the door in Korea to other medical missionaries who soon followed, initially to assist him and later to extend mission work in other parts of the peninsula. From the perspective of the missionaries,

8 Sin Tongwön, *Hoyölcha Chosön ül süpkyökhada: mom kwa üihak üi Han'guksa* (Cholera Invades Chosön: History of the Body and Medicine in Korea), Seoul: Yöksa pip'yöngsa, 2004, p. 224.

9 "Wealth and power" refers to the larger pursuit of "rich country and strong military" (*puguk kangbyöng*), a slogan with classical Confucian roots associated with self-strengthening efforts of late nineteenth-century East Asia, including Korea. For more on early health reforms implemented by Koreans before 1910, see Sin Tongwön, *Han'guk kündae pogön üiryosa* (History of Health and Medicine in Modern Korea), Seoul: Hanul Academy, 1997; and Pak Yunjae, *Han'guk kündae üihak üi kiwön* (The Origin of the Korean Modern Medical System), Seoul: Hyeon, 2005. In English, see Soyoung Suh, "Korean medicine between the local and the universal: 1600–1945," Ph.D. dissertation, University of California, Los Angeles, 2006; and Sonja Kim, "The search for health: translating *Wisaeng* and medicine during the Taehan Empire," in *Reform and Modernity in the Taehan Empire*, ed. Kim Dong-no, John B. Duncan and Kim Do-hyung, Seoul: Jimoondang, 2006, pp. 299–341.

10 In a letter (dated 27 January 1885) to the Foreign Office of the Korean government which he copied into his diary, Allen assured the court that the hospital would be "called 'His Korean Majesty's Hospital,' and ... it would undoubtedly still further endear the people to their monarch and elevate them in many ways." Horace N. Allen, *Allen üi ilgi* (The diary of Horace Allen), trans. Kim Wönmoo, Seoul: Dankook University Press, 1991, p. 431. The original name of the hospital was *Kwanghyewön* ("House of Expanded Grace") but was quickly changed to *Chejungwön* to strengthen its image as succeeding former Chosön welfare institutions. Sin Tongwön, *Han'guk kündae pogön üiryosa*, p. 81.

medical work aimed to break the prejudice and gain the trust and confidence of the Korean people in their evangelistic institutions, a strategy commonly used in other mission fields. Medical work was found to be so effective in gaining Koreans' interest in missionaries and their messages that it became a principle of all missions that no station would be opened in the interior without the presence of a doctor. As Reverend Hoffman acknowledged, "The best means to prepare a people's mind to lend an ear to the gospel message is the surgical work of the hospital."¹¹

A common theme running across missionary accounts is the varied, even colourful, medical landscape missionaries encountered. They were appalled by what they determined were inferior, inadequate, or barbaric native healing traditions in Korea, "The differences in habits of life, of food, of standards of social customs are calculated sometimes to produce a feeling of disgust."¹² Challenges were allegedly many for "the medical missionary has not only to heal sickness, but to try and remove gross ignorance and superstition regarding diseases."¹³ These "superstitions" could be outright dangerous, "pathetic and sad," and physicians recorded injuries caused by Korean therapeutics such as blinding an eye when needled, burning of skin and delayed treatments because a patient sought a shaman.¹⁴ To the missionaries, many of their patients were "grateful" for their services, an appreciation resulting with the Gospel "finding an entrance into hearts and homes of many."¹⁵

On one hand, these narratives speak to the increasing acceptance of Western therapeutics among Koreans. Coupled with the already existing self-strengthening desires mentioned earlier, when new methods become packaged with visible results, medical knowledge and practices associated with them become powerful. On the other hand, mission reports reveal the competitive nature of the Korean medical playing field. Missionaries grumbled about cases worsened by native practices, but they also demonstrated how patients chose from a broad spectrum of care providers, including the local shaman, acupuncturist, drug peddler or other healer. The supposed "superiority" of mission medicine was not necessarily readily or immediately accepted by Koreans. To them, mission dispensaries and hospitals were just one option out of many, and missionaries found themselves in a fierce contest. Sometimes mission clinics were consulted as a last resort. Other times, patients "experimented," testing to see which method provided the better result.¹⁶ Moreover, by the

11 C.S. Hoffman, "The Hospital as an Evangelizing Agency," *The Korea Mission Field* 12(1) (1916): 48–50.

12 "Books on Korea," *The Korea Mission Field* 4(1) (1908): 13–16.

13 E.D. Follwell, "Hall Memorial Hospital and Dispensary," *The Korea Mission Field* 2(1) (1905): 5–6.

14 E.D. Follwell, "Medical practice in Pyeng Yang," *The Korea Mission Field* 2(8) (1906): 149–50.

15 "Mokpo Station Report, Southern Presbyterian Mission," *The Korea Mission Field* 5(4) (1909): 53–55.

16 For example, one physician recounted a case that puzzled him until he realised that the patient used the remedy he gave in one eye while treating the other eye with medication given him by a local Korean healer. Apparently, the patient did this in order to find out which method (missionary or local) was more effective. See "Brevities," *The Korea Mission Field* 11(2) (1915): 54–56.

1910s the burgeoning pharmaceutical industry with new-style drug stores and vendors (including foreigners, especially Japanese) attracted Korean consumers with their products' promises to provide a quick fix, producing patients who were "double victim[s] of disease and mixed treatment."¹⁷

The awareness that their patients may go elsewhere exhorted missionary physicians to perform successively. As Dr Sharrocks reported, "Mission hospital exerts influence upon the general population through word of mouth, or base conclusions based on medical work."¹⁸ Then in order "to obtain results in the spiritual sphere, [the mission hospital] must obtain them surgically and medically as well," Dr Johnson concurred.¹⁹ Demonstrating "success," however, could entail a physician's selection of therapeutics that produced visible signs of efficacy but compromised sound medical judgment, for example prescribing opiates to relieve a cough.²⁰

Missionaries believed they were rectifying inferior, even abysmal, health conditions due to native ignorance, lack of common sense, or superstition. It was merely a matter of time before Koreans would "learn" and perform "proper" health practices. However, missionary reports were foremost in garnering support back home for their work by highlighting the superiority and necessity of their medicine. Their reports thus fail to inform us of the efficacy of other native healing methods (except in terms of lack with practices deemed barbarous or superstitious) or to provide a clearer understanding of patients' choices in health-related matters. Moreover, as Ruth Rogaski reminds us, the turn of the twentieth century was before the era of antibiotics and still a time of flux in etiological understanding of disease. Western confidence in "divergence" in medicine between the East and West was thereby misguided.²¹ Except in surgery, little difference in efficacy existed between Western and eastern therapeutics. A "divergence" in medicine lay rather in the political and social organisation of disease management, such as sanitary bureaus and hospital administration.

While missionaries endeavoured to gain trust from their patients, the very disconnect in communication could hinder that very goal. Their assumptions that their patients would understand their prescriptions or have the means to follow through on treatment belie the gulf not only in understandings of the

17 Miss Ernsberger, "Baldwin Dispensary Report, 1909," *The Korea Mission Field* 5(7) (1909): 112–14.

18 A.M. Sharrocks, "Can less than two doctors in a single hospital achieve the best result?" *The Korea Mission Field* 12(1) (1916): 15–19.

19 Woodbridge O. Johnson, "Personal report for 1909–1910 of Woodbridge O. Johnson, MD, American Presbyterian Mission," *The Korea Mission Field* 6(11) (1910): 274–79.

20 Follwell, "Hall Memorial Hospital and Dispensary," p. 6.

21 For further discussion on whether there was a "divergence" in medicine, see Ruth Rogaski, *Hygienic Modernity: Meaning of Health and Disease in Treaty-Port China*, Berkeley and Los Angeles: University of California Press, 2004.

body and management of illness, but also in modes of dialogue between these foreign visitors and their Korean hosts.²² For example, in Dr Nolan’s account, questions to one patient such as his age, location of residence and complaints were met with what Nolan perceived were irrelevant, perhaps amusing, responses: “Who? I?” “I was born on the tenth day of the fourth moon of the second year of the present King’s reign.” “Anybody can tell you where I live. Just take the big road and travel until you get nearly in sight of the big temple.” “I live in ... magistracy, but don’t see what bearing that has on the case; give me some medicine.”²³ But when his patient began to explain his complaint with, “My neighbor has a son Kim, who married...,” Nolan interjected saying he did not need to know the genealogy of the patient or his neighbour and for him to just “Answer my questions,” to which the patient replied, “As I started to say, Kim was beating his wife, my cousin. I interfered, and he struck me with his pipe, making a painful bruise.” To Nolan, he was asking simple questions to which his patient did not reply directly. To the patient, he did not understand the relevance of his residence to his case. Moreover, he felt the need to introduce the relationships of the people involved in order to provide a full account of how his injury was sustained to facilitate Dr Nolan’s prescription of treatment.

This could be interpreted as simply a language barrier. It also reveals differences in health-related practices that complicate medical missions. It was standard in the Sino-classical medical tradition, of which Chosŏn Korea was a part, for patients to provide detailed narratives of how they came to their ailments and not just a description of symptoms. Missionary physicians insisted on their routines in hospital-clinic administration with scheduled consultation hours and hospital diet with which Korean patients were not familiar. Physicians sometimes gave up expectations of payment in cash for their services—patients were accustomed to offer gifts in kind to express their gratitude, would wait until full recovery before offering remuneration, or assume treatments were offered in charity according to ethics of “Confucian benevolence.” Nevertheless, missionaries insisted on their therapeutic methods and were chagrined when patients did not behave accordingly. They reported patients who ingested the piece of paper on which a prescription was written or medications that were to be applied externally (the patients were not informed how to exchange the prescription for medication or proper application), took doses all at once (“take every three hours” did not make sense when one had never seen a clock) or stretched them out to last longer, did not return for further treatment, or refused surgical procedures or hospitalisation. Sometimes unfamiliarity with Western methods complicated

22 Limitation of space prevents a further discussion here of Korean health practices prior to Korea’s Opening in 1876. For more, see works such as Donald Baker, “Oriental medicine in Korea,” in *Medicine Across Cultures: History and Practice of Medicine in Non-Western Cultures*, ed. H. Selin, Dordrecht: Kluwer Academic Publishers, 2003, pp. 133–53; and Sin Tongwŏn, *Chosŏn saram ūi saengno pyŏngsa* (History of Birth, Aging, Disease, and Death during the Chosŏn Dynasty), Seoul, Korea: Hangyŏre ch’ulp’ansa, 1999.

23 J.W. Nolan, “An afternoon in the clinic,” *The Korea Mission Field* 2(7) (1906): 121–23.

their treatment. Other times, it was factors such as logistics (distance, finance, finding alternate childcare if mother is hospitalised), Korean habits (customarily reluctant to the cutting and opening of skin or leaving family members alone in the care of others), or family dynamics (lack of permission from parent, parent-in-law, or husband).

This discussion is not to castigate missionaries for lacking communication skills or being self-serving in their medical work, but to urge an understanding of their contributions within the framework they were offered and received. Many Korean patients found genuine relief and comfort from missionary dispensaries and hospitals, but they also approached them in ways that were familiar to them. Missionaries occasionally catered to their patients' wishes (such as use of heated beds to mimic the heated flooring of Korean-style *ondol*). They offered surgical and nursing training but that was geared towards Korean assistants and clerks who worked in the missionary clinics and dispensaries, and conversion to Christianity was a requirement. To missionaries whose primary objective was evangelisation and whose perception of Koreans as heathens informed their condescension towards native healing traditions and everyday habits, their medical work was foremost a moral mission. This shaped not only the rationale for their services but also the manner in which the services were carried out, including infant welfare work.

The clinical dispensary was central to missionaries' evangelising efforts. They held "regular service ... consisting of a song, simple Gospel talk and prayer" before opening.²⁴ Korean assistants were Christian converts who were "in attendance for the purpose of preaching, exhorting, distribution of tracts, and sale of Gospels," not necessarily to provide medical assistance.²⁵ Bible classes were open to patients.²⁶ Surgical operations began with prayer as well. Medical and nursing education for Koreans included daily Bible study. "My students must first be sincere Christians who are eager for souls," wrote one missionary.²⁷ It is this integration of medical work with missionaries' evangelical programs that is reflected in mission infant-welfare work built upon an existing system of mission dispensaries and hospitals. Missionaries provided the education and therapeutics needed by Koreans to rectify infant health care problems. Koreans (mothers in particular) were to adopt the new childrearing methods. All of this was to be along Christian lines.

24 Ibid., p. 121.

25 Ibid.

26 Dr J.W. Nolan, "How a doctor won his way," *The Korea Mission Field* 2(8) (1906): 157.

27 Dr H.C. White, "The doctor's point of view," *The Korea Mission Field* 3(2) (1907): 18–22.

Missionary players in a colonial medical system

With Japan’s colonisation of Korea in 1910, the Governor-General of Korea (GGK) overhauled Korea’s medical and health system centred on bio-medicine.²⁸ Elements included state management of the medical professions (regulation of the education, training, licensing and practice of physicians, nurses, midwives, pharmacists and drug-sellers); policing the population with country-wide sanitary administrative measures and a public physician system; strict regulation of private hospitals; and the establishment of a system of public (Municipal, Charity, Provincial) hospitals in major cities throughout the peninsula. Foreign missionaries and their medical institutions found themselves having to adapt to the new system or else close. An unstated tension emerged between medical missions and the colonial government in which the line between cooperation and competition was ambiguous.

Mission reports suggest frustration with the increasing restrictions on their medical work. Licensing requirements required all physicians trained in institutions other than those accredited and recognised by the GGK to pass a Government examination before being given a permit to practise in Korea.²⁹ Some missionaries sought to avoid the licensing exams altogether by getting their education or license from countries with reciprocity with Japan, such as Canada and Great Britain.³⁰ Licensing regulations hampered nursing efforts in Korea as potential nursing missionaries decided to go to China instead of Korea. Those who took the medical licensing exam had to do so in the Korean or Japanese language in Seoul, or they could opt to do it in English in Tokyo which

28 While the medical system was to be centred on bio-medicine, the GGK did allow traditional care providers to practice in limited ways. This helps account for the transformation and preservation of elements considered today as “Korean Medicine” or *Hanŭi*. See works such as Sin Tongwŏn, “Ilche ŭi pogŏn ŭiryo chŏngch’aek mit Han’gugin ŭi pogŏn ŭiryo chŏngch’aek mit Han’gugin ŭi kŏngang sangt’ae e kwanhan yŏn’gu (A study on the policy of health services and Korean’s health state in Japanese colonial state,” M.A. thesis, Seoul National University, 1986; Pak Yunjae, *Han’gŭk kŭndae ŭihak ŭi kiwŏn*; and Yonsei taehakkyo ŭihaksa yŏn’guso (ed.), *Han’ŭihak, singminji rŭl alda* (The Modernization of Korean Traditional Medicine during the Colonial Period), Seoul, Korea: Akanet, 2008. In English, see Suh, Soyoung, “Herbs of our own kingdom: layers of the ‘local’ in the *Materia Medica* of Chosŏn Korea,” *Asian Medicine: Tradition and Modernity* 4(2) (2008): 395–422. For English accounts of medical administration during the colonial period, see Soyoung Suh, “Korean medicine between the local and the universal: 1600–1945”; and Sonja Kim, “Contesting bodies: managing population, birthing, and medicine in Korea, 1876–1945,” Ph.D. dissertation, University of California, Los Angeles, 2008.

29 Letter from Wm H. Forsythe to A.W. Halsey, 13 June 1915, United Presbyterian Church in the U.S.A. Commission on Ecumenical Mission and Relations, Secretaries Files: Korea Mission, 1903–1972 (bulk 1911–1972), Presbyterian Historical Society, Record Group 140, Box 14, Folder 19 (hereafter, PHS, RG 140-14-19).

30 Sherwood Hall, the son of missionaries James and Rosetta Hall and anti-tuberculosis campaign advocate in colonial Korea, received his medical licence in Great Britain. Douglas B. Avison, the son of the superintendent of Severance Hospital Oliver Avison and a paediatrician active in infant welfare work in colonial Seoul, received his medical training in Canada and was thus exempt from GGK licensing exams.

was offered only twice a year. But the expenses involved in travelling to Tokyo amounted to 350 yen. The same sum would support a local preacher in Korea for an entire year.³¹

Other obstacles to mission medical work included higher credential requirements for professors at the Severance Hospital, interference from Japanese police and red-tape from the Japanese Association of Nurses which prevented the Korean nursing organisation's entrance into the International Council of Nurses. Only Severance, among the mission hospitals, was accredited as a medical school. In 1919, the mission hospital in Syen Chen (Sinch'ŏn) attested to anxieties among missionaries over the new medical ordinances, which "exercise an impartial control over all hospitals. In most respects the Provincial Chief of Police interprets and enforces the ordinance, but in many details the County or Township head police holds the power of life or death over the hospital."³² For example, the requirements of the 1919 Private Hospital Regulation for hospitals to have a separate isolation ward and at least ten beds were difficult for mission hospitals to meet, and so many shut their doors.

Furthermore, competition with Government and charity hospitals meant the loss not only of patients but also of personnel. Korean physicians and nurses left work at mission hospitals for better pay elsewhere, and foreign medical workers and hospitals failed to meet licensing, teaching or operating requirements. Even missionaries were not immune from the allure of other opportunities made available. For example, Dr Wells active in P'yŏngyang resigned from the Presbyterian Mission in 1916 in order to work as a physician for the Seoul Mining Company.³³ The sense of competition medical missions faced from the changed colonial situation was so intensified that in 1913, the Korean Medical Missionary Association admitted:

In view of the fact that the establishment of medical work in many places in Korea by the Japanese government, has caused some to think that this might seriously affect our medical missionary institutions, even perhaps to the extent of rendering the continuance of our work unadvisable, or at least to the point of making it unwise to plan any further enlargement of the present staff and equipment.³⁴

31 Letter from Dr Brown to E.M. Dodd, 27 November 1922, PHS, RG 140-14-19.

32 "Annual Report of 'In His Name Hospital,' Syen Chen (Sinch'ŏn), Korea, 1918-1919," PHS, RG 140-6-46.

33 "The Resignation of Dr and Mrs. Wells from the Presbyterian Missions, North," *The Korea Mission Field* 12(1) (1916): 29. He was not the only one to do so. In 1909, another medical missionary resigned to work for the American Gold Mining Company. "Annual Report of Kwangju Station, Southern Presbyterian Mission," *The Korea Mission Field* 5(4) (1909): 58-64.

34 W.E. Reid, "The Annual Meeting of the Korea Medical Missionary Association, Sept 30 to Oct 2, 1913, at Severance Hospital, Seoul," *The Korea Mission Field* 9(12) (1913): 316-18.

Dr Roy Smith of the Northern Presbyterian mission reported that Japanese hospitals had more medical personnel on staff (in contrast to usually one at mission facilities), were able to treat 3–5 times more patients, and appealed to Koreans in that they were operated on by Asians in Asian-style.³⁵ Missionaries admitted that improvements in sanitation and hospital care were attributed to the GGK. They recognised that they were competing not only with the government hospital which handled many charity cases, but also with private Japanese and Korean physicians.³⁶

This did not, however, lead missionaries to conclude that their work was no longer needed. Rather, they endeavoured to strengthen medical mission facilities so as to not fall behind the standards and services of Japanese hospitals. "What if [Koreans] compare this apparent indifference to their needs with the diligence of the Japanese government in manning and equipping institutions for the sick?"³⁷ The Korean Medical Missionary Association in 1913 resolved that no new stations were to open unless they had at least two missionary physicians and a trained nurse with proper equipment. "Japanese medical work ... greatly increases the urgency of a more efficient manning and equipment of our medical missionary plants."³⁸

Moreover, there was a consensus among missionaries that they filled a spiritual void left, a point further explicated later in this chapter. Medical missions cultivated Christian workers who offered proper care, healing both the body and the soul in Christian service. While the government may be better at providing costly, "good, modern treatment and proper appliances," this did not relieve the church or mission boards of providing care for Korean patients. Dr Weir exhorted, "No amount of Government Charity hospitals, no increase in the number of non-Christian doctors can in the least relieve the Church of Christ of her responsibility to the bodies as well as to the souls of men.... No, the work being done by the Government does not make ours less necessary, but more."³⁹

Despite the ambivalence they felt in regards to the medical system put in place by the GGK, missionaries did ally with the colonial government in areas of shared goals and interests. They were impressed with the material benefits Japan promised to provide. They agreed that the poor state of health in Korea was due to ignorance and superstitious customs. Thus they welcomed Japanese sanitary and medical work. As Dr Smith wrote in 1934, "Government control has done much to teach the Korean people the need for and methods of modern

35 R.K. Smith. "Medical practice in Chosen," *The Korea Mission Field* 13(5) (1917): 120–22.

36 A.G. Fletcher, "Concentration and efficiency," *The Korea Mission Field* 12(2) (1916): 39–44.

37 "From the view point of the Doctors," *The Korea Mission Field* 9, (2) (1913): 43–45.

38 Reid, "The Annual Meeting of the Korea Medical Missionary Association," p. 318.

39 Hugh H. Weir, M.B., "The place of medical mission work in Korea" *The Korea Mission Field* 10(7) (1914): 191–93.

sanitation, but they still have a long ways to go in assimilation of the teaching, and every word of encouragement we can give help[s] in the process.”⁴⁰ Missionaries cooperated with quarantining efforts, accepted Imperial donations and recognition,⁴¹ participated in government-initiated health campaigns, and strove to meet the higher standards demanded by the government. They invited Japanese physicians and administrators to medical mission events such as the annual meeting of the Korea Medical Missionary Association or medical student graduate ceremonies at Severance Medical College.

Medical policies in colonial Korea were implemented as part of broader strategies to expand population growth and cultivate healthier bodies both in the Japanese empire at large and at home to extract necessary human resources for imperial expansion. In Korea, the GGK pursued pro-natalism by restricting threats to population growth (criminalising abortion, infanticide and certain forms of birth control), promoting new childbirth practices through the professionalisation of new-style midwives and curricula in girls’ schools, and detailed record-keeping so the state could keep track of birth, mortality and morbidity statistics.⁴² In 1914, the GGK adapted Meiji regulations regarding the training and licensing of new-style midwives in Korea (the “New Midwife,” *J. shin-sanba*), the gateway through which the state supervised and intervened in women’s reproductive activities (such as preventing unregulated abortions and infanticide) by replacing older childbirth cultures with new medicalised practices.⁴³ Public health activities such as mandatory smallpox vaccinations (a major child killer), licensing prostitution in hope of regulating sexually transmitted diseases (a cause of infertility and debility), and sanitation programs (to curtail contagious disease) aimed at enhancing the health of the general population.

Despite the professed concern of the colonial authorities in the health and welfare of their ruled population, however, infant-welfare work in Korea was woefully lacking. The state may have sought to enhance women’s reproductive health, which in turn was to strengthen the conjugal unit on which the imperial state was based, but midwives in colonial Korea were overwhelmingly Japanese

40 “Personal report of Roy Smith, 1934,” PHS, RG 140-9-1.

41 Some examples include Rosetta Sherwood Hall who was honoured on the birthday of the Japanese Emperor and received a set of silver cups for her medical work with women and children and educational work with the blind and deaf in 1915. The Presbyterian Hospital in Taegu received a gift of 500 yen from the provincial governor. See “Annual Report Taiku (Taegu) Station for 1929–30,” PHS, RG 140-7-1.

42 For more on GGK biopolitics, pronatalism and statistics, see Theodore Jun Yoo, *The Politics of Gender in Colonial Korea: Education, Labor, and Health, 1910–1945*, Berkeley and Los Angeles: University of California Press, 2008; Jin-kyung Park, “Corporeal colonialism: medicine, reproduction, and race in colonial Korea,” Ph.D. dissertation, University of Illinois at Urbana-Champaign, 2008; and Sonja Kim, “‘Limiting birth’: birth control in Colonial Korea 1910–1945,” *EASTS* 2 (2008): 335–59.

43 For more on midwives and reproductive politics in Japan, see Julie M. Rousseau, “Enduring labors: the ‘new midwife’ and the modern culture of childbearing in early 20th century Japan,” Ph.D. dissertation, Columbia University, 1998; and Sabine Frühstück, *Colonizing Sex: Sexology and Social Control in Modern Japan*, Berkeley and Los Angeles: University of California Press, 2003.

and located in urban areas, largely servicing the Japanese settler population.⁴⁴ Korean customs dictated that women were not inclined to be examined by male physicians, yet there was a dearth of female physicians who remained a small minority of the physician community throughout the colonial period and who lacked an accredited medical school (Keijō Woman’s Medical School) until 1938. Women who wanted to practise medicine studied abroad or under the tutelage of mentors. Unless they attended a recognised medical educational institution such as the Tokyo Women’s Medical College, they qualified to practise medicine only after passing the GKG licensing exam. Korean commentators in the late 1930s, alarmed by continued infant mortality rates, pointed to the lack of maternal and infant facilities and services.

Lack of funds and administrative burdens may account for the GKG’s general negligence in maternal and infant welfare. However, comparisons with Japan and the shift towards increasing attention to maternal services after 1937 highlight imperial characteristics of the medical system implemented in Korea. There were a number of educational facilities geared towards the training of female physicians in Japan, whereas none were implemented by the GKG in Korea.⁴⁵ Midwives in Japan formed professional organisations and local governments and private organisations instituted maternal health centres such as family planning and maternal clinics. Post-1937 policies to improve obstetric conditions and encourage reproduction in Korea included: increasing food rations for pregnant women, day nurseries, etc. Plans to establish maternal health services did not materialise.⁴⁶ In general, limited health campaigns in Korea reflect an official attitude that medical services were foremost to serve imperial goals of conciliation, protect the Japanese settler community, and “offer” nominal health education, while access to medical care remained pitifully inadequate, especially in the countryside, and much less for women and children.

A “better baby movement” in Korea

It was in this vacuum that infant-welfare centres in Korea were started, funded, and staffed overwhelmingly by foreign missionaries. Even before 1924, missionaries expended considerable effort in spreading the “gospel of hygiene,” especially as it related to everyday practices within the domestic space, whether from the pulpit, in hospitals and schools, through women’s groups,

44 See Yi Kkonme, *Han’guk kũndae kanhosa* (History of Modern Nursing in Korea), Seoul: Hanul Academy, 2002.

45 The medical school for women accredited in 1938 emerged out of joint efforts by Korean physicians and missionary Dr Rosetta S. Hall and was thus a private, not a public, school.

46 An T’aeyun, *Singminji chõngch’i wa mosõng: ch’ongdongwõn ch’eje wa mosõng ãi hyõnsil* (Remaking Mothers: the Politics of Motherhood in Colonial Korea), P’aju, Korea: Han’guk haksul chõngbo, 2006.

printed literature, or other informal means. Tracts such as the “Care of Infants” written by Dr James Van Buskirk were handed to mothers of small children in dispensaries. “Hygiene of Parturition” by Dr Alfred M. Sharrocks and “Advice to Mothers” by Mattie Noble were used as basic texts in women’s meetings and classes.⁴⁷ The women’s mission hospital at East Gate was committed to teaching young mothers how to care for themselves and their babies, and infant welfare workshops with free baths and care during the summer months were held.⁴⁸

Modelling similar events in the United States, missionaries held baby shows—one record indicates as early as 1916 at the Songdo (Kaesŏng) Station—which awarded babies according to their sex, weight, height, proper number of teeth and chest measurement, and distributed educational information on the food, rest, hygiene and care of infants in the hopes of a “full fledged Better Baby Movement here and thereby help lessen the frightful mortality among infants.”⁴⁹ In 1919, missionary Mabel Genso conducted a Mothers’ Club in Seoul to partake in this “Better Baby Movement” with monthly weighing and examination of infants and lectures by physicians and nurses.⁵⁰

The work, however, was sporadic depending on interested missionary involvement until it became systematic with the new infant health clinic at the T’aehwa in 1924. T’aehwa pioneered a strong commitment to comprehensive social services by combining preventative and therapeutic medical care with an educational component, reinforced by home visits and return trips to the clinic. Babies attended periodically to be weighed, measured, examined and treated for minor ailments. A Korean Bible woman or nurse, if available, provided a follow-up home visit. T’aehwa began a Baby Show in 1925, which became an annual event, spreading to other mission stations and later conducted in conjunction with G GK-sponsored Children’s Day. Missionaries offered free medical examinations, toys and prizes for the “best” baby according to standards of weight, height and health.”⁵¹

Out-clinics started in three different parts of the city.⁵² Prenatal work functioned in conjunction with mission hospitals. Mothers registered with T’aehwa went to East Gate Woman’s Hospital for delivery, and Severance Hospital treated sick babies. Baths at T’aehwa started in 1927 for a nominal fee, and then water

47 A.F. Hillman, “Chong dong dispensary and medical work in Ewha Haktang,” *Annual Report of the Korea Woman’s Conference of the Methodist Episcopal Church* (1912): 54–56.

48 See annual reports of the Korea Woman’s Conference of the Methodist Episcopal Church in the early 1900s.

49 “What are you doing in your station for the help of mothers, especially in the home and with little children?” *The Korea Mission Field* 12(4) (1916): 114.

50 Mabel R. Genso, “Work with Korean mothers,” *The Korea Mission Field* 15(12) (1919): 263–64.

51 Elma T. Rosenberger, “Public health work at the Social Evangelistic Centre, Seoul,” *Bulletin of Korean Nurses’ Association* 9 (1928): xv–xviii.

52 Elma T. Rosenberger, “Report of public health work, Social Evangelistic Centre, Seoul,” *Bulletin of Nurses’ Association of Korea* 13 (1929): 28–31.

was let loose for street children in exchange for recitation of Bible verses.⁵³ A year later in 1928, T'aehwa began a milk-feeding station that prepared and provided undernourished infants with supplementary nutrition. As it was soon discovered that some mothers abhorred the notion of their children drinking milk from an animal, a soy milk formula learned from China was used. The soy milk formula was deemed successful for catering to the dietary tastes of Koreans and, being more affordable to produce, T'aehwa even secured a government permit to can soy milk powder.⁵⁴

Women's and infant health care came to the forefront of cooperative medical mission ventures in the late 1920s. T'aehwa hosted the first public health conference in 1926, inviting nurses and midwives across denominations and from around the peninsula to come for lectures on hygiene and public health work with mothers and children. This became an annual event called the Public Health Nurses' Institute, and it was held at various infant-welfare centres throughout the peninsula. In 1928, the Korean Woman's Medical Training Institute opened its doors and devoted itself to the medical education of Korean women with the initiative and support of mission organisations, particularly through Dr Rosetta Hall.⁵⁵ In preparation for this work, Korean female physician Dr Kil Chŏnghŭi, co-founder of the Woman's Medical Training Institute, worked at East Gate Woman's Hospital, specialising in obstetrics, gynecology and pediatrics. The following year, T'aehwa joined forces with Severance Hospital and East Gate Hospital to create the Seoul Child-Welfare Union with Dr Douglas Avison, a pediatrician at Severance, as its director. The three sites shared personnel and resources, with a Well-Baby Clinic at each site. The clinics also served to train nursing and medical students in public health work. This was also the same year that Ewha Woman's College inaugurated its Home Economics Department.⁵⁶ According to one of its faculty and Korean graduate of mission schools, Home Economics was directly linked with efforts to reduce infant mortality and thus the same content on infant care given to mothers attending infant-welfare clinics were given to Home Economics students.⁵⁷ Furthermore,

53 Clean, heated water as well as a large enough container to bathe in were luxuries that many Korean households did not have. Bathing was considered necessary to cleanliness, paramount in missionaries' understandings of health. Thus baths were common in infant welfare programs, although in this case, they were aimed at bringing older street children into contact with the Centre, staff who would later visit their homes to evangelise. "Annual Report, Social Evangelistic Center, Seoul, Korea, January 1932," PHS, RG 140-14-9.

54 The soy formula was developed at Peking Union Medical College and at T'aehwa it was deemed to cost only 3 sen per feeding in contrast to the 10 sen for canned cream. N. Found, "A cheap substitute for milk," *The China Medical Journal* 45(2) (1931): 144-46. See also "Annual Report Social Evangelistic Center, Seoul, Korea, January 1932."

55 This is the training institute that later became accredited as the Keijō Women's Medical School in 1938.

56 See Hyaewol Choi's chapter, "The missionary home as a pulpit: domestic paradoxes in early twentieth-century Korea," in this volume.

57 Hanna Kim, "The need of home economics education in Korea," *The Korea Mission Field* 25(10) (1929): 215-16.

a printed list of publications endorsed by the missionary-dominated Korean Nurses' Association (*Chosŏn kanhobuhoe*) for the edification of Korean nurses included health tracts given to mothers at the infant-welfare clinic.⁵⁸

Other mission stations throughout the country followed suit with similar programs. Missionary Maren Bording started the infant and maternal health clinic in Kongju at a similar time as T'aehwa in 1924, and opened a new branch in Taejŏn when the provincial capital moved there from Kongju in 1932. Medical work here differed from other mission stations in that it lacked a doctor and hospital but housed a full-service infant and maternal health centre. Besides a bi-monthly Well-Baby Clinic, Kongju started a Milk Station in 1927 and a nursery for motherless babies or babies of sick mothers in 1930. It also offered a two-year training course for baby nurses targeting high school girls and a four-month post-graduate nursing course in Public Health and Infant Welfare. There was a clinic for Japanese babies, and a Korean nurse-midwife was on staff devoted to the pre-natal, delivery and post-natal care of Korean mothers and babies in their homes.⁵⁹

How, then, did missionaries understand the problems facing Koreans in terms of infant welfare? While recognising the inferior state of public works or family finances, they attributed early childhood mortality largely to maternal ignorance, particularly in regards to feeding, fueled by Korean customs. In other words, mothers did not know the proper methods of feeding and failed to offer nutrition required for healthy growth. Late weaning and the lack of milk after weaning, the inferior quality of the Korean diet (as perceived by missionaries), pre-mastication of food (transferred from adults' mouths to infant), the early start of solid food (while still breast-feeding), restrictions in the diets of sick children and feeding infants on demand instead of on schedule were said to tax the health of infants through their digestive tracts, exacerbating or even bringing on illnesses leading to an untimely demise.

According to the *Chōsen sōtokofu tōkei nenpō* (GGK annual statistical yearbook) in 1920, nervous system-related disorders accounted for 21 per cent and infectious diseases 29 per cent of infant deaths under the age of one year. In 1925 and 1930, nervous disorders again were reported as the number one cause of infant mortality, claiming 25 per cent of all (reported) infant deaths (under 12 months of age) in both years. The category of nervous disorders likely included infants who suffered from convulsions brought upon by high fevers or dehydration from diarrhea that stemmed from infections or other illnesses. Nevertheless, while

58 One example of the association's endorsed publications includes Frances Lee's, *Children Nutrition and Health*. "Endorsed N.A.K. Publications," *Bulletin of the Nurses' Association in Korea* 24 (1932): 64–65.

59 "A public health aeroplane trip from North to South in Korea," *The Korea Mission Field* 36(5) (1940): 81–83; and Maren P. Bording, "Infant welfare and public health work in Kongju," *The Korea Mission Field* 24(3) (1928): 52–53.

government statistics presented respiratory and nervous ailments as the more common causes of infant mortality, missionaries focused on proper nutrition and eating habits, particularly the scheduled feeding of infants, as the root of most infant illnesses. The Kongju Infant Welfare Center handed out a Feeding Schedule pamphlet written in vernacular Korean to mothers. The rhetoric of the pamphlet was frightening. It warned, "44 out of 100 newborns are dead in their first two years." The reasons lay in the inability to stick to scheduled feeding, clean bathing and clean clothing. "Do you want to kill your beloved child?" the pamphlet asked, "Or do you want it to live?"

This stress on proper feeding, while common in other areas of the world, was more than simply an application of foreign methods in Korea. It also indicated missionaries' more general concerns about digestive-related ailments in Korea. Anxieties about their own digestive health were rampant in the Korean missionary community. The gluten-related ailment sprue was cited as one of the major health concerns for the foreign population. The Research Department of the Severance Union Medical College conducted several studies on Korean foods and food values, dietetic conditions and the negative impact of the Korean diet on missionaries.⁶⁰ Missionary children, including the daughter of Dr Rosetta S. Hall, fell victim to dysentery with its symptomatic diarrhea and mode of transmission through drinking water. Digestive-related maladies were highlighted as the most common cause of illness among missionaries after exhaustion or overwork.

Moreover, while infant-welfare work in Europe and America retreated from a focus on milk supply to a focus on labour legislation (to enhance breastfeeding), free meals to supplement breastfeeding mothers' nutrition and mother pensions, missionaries in Korea concentrated their efforts on changing Korean child-rearing customs particular in terms of diet. They circulated detailed instructions on solid foods in addition to scheduled feeding. Korean children were "fortunate" if they survived habits that allowed them to "eat nearly all kinds of green fruit and vegetables," only to suffer from the intestinal parasites contracted from the not-so-dead-and-dried-fish at the markets.⁶¹ Perhaps because breastfeeding was nearly universal, missionaries felt little need to mention its benefits, although they were disquieted by the fact that Korean infants seemed to nurse constantly for three to four years, way beyond the recommended one year. Cow's milk, which was uncommon in the Korean diet and generally out of the reach for many, was encouraged to supplement nutrition. Missionaries may have invoked

60 Two published reports include James Van Buskirk, *The Composition of Typical Korean Diets*, Seoul, Korea: Severance Union Medical College, 1924; and J.D. Van Buskirk and F.M. Stites, MD, "The health of missionaries in Korea," *The Korea Mission Field* 18(8) (1922): 163–86.

61 A.G. Fletcher, "Concentration and efficiency," p. 42.

poverty, poor sanitary works and improper pre- and post-natal care in passing, but they did not pursue these aspects of infant-welfare work with as much fervour as they did Korean feeding habits.

By the late 1930s, mission infant-welfare work existed in some shape or form in Seoul, Taejŏn, Kongju, Andong, Kangye, Taegu, Sinch'ŏn, P'yŏngyang, Haeju, Chemulp'o, Wŏnsan, Kaesŏng, Chŏrwŏn, Ch'unch'ŏn and Suwŏn. The expansion of this new field of medical work, however, seemed precarious in a time of retrenchment. For example, even when financial support was offered to expand or develop hospitals, as in the case of Ms. Schaufler who in the mid-1920s was considering to donate more funds to the Cornelius Baker Memorial Hospital in Andong which was named after her father, Mission Boards refused, not wanting to commit to sustain hospitals at expanded levels.⁶² They also expected medical missions to be self-supporting. By the 1920s, North Methodists closed three of their six medical stations. Medical missions in P'yŏngyang decided to consolidate their efforts through union work with one hospital. Medical work was heavily dependent on personnel and funds—should the physician or nurse go on furlough, mission hospitals closed unless they were able to procure replacements, often employing Korean graduates to serve in the meanwhile. The global economic recession of the 1930s further cut back on appropriations, and missionaries often had to dig into their own pockets or appeal to personal friends and supporters to fund their clinics. Well-baby clinics required a doctor's time—precious when doctors at mission stations were already overtaxed.⁶³ Clinics demanded a full-time nurse when few could be spared, and someone preferably Korean to communicate with mothers. Space was an issue, with church offices being used if there was no room at the hospital or dispensary. Milk was not inexpensive either—hence the centre at Kongju had to resort to serving a more upper-class clientele in order to fund the service, thereby deviating from their professed goals of social service.⁶⁴

The work at times seemed to cost too much with little result. The Well-Baby clinic in Andong shut down for a few years in the early 1930s for this reason. According to its annual report, "One of our saddest set-backs has been the dropping away of the baby clinic. It was found that we were giving too much charity."⁶⁵ Nevertheless, despite the strain on resources, by 1940 most Presbyterian and Methodist mission stations offered some form of infant welfare service.

62 See letter from Arthur J. Brown to Ms. Schaufler, October 19, 1925, PHS, RG 140-14-22. This was in fear that should support not be continued, the Mission Board did not want to be financially responsible for maintaining hospital operations.

63 Dr Douglas Avison noted, "[Child welfare clinics] take time, workers, and money. The work is enjoyable but when added to an already overload, they sometimes tax both patience and strength." See "Personal report of Douglas Avison, 1932-3," PHS, RG 140-9-14.

64 Soy milk formula was offered as an alternative to poorer patients.

65 "Report of the Cornelius Baker Memorial Hospital, Andong, 1930," PHS, RG 140-7-29.

Placing Christian service and family in infant welfare work

Situating infant welfare work within the larger context of global missions and Korea’s colonial medical system furthers our understanding of why health services for infants were promoted in a period of declining resources. Medical work, in general, was believed to be an essential part of Christian work, even “an outgrowth of Christianity” as “Jesus Christ had compassion on the multitude” and commissioned that there be healing of the sick in the Church.⁶⁶ In the mid-1920s, the Rockefeller Foundation sponsored the Layman’s Inquiry which produced a report representing seven American Protestant denominations that assessed the work of, and suggested reforms for, Protestant missions. It reflected the unease Protestant denominations felt about the role of Christianity and missions particularly in Asia and the relationship between evangelism and social service. Moreover, it addressed concerns about whether medical missions were needed where imperial powers proactively constructed modern medical systems, as in the case of Japan in Korea. The report acknowledged, “With a Government so progressive, and so intent on making the best of Western science its own, there has seemed to other boards little need of embarking upon a costly program of medical relief.”⁶⁷ However, the report concluded that this did not signal the end of medical mission work. Rather, the report justified their work with the ideal of Christian service.

This articulated a sentiment begun in the early years of Japan’s colonial rule that Christianity in Korea offered different and better modes of medical service and education. A missionary strategy that Hyaeweol Choi calls “Christian modernity,” placed Christianity at the heart of the missionary modernising enterprise. Their presence was justified by the claim that missionaries added moral and spiritual dimensions to modern ways of being that Japan’s colonial project of material and technological modernisation lacked.⁶⁸ One mission hospital reported, “As Government institutions and native physicians increase and as the church grows the purpose and need of the mission hospital changes from its importance as a means of contact more and more to that of the Good Samaritan.”⁶⁹ Medical education at Severance was essential for it offered “medical education under Christian influence and in the Christian spirit.” Imagine the danger when, as

66 Sharrocks, “Can less than two doctors in a single hospital achieve the best result?” p. 17.

67 William Ernest Hocking, *Re-thinking Missions: a Laymen’s Inquiry after One Hundred Years*, New York and London: Harper and Brothers Publishers, 1926, pp. 198–99.

68 See Hyaeweol Choi, “Christian modernity in the missionary discourse of Korea, 1905–10,” *East Asian History* 29 (2005): 39–68.

69 “Kennedy Memorial Hospital Report, 1919–1920,” PHS, RG 140-7-36.

Dr Van Buskirk then a professor at Severance continued, "if we fail to do this ... we allow the great and influential medical profession to fall into non-Christian or anti-Christian hands."⁷⁰

Missionaries feared that a "Japanese system of medical treatment, empirical remedies, shot-gun prescriptions, and intra-cutaneous, intra-muscular, intra-venous, and intra-anything injections" would let the "lust for gold" rule the work of the physician.⁷¹ In such a system, "it is only the charity patient who is being turned away." Private duty nurses would have no place. To counter this, Christian physicians and schools producing Christian medical workers instilled "the spirit of Christian Service" to bring about "the milk of human kindness." Thus, the future of medical missions was to lie in public health, particularly with social services as the extension of "the usefulness of the hospital by connecting its helpful service with the homes of the people."⁷² They were to ensure Koreans' access to medical services that may be hampered by their material, economic or social conditions through the provision of care in the home "as a practical expression of the gospel of Christ." The Laymen's Inquiry concurred, "the Commissioners are convinced that ... much that is worthwhile can be done in [fields of health education, preventive medicine and public health nursing].... In particular, efforts in health education should be focused upon school children and mothers."⁷³

For these reasons, medical missionaries insisted on the value of their presence. Keeping the Christian mandate in mind, they persevered to continue medical services by meeting GKG licensing and operating requirements, particularly in areas of common interest such as infant welfare. In this way, there was a tacit partnership between the missionaries and the colonial authorities. The 1927 mission Public Health Conference included a visit to the Government Hospital.⁷⁴ Mission-affiliated visiting nurses and midwives used a Midwife Bag that was used in Japan.⁷⁵ It was said that "government officials approve highly of anything done for public health," and that the work in Kongju was "shown much consideration by them."⁷⁶ The milk station in particular was supported by the local police and higher officials.⁷⁷ The East Gate Woman's Hospital started a special training session for senior nurses in midwifery in 1929, equipping the classroom in the same way as the Government Hospital School for Midwives and

70 J.D. Van Buskirk, "Christian medical education, its place and opportunity," *The Korea Mission Field* 20(7) (1914): 213–14.

71 E.W. Demaree, "The future of medical missions in Korea," *The Korea Mission Field* 30(4) (1934): 74–76.

72 O.R. Avison, "Social service and the hospital," *The Korea Mission Field* 20(7) (1914): 203–06.

73 Hocking, *Re-thinking Missions*, p. 213.

74 "Public Health Institute," *Bulletin of Nurses' Association of Korea* 5 (1927): 5–13.

75 *Ibid.*, p. 11.

76 *Ibid.*, p. 12.

77 *Ibid.*, p. 6.

employing the same teacher.⁷⁸ This was conducted in hopes that their graduates would pass the Government Licensing Examination and receive their licences as midwives.

Infant welfare work in Kongju (and later Taejŏn) demonstrates most clearly this relationship between medical missions and the colonial state. The director Maren Bording was permitted a new building to house the infant welfare work by local authorities in 1929. For her work, they granted Bording a medical licence although she was not a trained physician.⁷⁹ They also made annual contributions starting in 1930. As children of Japanese officials enrolled with her services, the local government loaned a small building for a milk station so that milk would not have to be transported daily from Kongju to Taejŏn. In other centres, Japanese support came as single donations, such as the 50 yen received from Countess Kadama, wife of the Vice-Governor of Korea, to be used for prizes in the Baby Show in Seoul in 1932, or serums to vaccinate children. If tensions existed with the colonial government in the carrying out of infant welfare work, mission records were relatively silent.⁸⁰

In addition, missionaries saw infant welfare as an area not fully met by the state. While the GKK established an elaborate system of hospitals and medical education throughout the peninsula and proclaimed various public health campaigns, GKK campaigns lacked the resources to effect significant material improvements in Korea's health conditions. Elma Rosenberger attributed high infant mortality rates to the "ignorance of hygiene and sanitation, low economic status, lack of effective quarantine arrangements, poor housing, and early resumption of household duties after confinement."⁸¹ The poor state of public works (such as open sewers) in Korea did not help matters, but until proper infrastructure could be implemented, missionaries sought public health work as means to "preach prevention and prevent sickness."⁸² The state through its social service arm, the Chōsen shakai jigyōkai (Chōsen Welfare Society) began to sponsor a Children's Day in 1928 three years after T'aehwa began its annual Baby Show. This Day was later extended in 1931 to an annual week-long public education campaign in May termed "Loving and Protecting the Child (K. *yuyu-a aeho*. J. *nyūyoji aigo*)." But while the activities of the Chōsen shakai jigyōkai were generally limited to working with other medical institutions to provide free health and dental exams for the young and broadcasting the proper health care of infants, standard weight and height charts, statistics on infant mortality

78 Elisabeth S. Roberts, "Report of East Gate Hospital," *Bulletin of Nurses' Association of Korea* 13 (1929): 26–27.

79 Hall, "Pioneer missionary work in Korea," p. 105.

80 This is in contrast to other aspects of medical work missionaries contested with the state, such as physician licensing, teaching credentials and operation of smaller or less equipped clinics.

81 Elma T. Rosenberger, "The new 'Seoul Child-Welfare Union,'" *The Korea Mission Field* 26(5) (1930): 109–10.

82 Esther L. Shields, "Mrs. Ludlow and Kim Whe Soon," *Bulletin of Nurses' Association* 3 (1926): 12–13.

during the week, missionaries endeavoured to work directly with their Korean clients on a long-term and frequent basis. Despite the annual exhortations of the “Loving and Protecting the Child” campaigns, infant welfare institutions failed to materialise in a significant way in the 1930s. In 1936, there were around twenty infant welfare-related institutions and daycare centres, most of them run by Christian missionaries.⁸³

Moreover, the mode of infant-welfare operations with their periodic check-in and follow-up illuminates their importance to overall missions. Periodic medical examinations to prevent and treat ailments before they become fatal conformed generally to medical recommendations in the West. But this was time-consuming and costly, sometimes with little improvement in overall mortality or morbidity. This pattern used in mission hospitals and dispensaries, however, allowed missionaries to pursue other goals, most obviously that of evangelising and, in the case of infant-welfare work, the transformation of domestic practices. Continued visits to the infant-welfare clinic by the mother and infant, followed up with visits home by a nurse or Bible woman and Mothers’ Meetings to reinforce instruction certainly aided evangelising efforts. As one station reported in 1930, “The humanitarianism of the work is therefore apparent, not to mention the opportunity it offers for catching and holding the mothers for Christ.”⁸⁴ At T’aehwa, “the mothers who bring their babies regularly to this Clinic are almost sure to become Christians.”⁸⁵ Clinic reports listed statistics not only of the number of infants examined and treated, but also the number of mothers who converted to Christianity.⁸⁶

That some clinics were conducted through Cradle Rolls of churches attests to the close link between church and evangelising goals exhibited in infant welfare work. Cradle Rolls were rosters of infants and their mothers associated with local churches. What missionaries discovered was that many young mothers who expressed little interest in Christianity were interested in care for their children. Whether their children became part of the Cradle Rolls before or after they attended the clinics, the mothers of Cradle Roll infants were organised into Mothers’ Meetings, offered medical examinations for their children, and lectured on childrearing techniques. Cradle Rolls and infant welfare work were deemed “a real help in winning some of these who have been so slow to hear when preached to.”⁸⁷ “Graduates” of the Cradle Roll would then move into the

83 Kim Hyegyŏng, *Singminji ha kŭndae kajok ŭi hyŏngsŏng kwa chendŏ* (The Formation of the Modern Family and Gender during the Colonial Period), Seoul: Ch’angbi Publications, 2006, p. 152.

84 “Kangkei Station Report, June 1930,” PHS, RG 140-7-1.

85 “Annual Report of Seoul Station, 1927–1928,” PHS, RG 140-6-55.

86 Interestingly, the numbers were quite marginal, relative to the number of infants examined. This corroborates my point later in the paper that Korean mothers found the medical exams more appealing than the Christian religion itself. For example, in 1932, Elma Rosenberger reported that only seventeen people converted to Christianity through the Child Welfare work. A total of 2,533 babies attended the clinics. See Elma T. Rosenberger, “Child welfare work,” *Bulletin of Korean Nurses’ Association* 24 (1932): 36–40.

87 Rosenberger, “Child welfare work.”

kindergarten department of local church Sunday Schools. Cradle Rolls in fact were a means to obtain future Sunday school students and bring families into the church.⁸⁸

In this way, infant welfare work allowed missionaries to reinforce and bring to fruition ideal visions of the Christian family in the Korean home. They interpreted certain aspects of Korean family dynamics as antithetical to Christian life, particularly those categorised as ruled by Confucian patriarchal principles and filial piety which demanded respect for (and perhaps unilateral submission to) parents, husbands, in-laws and the elderly. Children were relegated to marginal, perhaps pitiful positions, their physical and mental health an afterthought. It was claimed that "Korean children have very little amusement.... Fun must not be allowed even to children."⁸⁹ How could children thrive in such an environment, especially when they were not wanted or neglected as in the case of one girl whose father would not give permission for her to receive treatment because she was a girl?⁹⁰

Missionaries believed Christianity offered Korean children humanity not found elsewhere. As Mrs. Norton claimed, "Christianity is the only religion that appreciates childhood."⁹¹ In this way, "children were gifts from God and to be cherished. They were to pray and be thankful for, and happy about their children."⁹² Thus, "the recognition of childhood is a sure test of the narrow or full development of Christianity." To be Christian, to live a Christian life, was to ensure the development of children's faculties, and that meant addressing the physical, mental and spiritual needs of children.⁹³ Christianity required the reformation of childrearing techniques. Parents should not only ensure the health of their young but also change how they related to their children, for example by setting a moral example and not using corporal punishment when disciplining. This connection between Christianity and childhood better contextualises the Sunday school movement in Korean churches and the emergence of mission kindergartens and formal baby welfare clinics in colonial Korea.

"And a little child shall lead them." So it was written in the Taegu station report in 1930. The leadership of the child in his/her purity and innocence had the ability to bring his/her family to church and Christian living. "The child of

88 "Chuil hakkyo, yŏngabu 1, yŏngabunŭn muŏssinyo" (Sunday School, Cradle Roll 1, what is the Cradle Roll?), *Kidok sinbo* (Christian Messenger), August 2, 1916.

89 Syngman Rhee, "Child life in Korea," *The Korea Mission Field* 8(3) (1912): 93–98.

90 "Brevities. Medical," *The Korea Mission Field* 10(8) (1914): 246–48.

91 Mrs. A.H. Norton, "Kindergarten work," *The Korea Mission Field* 8(8) (1912): 234–36.

92 Other articles in the Korean Christian newspaper *Kidok sinbo* attest to this view on children. See for example Mrs. Avison, "Kajŏng tamhwa, Christian ŭi kajŏng ŭi kŏnsŏl kwa palchŏn," (Building and developing a Christian home), *Kidok sinbo*, 26 April 1916.

93 Chŏnju Ch'oe puin, "Kajŏng pogam, pumo ka chanyŏ ege ch'aegim" (Protecting the home, responsibility of the parent towards children), *Kidok sinbo*, 24 December 1919.

today is the man of tomorrow. How important was it, therefore, that children shall grow up healthy and strong.”⁹⁴ With these words, the Presbyterian Hospital at Taegu fulfilled “a long cherished dream for a Baby clinic.” The physical well-being of the child was thus central to the project of the Christian home. Other scholars have demonstrated how gender relations, particularly between husbands and wives, were central to mission-modernising projects to reform the domestic space. Korean women were to achieve “true womanhood” and build an ideal Christian family based on a companionate marriage.⁹⁵ They were also to ensure that “special care is taken of the health and the moral development of the child,”⁹⁶ and it was “‘Mother and Child Welfare Work,’ which is proving a great help to the Church in ... building healthy Christian homes.”⁹⁷ Perhaps missionary infant-welfare work can best be summed by Elma Rosenberger:

We do not only try to help them physically but we always like to talk to them about that biggest and brightest hope in our lives which is Jesus Christ and the Christian hope for which we live and move and have our being, and many times we have the privilege of praying with them. We want to teach them that without this hope they cannot quite raise their children as they ought to, nor have the highest purpose in life for them.⁹⁸

This then was the bio-politics of mission infant welfare work. Christian principles demanded missionaries provide social services (including health care) in a world devoid of Christian spirit or morality. They were also to build Korean Christian homes by promoting the health and welfare of the very young. And medical and other services protecting the young were best realised with the Christian faith amidst a secular world. For these reasons, infant welfare work was to remain an integral part of medical missions. There was to be no rest “until in all the Christian homes, the children are passionately loved, are wisely and patiently taught, their future planned for and in fact the responsibility of such a gift from God more fully appreciated.”⁹⁹

94 “Annual Report of Taiku Station for 1929–1930,” PHS, RG 140-7-1.

95 Views like this are well expressed in reports such as Mattie Wilcox Noble, “What the Bible has done in Christian Korean homes,” *The Korea Mission Field* 11(1) (1915): 11–13. For example, Christianity was believed to prevent husbands’ violence against wives, raise the marriageable age and eliminate concubinage. Hyaewool Choi in *Gender and Mission Encounters* discusses further the complicated relations between missionaries and their projects in cultivating “ideal womanhood” in Korea.

96 Noble, “What the Bible has done in Christian Korean homes,” p. 11.

97 “Mission hospitals in Korea,” *The Korea Mission Field* 33(5) (1937): 94–103, p. 102.

98 Elma T. Rosenberger, “Public health work in Seoul,” *Bulletin of the Nurses’ Association of Korea* 1 (1925): 12–13.

99 “The child, the home and the Sunday School,” *The Korea Mission Field* 11(10) (1915): 282–83.

Conclusion

By the 1920s, infant mortality statistics worldwide became sensitive indices of social welfare and sanitary administration, resulting in a growing anxiety about infant mortality rates, and the recognition that such rates needed to be lowered.¹⁰⁰ How societies addressed the concern varied. However, as Alisa Klaus noted, “The social visions of reformers and politicians and the political culture in which they worked determined the institutional structures through which scientific principles were put into practice.”¹⁰¹ For example, the more private and unregulated nature of American medicine and the social activism of women’s groups help explain their local character, and opposition to public infant welfare centres from the medical community, as well as the large presence of women in baby-saving campaigns and child-welfare administration in the United States. France’s main concern with military preparedness, a tradition of government intervention in social life, and an understanding of infant mortality as related to women’s wage labour account for larger state involvement and the funding of medical and economic provisions for pregnant and post-partum women, and cooperation from the organised medical profession.

Missionary infant welfare work in Korea, likewise, was shaped by the vision of its reformers and the colonial medical system in which they found themselves. It is facile to assume that the missionaries provided Koreans with universal health care standardised by a science with its objective claims. This chapter suggests, however, that missionaries’ interpretations of the health needs of and solutions for Koreans informed the kinds of services they provided. They reflect assumptions missionaries made when equating their medical knowledge and practices with civilisation. In addition, Christian ideals of service and domesticity surrounding family, home and childhood were pivotal in shaping the ways missionaries pursued infant welfare programs to meet evangelistic goals. These were done under what they perceived as secular and perhaps inferior conditions of the Japanese colonial medical system. While missionaries were not a unified contingent, as far as infant welfare was concerned, they agreed that Christian medical and social services were sorely needed within a Japanese colonial context. Moreover, Christian visions justified the physical well-being of the child which would be best served by the mode of infant-welfare clinics and mothers’ clubs. Maternal ignorance of child-rearing techniques, particularly feeding, were targeted as the primary cause of infant death and best combatted

100 United States Children’s Bureau and Nettie Pauline McGill, *Infant-welfare Work in Europe: An Account of Recent Experiences in Great Britain, Austria, Belgium, France, Germany, and Italy*, Washington, DC: US Government Printing Office, 1921, p. 7.

101 Klaus, *Every Child a Lion*, p. 16.

with health education. Already established church traditions such as mothers' clubs and rosters of infants in the Cradle Rolls and Sunday Schools of local churches facilitated infant-welfare work.

Moreover, it is common to characterise this infant welfare work as primarily provider-client, moving in one direction from missionary to Korean mother. Unfortunately, Korean participants in infant-welfare work left little written record besides some articles on women's and child health issues in the vernacular media.¹⁰² As is usually the case with mission archives, Korean participants are relatively absent, appearing mainly as anonymous clients whose cooperation or lack thereof was used to reinforce claims made in mission reports, or as examples of mission success in transferring proper infant-welfare work, knowledge and practice. It is thus difficult to gauge how they perceived and interacted with the new modes of maternal and infant care practices presented through mission infant-welfare work, or the extent of missionary influence. Moreover, the scope of this chapter does not allow for a fuller examination of Korean workers such as physicians, nurse-midwives, Bible women, or Mother Meeting leaders who were integral to the successful operation of missionary infant-welfare work through their close interactions with Korean families who had young infants.¹⁰³

Regardless, what remains clear is that foreign missionaries were more effective than the colonial authorities in implementing systematic and sustained maternal and infant welfare programs. Perhaps the GKK's later involvement in consolidating infant health programs reveals both anxiety that private health and welfare projects were growing into a formidable force and a lack of genuine interest in paediatric and women's health (with pre and postnatal services) beyond their reproductive capabilities. As discussed, the GKK supported a "Love and Protect the Child" campaign ostensibly to address the problem of high infant mortality in Korea. The timing coincided with the missionary annual Baby Show, and missionaries cooperated with the week-long campaign. In the 1930s, however, the campaign's name was changed to "Health Week," thus eliminating the concentrated focus on infant welfare. Missionaries maintained their focus on consistent infant welfare work in their missions.

For the most part, the GKK condoned missionary infant welfare activities. The missionaries' fragile partnership with the authorities in the realm of medicine, however, restricted their activities. Moreover, their belief in shared goals of civilisation tacitly tied them to imperial goals of conciliation and nominal health

102 One example is Ms Ch'oe from Chŏnju whose articles appear in the Christian newspaper *Kidok sinbo* in 1919 and 1920. Those who did write, for the most part, adopted exhortations to maternal attention to infant care and criticism of Korean daily habits in the home similar to those of missionaries. In terms of general rhetoric, it is difficult to distinguish between that of the missionaries and the colonial authorities. Both shared similar condescension towards Korean customs and habits in daily life including childcare.

103 I address this in my current work in progress.

education. They thus failed to muster a movement to sufficiently address the structural factors contributing to infant mortality, a concern many Korean reformers raised in the press. Perhaps missionaries considered labour legislation, maternal insurance and public sanitation as outside their jurisdiction. It is more likely, however, that these were not as fitting with their bio-politics in the creation of Christian homes.

The lack of finances, withdrawal of missionaries with Japan’s military escalation in Asia, and inadequacy of state initiatives further prevented the emergence of major public maternal and infant health programs during the colonial period. The missionaries’ legacy, however, may not be best measured by the number of infants examined and treated, or the mothers who converted to the new regimes in child-rearing or even Christianity. Rather, they left behind a firm rationale for, model of, and experience in infant welfare work. The leadership experience gained by Korean women as medical and social service professionals and organisational leaders left an indelible mark as some women took up leadership positions in re-building Korean society after its liberation from Japanese colonial rule.¹⁰⁴ Mothers’ clubs as a means through which to transmit “ideals of domesticity” particularly in their relation to child-rearing techniques as directed from above, whether it be United States military occupying forces, South Korean state, or missionaries, were to re-appear continually throughout the twentieth century.¹⁰⁵

Acknowledgements

I would like to express special appreciation to Hyaeweol Choi, Margaret Jolly and Carolyn Brewer, for their constructive comments and meticulous editing. In particular, I also thank Paul Chang, Suyun Kim, Sung-deuk Oak, Andre Schmid and Theodore Jun Yoo who have read and advised on earlier versions of this chapter. I would also like to thank the various archives and their staff who have assisted my visits to their collections: the Presbyterian Historical Society; United Methodist Archives & History Center; Thomas Fisher Rare Book Library, University of Toronto; the Center for Korean Classics Collection, Yonsei University Library; Rare Books Collection, Ewha Woman’s University Library; and the Institute of the History of Christianity in Korea.

104 One example is Esther Koh (Ko Hwanggyŏng) who worked in mission social service centres during the colonial period and continued welfare work with women and children in the post-liberation period. She was the only woman to serve on a committee advising Park Chung Hee on family planning.

105 For more on how Mothers’ Clubs functioned in family planning and home economics campaigns under Park Chung Hee see John DiMoia, “알맞게 낳아서 훌륭하게 기르자!” (Let’s Have the Proper Number of Children and Raise Them Well!): Family Planning and Nation-Building in South Korea, 1961–1968,” *EASTS* 2 (2008): 361–79; and Seungsook Moon, *Militarized Modernity and Gendered Citizenship in South Korea*, Durham, NC: Duke University Press, 2005.

This text taken from *Divine Domesticities: Christian paradoxes in Asia and the Pacific*, edited by Hyaeweol Choi and Margaret Jolly, published 2014 by ANU Press, The Australian National University, Canberra, Australia.