A Social History of Bethesda Hospital, 1937 – 1982.[1]

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> Here is Africa – backward, content, dark and ridden by the power of the witchdoctor. His baleful influence is ever at work, and instances continually occur to make one shudder with horror. In such circumstances it is good news to report that through the generosity of Lord Maclay there is a possibility of a Medical Mission being established at Ubombo.
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> - H.S. Robinson, Secretary of the Maputaland Mission, January 1938[2]

Introduction

These words, echoing long-established missionary sentiments, document the beginning of Bethesda Hospital – located in the district now known as Umkhanyakude in northern KwaZulu-Natal – which was to receive a formal opening in 1940. When Edinburgh-trained doctor, Robert Turner, arrived with his wife Lena – a trained nurse – and their two young daughters, to take up his post as District Surgeon in the village of Ubombo in October of 1937, following an arduous three day journey from Durban, the local magistrate showed them to the only available accommodation in this mountaintop village: a 'shack' of two rooms, 'running with rats and cockroaches'.[3] A nearby sweet potato field on six and a half acres of government-owned land was soon to become the site of a new hospital. Scottish philanthropist Lord Maclay donated £2,500 towards the initial building costs, and the project was taken on by the Zululand and Maputaland Missions of the South African Methodist Church. Like the opening quote, Lena Turner's account of their time in Ubombo is charged with a familiar tone of missionary zeal. She tells her reader of a treacherous journey to this most remote of places, a people whose heathen practices passed down 'from generation to generation', and describes stories in which witchdoctors received bodily and spiritual healing through their conversion to Christianity. These accounts evoked a distant place, frozen in time and space, in which witchcraft and heathenism were the overwhelming causes of ill-health.

[1] Please note that this is a draft in progress: most of the footnotes are still in the format of my personal archival coding so will be unintelligible!
[2] The Fifty-Sixth Annual Report of the Missionary Society of the Methodist Church of South Africa, January 1938.
[3] Lena Turner

Yet such representations stand in stark contrast to the huge upheaval and social change that marked this period. Growth in the mining and industrial centres had brought about rapid industrialisation, whilst the labour migration system became increasingly entrenched and the government's segregationist agendas consolidated (Beinart 2001). Ill-health in the reserves was closely linked to a deteriorating rural economy as malnutrition, TB and other infectious diseases – virtually unknown prior to colonial expansion – became increasingly widespread as well as, in Zululand, the additional burden of malaria (Marks & Andersson 1992). Efforts at salvaging the reserves through the 'betterment' scheme largely failed, yet created increasing political tensions between peasants and chiefs (Evans 1997: 201). By the mid-1940s maize production was at a minimum, and agricultural instability was compounded by periodic draughts and floods. Meanwhile, increasing political pressure and the need for a sustained workforce compelled the government to turn its attention to the scale of African ill-health. In rural areas, the government turned its attention to a network of mission hospitals to address health needs. Thus when Bethesda was established, it was immediately incorporated into a wider political economy of health care provision.

Bethesda emerged in the context of an already well-established field of missions in which several denominations were active. Methodists began their missionary work in the area at the turn of the twentieth-century (Whiteside 1906: 397), and medical work several years later with a small clinic based at the Threlfall mission in Kosi Bay in 1930, followed by Bethesda in 1937 and Manguzi in 1947 (Gelfand 1984: 25). This chapter includes, where relevant, a discussion of Manguzi Hospital, due to its close relationship with Bethesda Hospital throughout the period of mission control. Both were controlled by the board of the Zululand and Maputaland Mission of the Methodist Church of South Africa, and later in 1970 formed two hospital boards independent from the wider mission but integrated with each other through shared meetings and many members sitting on both boards.[4] Other missions were involved in medical work in this area at around the same time, most notably Mseleni hospital, began in 1914 by the South African General Mission (ibid.: 218), Mosvold Mission Hospital in 1936 by the Scandinavian Alliance Mission, a branch of the Lutheran group (ibid.: 206), and Hlabisa Lutheran Hospital, began as a dispensary in 1923 (ibid.: 133). Mission activity in the area was, overall, prolific. By the mid-1970s, Helen Sweet notes, 'Natal and Zululand together had the highest concentration of mission hospitals in South Africa' (Sweet: 13).

From 1970 onwards, the government took over the running of all the mission hospitals in this region. Bethesda was taken over in 1982 and was handed over to the control of the government of the KwaZulu 'homeland'. This chapter deals, therefore, with the period of Bethesda Hospital's existence under mission control drawing primarily on hospital reports and the minutes of board meetings, in addition to some written and oral accounts. I describe how this small mission hospital, set up by the Methodist Church of South Africa and thus with a very specific set of ideas about its

[4] E151

purpose and aims, was quickly drawn into a wider apartheid system of health care and labour control that was increasingly incompatible with the missionary vision of health care. Yet, in the hospital's final years under Methodist control, missionaries drew on a broader, international shift of rhetoric towards that of primary health care, enabling a reinvigoration of the original aims and ideologies of the mission, even as imminent take-over loomed large. This account, therefore, describes a complex and changing micro-struggle for power over a single hospital in the context of a wider political economy of health care, and the effects of this struggle on service delivery in the area now known as the Umkhanyakude district of northern KwaZulu-Natal.

The Setting Up of Bethesda Hospital

When Robert Turner began his medical work in Ubombo in 1937, his wife Lena, herself a trained nurse, was his only assistant. They soon employed an African nurse who had previously trained at McCord Mission Hospital in Durban who, comments Lena Turner in her short unpublished bibliography, 'proved to be a great help'. During the initial years treatment was often basic and makeshift. Lena Turner describes the preparation for their first operation, a Caesarean, that took place in the new operating theatre:

> Instruments were boiled on our stove in a fish kettle, cottonwool swabs and gauze were sterilised in a brown paper bag in the oven for twenty minutes. Ordinary surgical catgut was available but not twenty-one day catgut known to us for internal stitching. So what to use? Remembering that a purse string suture in silk was used to tie off an appendix stump why not to sew up the uterus? The work basket produced necessary silk thread which was boiled up and the scene was set to commence our first operation.

By 1940, the hospital consisted of one 14-bed ward, 3 rondavels, 6 cubicles, an operating theatre and the doctor's house (Gelfand: 1984: 214). Bethesda was opened officially on 4th July, 1940 with a 'Service of Dedication' carried out by Rev. Wilkinson, President of the Methodist Conference, and an opening ceremony performed by Mr H.C. Lugg, the Chief Native Commissioner who, during his speech, expressed 'the deep and practical interest of his Department in the plans of the Church for medical missionary work'.[5] As this quote suggests, the presence of Mr Lugg was not simply ceremonial, but marked the beginning of a close involvement of the government with Bethesda Hospital, a relationship which was to prove both financially necessary yet increasingly fraught.

Dr and Mrs Turner soon sought more help and by June 1941, had five 'local girls' in training. Turner wrote in his annual report that 'they are shaping well, and take a keen interest in their work, both medical and spiritual'.[6] The Native Affairs Department assisted this aspect of the hospital's

[5] Reported by A.W. Cragg, Missionary Secretary of the Zululand Mission in 'The fifty-ninth Annual Report of the Missionary Society of the Methodist Church of South Africa'.
[6] B10

work, contributing £300 towards the cost of the nurses' home. Robert and Lena Turner left Bethesda in 1st January 1944 in order to find appropriate schooling for their daughter Sheila, and moved to Amanzimtoti near Durban, setting up a private medical practice there. They were replaced by Dr Farren, his wife and four children who were to see the hospital through several years of growth, before their own departure in 1953, followed by the return of Robert and Lena Turner for a further 17 years. These long periods of medical work are testimony to a level of commitment on the part of missionary nurses and doctors that, as mission staff themselves predicted prior to the take-over years later, would become extremely rare under government control. Indeed, these lengthy durations that doctors stayed during this earlier period in Bethesda's history contrast significantly with the rapid turnover currently experienced. The contrast is less severe with nurses, several of whom began their training at Bethesda under missionary leadership during the 1970s and are still working there now. They provide a level of consistency, stability and knowledge that helps to reduce the negative effects of high-turnover of other clinical, managerial and administrative staff.

Whilst the government paid an increasing proportion of the hospital's costs, the church was a major source of income throughout. Groups associated with the Church, such as the Women's Auxiliary and the Durban Men's League, as well as a large number of individuals, contributed through donations of money and other items during these initial years. Fundraising pamphlets produced by the Missionary Department of the Methodist Church reveal most clearly the central themes and ideologies upon which the hospital and its board drew in order to appeal to a wide conglomerate of church members and associates. They contain short accounts of incidents both of the hospital's struggles – mainly caused by 'superstition', 'witch doctors' and child 'neglect' – as well as its successes:

> A call came one day, from a very large heathen area, asking the Doctor to see a man who was far too ill to travel. On arrival it was found that the man had had pneumonia for five or six days… He was removed to hospital and for days this man's life hung in the balance, but eventually he pulled through and was ready for discharge. He was a very wealthy and influential man, but, like all men in his area, a heathen. A couple of days before his discharge, however, he announced that he had been raised to lead a new life. He is now carrying out his statement in word and in deed; he has cut away from all that belongs to heathenism, and by way of life, by word, and by act, is witnessing to the power of the Great Physician of Souls.[7]

Such accounts, triumphalist and wildly optimistic in their proclamations of divine Christian providence, continued throughout the decades of missionary leadership at Bethesda, not only appealing to a wider sphere of potential support and donors, but driving intensely the motivations of missionary doctors and nurses. A doctor wrote years later in 1973:

> We are thrilled to report that recently a number of men have responded to the claim of our Lord on their allegiance. The smile on a young T.B. Patient's face exemplifies the

[7] 'Is It Nothing To You?'

> change He brings to a distraught, demon possessed, confused mind after personal prayer and the laying on of hands.[8]

Christianity played an important role in the structuring of day-to-day activities at the hospital. Nurses were expected to attend morning and evening prayer sessions on the wards, as well as regular hospital-wide services. In the later years, bible groups called Hospital Christian Fellowship were encouraged. Oral accounts of some of the older nurses still working at Bethesda give a sense of how such practices took place, at least in the later years of the 1970s during the period that Dr Hackland was Medical Superintendent. Some recalled how their Christian faith was closely integrated with their work: 'During the relax hours, we would sometimes take a bible and sit with the patients and read to them. If they were very ill, we would call the minister for the sacrament.'[9] Nurses described how regular prayers and events taking place at Christmas and Easter generated a strong sense of community that was not just to do with working: 'Before, the hospital was like a family. During Christmas we would have big parties with everyone included. At Easter, we would even go to Dr Hackland's house, there by the gate, and have morning tea in his garden'. Such recollections were raised in conversation frequently during fieldwork, acting as a frame of reference to understand contemporary experiences of Bethesda. In the next chapter I explore the sense of loss and deterioration, both within the nursing profession, and at Bethesda specifically, in which memories of the past play significantly into such perceptions.

Although, when the hospital was first set up in 1937, the motivations for the missionaries' involvement in the provision of health care differed substantially from those of the government, mission ideology nevertheless seemed to fit quite comfortably with the paternalistic attitude embodied by the Department of Native Affairs (DNA) prior to 1948. At this stage, Ivan Evans explains, the DNA 'viewed itself, and was perceived by an appreciable number of Africans in the reserves, as safeguarding their interests in a rapidly transforming world' (Evans 1997: 163). Thus both the missionaries and the DNA shared an attitude of 'benevolent paternalism', united – at least in rhetoric – by a shared desire to assist Africans' wellbeing in the reserves. In a context, however, of rapid deterioration of agriculture, livelihood and health, alongside increasing rural resistance, tensions between the hospital and government increased. In the next section, I focus on this changing relationship and examine the hostility that developed as the state's involvement became increasingly felt.

A dubious dependence: the relationship between mission and state at Bethesda

Whilst mission activity as a whole may have peaked during the late nineteenth century, mission medicine saw its heyday in the decades following the second world war. Mission and state

[8] E345
[9] Interview 17/07/07

medicine therefore developed side by side, and the state incorporated the network of mission hospitals within its wider plans for health care delivery in South Africa. Thus in the case of Bethesda, along with many other mission hospitals, a significant proportion of funding came from the South African government from its inception. The extent of this financial support is reflected in a published report by the mission in June 1948, speaking about the first decade of medical care at Bethesda: 'Most of this expansion has been made possible by the generous help of the Native Affairs Department of the Union Government indeed, the hospital is very largely a child of that Department'.[10] This somewhat deferential statement, however, disguised an antagonism – revealed in the minutes of the hospital board's quarterly meetings – that was growing between the hospital and the department.

In this section, I discuss three characteristics of the government's involvement that influenced its ambivalent and often frustrated relationship with the Methodist mission. First, the erratic and often unreliable provision of funding. Secondly, the government's increasing attempts at controlling and shaping the health system through legislative restrictions and demands. Finally, the confusions arising from an ambiguous and shifting delineation of responsibility between different and independent government institutions. I will argue that all three are symptoms both of a disorganised bureaucratic machinery and an often inconsistent attempt to juggle various and conflicting political pressures.

At the outset, the hospital was largely funded by the Methodist Church; the important financial resource that the state would quickly come to embody was not initially realised. Thus, in 1941, just after the hospital's opening, 'the Committee learnt with pleasure that the Native Affairs Department had made a grant of £300 towards the cost of a Nurses' Home'.[11] In addition, the Public Health Department began providing a regular grant for the treatment of infectious cases.[12] Throughout the 1940s, with increasing reliance on state funding, the hospital grew, gradually yet steadily. The total number of patient days, for example, rose from 2833 between June 1940 and June 1941, to 17,565 between June 1947 and June 1948.

On 25th April 1944, Mr Hosking of the Provincial Council visited the Zululand Mission Committee meeting which was held in the Wesley Hall in Durban. His statement to the Committee was summarised in the minutes as follows:

> …he wished to discover, on behalf of the Provincial Executive, the extent of our medical work in Zululand. He thought the Native Affairs Department had been generous. There was a new outlook in the Provincial Council toward hospitalisation. They intended to develop rural hospitals. It was the desire of Dr. Stevenson to set up a hospital in every rural area and further, to develop the programme of Clinics. The Church had been too modest in making known the nature and extent of its works and

[10] 'Reports and Statement for the Year 1948'
[11] C3
[12] B20

> in appealing for public grants from their supporters. In the future, grants would be considered and given on the basis of services rendered. Competition in mission hospitals in the same rural areas would be discouraged. It would be desirable that each Church and missionary society should concentrate on its own sphere of work and for effective services under these conditions he was sure that substantial grants would be given.[13]

This was an important moment that expressed a shift in government thinking about its role in rural health care provision, whether or not such aspirations were, in practice, to be met. Mr Hosking conveyed the government's desire to make a break with the past by shifting authority from the Department of Native Affairs to the Provincial Administration, and in doing so, to instigate a more rigorous and centralised approach to health care delivery which inevitably would entail greater overseeing of medical missionary work. This was a promise not only of more funds but also constituted a warning of greater state involvement expressed explicitly through a caution that, in future, financial assistance would be dependent upon certain conditions being met. These conditions indeed became more rigorous and standardised, such as the grading system for hospitals that determined how much money they received.

As forecasted in Mr Hosking's speech, three years later in 1947 the Provincial administration took over from the DNA the role of hospital subsidising. That year, grants were delayed by nine months whilst the Provincial Administration established its new policies pertaining to mission hospital funding, and when it finally arrived, was based on the same scale as the DNA grants of the previous year, so the hospital failed to benefit from the usual increase. The Medical Superintendent, Dr J. Farren, stated in a report at this time:

> 'At present, income just about balances expenditure, but there is no leeway to meet the rising costs and necessary expenses. As a Hospital becomes more efficient so does its expenditure, but there is much smaller increase in income.
> There is no doubt that the hospital is expanding, and if developments planned by the Railways and the Government in the area do materialise, we shall be called upon to double our size within a year.'[14]

Such a statement was one of a number that together expressed an increasing sense that the hospital's financial costs were – and should be – the government's responsibility. A year later in 1948, Dr. Farren reported: 'The Province has decided to give us an annual grant of £700. This is an advance of only £100 on what we received last year from both N.A.D. and Province – in spite of the growth of the work.' The committee supported him by stating that this amount was 'far from adequate to successfully run the Hospital and cater for the needs of the people'.[15]

The 1940s, therefore, was a period of reluctant and partial acceptance of responsibility by the state and an increasing realisation by the mission that they were in a position to make demands. With

[13] C23
[14] C60
[15] C63

this acknowledged on both sides, the power implied in the earlier address given by Hosking – who at that stage was able to represent the state simply as a generous benefactor – was beginning to shift and to balance out, as the mission came to realise it was filling a welfare gap for which the state should really be providing. The relationship was one of mutual benefit, therefore, but one that was becoming increasingly fraught by the government's delayed and insufficient payments.

These sentiments were eventually stated directly in a hospital memorandum written by Dr Farren in response to a Provincial Hospitals Commission in 1951. The memorandum laid out the main resource shortages suffered by the hospital and possible suggestions for how these might be relieved, including a rough breakdown of expenditure and a recommended grant to cover these basic costs. It also outlined the overall benefits of Mission Hospitals including the willingness of staff to work in remote areas:

> By virtue of their missionary staff, they are supplying hospital services in areas where it would be impossible to place Provincial Hospitals, and therefore relieve the pressure on beds in the Central Hospitals. They also serve to limit the spread of infectious disease by treating patients before they travel far in search of aid.[16]

Whether intentionally or not, this statement played into wider themes that were a source of considerable concern to the state at that time. Firstly, the control of infectious disease was a huge preoccupation, particularly given the rapid urbanisation of industrial areas, and influenced considerably state policy on health reform for much of the twentieth-century (Marks & Andersson 1992). The government's subsidising of the treatment specifically of infectious diseases at Bethesda and other rural hospitals, for example, was evidence of its strategic, rather than overall, interest in the health and well-being of the African population. Secondly – and closely related to the first – were the myriad strategies in place to control the movement of people in the pursuit of segregationist aims of apartheid, which in the 1950s and 60s became much more regimented. As Price argued, state support of such hospitals had much to do with 'controlling the movement of "surplus" Africans out of the Bantustans to the cities' by providing basic services in the Bantustans (Price 1986: 168).

In Farren's final point regarding the advantages to the state of mission hospitals, he writes:

> In the past Mission Hospitals have taken a considerable burden off the shoulders of the tax-payer. Their running costs are much lower than those of Provincial hospitals, owing partly to their missionary staff, and partly to the help given them by their Missions. The moral responsibility for hospital services having been looked upon more favourably by the public and having been accepted in principle by the Provincial Administration it is obvious that Missionary bodies should now be relieved of the financial burden of providing the considerable services they have done in the past. In particular capital expenditure must be met by the Provincial Administration.[17]

[16] B53
[17] Ibid.

Unusually candid, this statement made perfectly clear the mission's attitude towards funding. This illustrates once again that since the initial reception of a government grant in 1941, the language used by mission doctors and board members had shifted from one of pleasant surprise and grateful acceptance, to one increasingly characterised by entitlement and demand. This confidence on the part of the mission was undoubtedly spurred by a wider groundswell of political resistance in South Africa as a whole. During the 1940s, African nationalism had taken hold and the ANC adopted a more cohesive, rights-based discourse such that previously localised problems and struggles became 'transmuted into a broad social vision encompassing basic economic reforms, land redistribution, and the provision of health and education services on the basis of need' (Dubow 2005: 3). Internationally, concepts of 'democracy' and 'citizenship' were taking shape, giving ideological weight to emerging demands for social entitlements (ibid.: 14). Many of the high hopes for progressive change emerging during this period were, however, disappointed following the change of government in 1948 and the emergence of a more severe and oppressive apartheid regime. The temperament of hospital reports seems largely to follow the contours of this much wider national discourse. For in the following two decades, the government appeared to assert increasing control yet without meeting the growing needs of the hospital.

A lack of archival data for the duration of the 1950s prevents me from knowing in any detail how the situation progressed. It seems that government grants increased, but generally not enough to meet the growth of the hospital. Therefore, deficits continued to be a problem. By 1963, the needs of Bethesda had become dire, and the prospect of closure was voiced.[18] In 1965, government grants increased to meet 90% of the hospital's running costs[19], although staff shortages persisted. In 1969, due to a failure of the hospital to employ a second doctor, the hospital was re-graded to Grade C, which meant that grants were once again reduced.

A very similar state of affairs existed at Manguzi Hospital. Its report of 1974 raised one of the central difficulties:

> All the mission hospitals are having difficulty with multiplicity of authority. The hospitals are run by mission staff under a mission hospital board, financed for running and capital costs by the Department of Bantu Administration through the Department of Health. In many areas the Homeland Government too is playing a significant role. Thus most mission hospitals have to deal with four different and independent authorities. A very difficult situation for all concerned.[20]

This statement summarised a theme that had emerged strongly over the years of mission control at both Manguzi and Bethesda Hospitals, that fluctuation of responsibility between different departments further stalled access to financial resources by both hospitals. This was the case particularly following the Bantu Self-Government Act of 1959 that began to consolidate separate

[18] D123
[19] E21
[20] E322

administrative structures within the homelands to which the government increasingly attempted to transfer control of industry and welfare in these areas. A report from 1970 states:

> When we ask for funds and permission to develop, the repeated cry of the Government Departments concerned is that they wish to plan Far Northern Zululand as a whole… and are not prepared to make any expensive decisions until this has been done. It is frustrating to see present opportunities being lost and development stunted…[21]

The situation escalated in the 1970s, partly a result of the fact that as apartheid became increasingly subject to political criticism and pressure, the government took quicker strides in pushing through its plans for independent 'homelands'. This led to crippling inefficiencies in the system of hospital funding. In 1972 the Bethesda hospital board appointed a committee to investigate the 'deadlock' that had emerged over the provision of grants between the Provincial Administration and the Departments of Bantu Administration and Development and of Health. [22] Likewise at Manguzi the previous year, the board minutes describe a situation of 'utter confusion' as none of the various authorities appeared to be including provision for the hospital within their budgets.[23] Despite repeated appeals for clarification, as well as for further grants to meet the hospitals' growing costs, the confusions and delays continued until eventual take-over in 1982. It is clear that in seeking to establish the legitimacy of the Bantustan authorities by transferring the institutions of welfare to their control, considerable and often debilitating inefficiencies resulted, supporting Price's claim that 'the political priorities of "independence"… over-ruled the interest in improved health care' whilst at the same time, 'allow[ed] the White government to deny responsibility for both ill health and poor services' (Price 1986: 165-6).

The increasing political control of the state over Bethesda Hospital took place gradually since its inception, yet as I have shown, this was rarely met with sufficient funds. On the contrary, financial accountability was even evaded by devolving responsibility onto the less specialised Department of Bantu Affairs and later the KwaZulu department of health even though, as Digby points out, this was 'a particularly blatant omission given that the department continued to resource Bantustan health budgets' (Digby 1996: 423). Such a gap between the rhetoric of rural health care and its effective practice was significant, for it indicated that the state was forced to respond to increasing political pressure, but lacked the genuine political will to solve the problem of ill-health in rural areas.

Thus whilst the government attempted to assert increasing control over the hospital, such inefficiencies significantly undermined its efforts. Another challenge to state authority operated at the ideological level, for whilst as I suggested in the previous section, the Methodist mission's vision for health care initially sat comfortably with that of the DNA, the increasingly harsh and

[21] E155
[22] E249
[23] E196

oppressive apartheid system became drastically at odds with the 'liberal' attitude of the missionaries.

Mission Culture and Emerging Dissent

Shula Marks observed that in the 1940s and 50s in South Africa, 'the regimentation of the nursing hierarchy was formidable' (Marks 1994: 103). Bethesda was no exception. The relationship between doctors, nurses and patients, and between white and black nurses, is one of the clearest manifestations of wider political and cultural discourses on the hospital and the attitudes of its staff. In the ongoing attempts of the hospital board to recruit white missionary nurses, for example, Dr Farren – medical superintendent between 1944 and 1953 – wrote in a letter to Miss Evard, a sister then working at King Edward Hospital in Durban in 1952: 'Although our patients are primitive, they are a cheerful lot. You would find an absorbing interest in the training and "mothering" of the nurses.'[24]

White Sisters' attitudes towards, and treatment of, their students did indeed appear – as Farren's letter suggested – to resemble a style "mothering" towards children, characterised by strict disciplining and safeguarding. One nurse, now a senior matron at Bethesda, recalled with amusement her memories of a male nursing tutor, Mr Oram, who worked at Bethesda between 1965 and 1979 and who – I discovered through various conversations and rumours – had gained rather a reputation for his strict approach:

> I can tell you my story. I was with a friend and we were in the kitchen. We were there because we were expected to make coco for patients sometimes. While we were doing that, we were talking in Zulu. We were not allowed to speak Zulu at all during shift time. While we were speaking to each other, Mr Oram caught us and said, "Go to my office". In his office, we pleaded with him that the shift is over. He said, "You are still wearing your uniform. Therefore the shift is not over!" He gave me the punishment that from 7 until 8 every morning, I had to go to laundry and be assigned a different task each day. This lasted for a whole month! Just for speaking Zulu! He would give all sorts of punishments; working with your cap off, working with your shoes off, washing the walls.. and always for one month. The punishment always lasted that long. It was so cold to be working with no shoes![25]

Another nurse told me, initially with a serious tone, yet gradually turning to laughter:

> When you did funny things, they treated you like children. But we were adults… I remember one time when Mr Oram locked me in the linen room, I had to stay there for hours. I couldn't eat anything. When I wanted water, I had to knock loudly on the door and wait for someone to come.[26]

[24] D101
[25] Interview: 20/09/2007
[26] 17/08/2007

Lena Turner was described as a committed and hard working nurse and teacher. She was also allegedly extremely strict with the junior nurses and students. Her own description of her experiences at Bethesda dedicate several pages to describing light-heartedly the behaviour of nurses – what she describes as their "cheek and insubordination" – and her own response to this. Some of these incorporated somewhat crude racial or gendered narratives:

> Amongst the nurses there were tribal fights in the dormitories. Revenge was prevalent, and it became evident that it would be wiser to employ Zulu girls only. There was a strong spirit of rivalry between girls of a different tribe. On one occasion a Xkoza [sic.] girl broke into the box room and slashed all the dresses of a Zulu girl because of a small demeanour. Another Swazi girl had to be shut up in a room as she threatened to beat up another nurse with a heavy metal instrument. So never a dull moment'.[27]

After discovering that one nurse had given birth during the night without them realising, Lena stoically told her husband: "Well she can stay there [in the side room] and have no visitors. Otherwise the others will think she is very clever". Nurses were repeatedly penalised and sometimes dismissed for leaving the premises without permission, for trying to pursue romantic relationships and, on one occasion at Manguzi Hospital, for assisting a friend with an abortion.[28] Such concerns reflected a wider unease. As Marks describes, 'the virginity of young African girls was a recurrent preoccupation of missionaries, administrators and Christian Africans in twentieth-century South Africa' (Marks1994: 104). To be a nurse meant also to lead a respectable, Christian lifestyle. Thus discipline of this kind was an integral feature of nurse training.

Mr Oram's autobiography describes his strict and formal training in England, an account replete with jovial tales of his own misdemeanours as a young trainee in 'a profession dominated by female battle axes' (pg21). His stories of becoming a professional nurse evoke the experience of passing from childhood to adulthood, implicitly reaffirming the hierarchical status between students and their tutors. In South Africa, though, this took on a racial dimension. He writes: 'The black nurse has a different attitude to life than that of her white colleague but her skill has blossomed out with a higher standard of training' (pg38). Here, an implicit explanation of 'cultural difference' is drawn upon to define degrees of ability, signified by membership to different racial groups, that only a strict and formal nurse training can iron out.

Yet at other times, evident in reports that he wrote to the hospital board on behalf of the nursing services, Oram displayed a sharp awareness of the social and educational inequities that placed African nurses at a disadvantage. In a report written in June 1970, he recorded that 12 of 13 nurses had recently passed their examinations compared to a national average of 59%, a success he attributed to the quality of teaching at Bethesda. In his typically crass yet serious style, he continued:

[27] Lena Turner pg. 38.
[28] E20

> This prompts me to comment on the low standard of education resulting from the Bantu Education Act. The general knowledge of the African has deteriorated rapidly since the introduction of the present system in 1955. At the present time nurses with a Junior Certificate cannot calculate the simplest subtraction or multiplication without using the palms of their hands as a slate! Their general knowledge is less than a Std. IV white scholar. They have told me that their teachers instruct them when calculating in fractions to work to the nearest half! When coming here they are unable to express themselves in simple English.
> In the realm of education "divide and rule" has brought all it was designed for. This education system is an indelible blot in the history of a so-called Christian country. We as Christians must resist this insidious lowering of the education of the largest portion of the population.[29]

Oram's statement, devoid of the formality and equanimity of other entries in the hospital's reports and minutes, provides a window into a more subversive commentary that was perhaps more frequently spoken about rather than written down.

In the 1970s, then, an incongruity between the position of the hospital and the ideologies and bureaucratic applications of apartheid increased. This became apparent particularly over disputes relating to administrative and salary structures. For example, in 1977, following the demotion by the state of the hospital administrator, Mr Ryan, to the position of Coloured Assistant Clerk at 1/5 of his previous salary, the hospital protested in writing with a full motivation and managed to evade the strictures of the government's discriminatory policies by meeting the salary difference using the donation account of the church. Thus they rejected the policy, yet in a manner to which the government could not object.[30] In other instances, it is clear that the government's racial policies inhibited the work of the hospital. A statement from committee minutes dating 23rd August 1968 read:

> Dr Turner had made enquiries of the Nursing Council concerning the possible appointment of an African Matron.[31] The Council replied that it was policy to employ Bantu as much as possible for the nursing of Bantu patients, but no White person could be employed under the control of anyone other than a White person. Dr Turner reported that after much thought, he could not see any way to fulfil this regulation without impairing the efficiency of the Hospital.

In 1977, the hospitals were told 'quite emphatically' by the president of the Nursing Council that this regulation no longer existed.[32] The many years of trying to enforce apartheid segregation within the nursing profession had eventually become unsustainable, due partly to increasing political pressure that developed throughout the 1970s, yet even more so, because of the huge, nationwide shortage of nurses that ultimately necessitated the recruitment of black nurses to all levels of the profession (Marks 1994: 189).

[29] E143
[30] E458
[31] 'Matron' is the most senior nursing position.
[32] E490

Another indication of the shift towards a more liberal approach at the hospital was the attempts by Dr Hackland to challenge some of the most crude manifestations of a taken-for-granted hospital hierarchy. During an interview, Priscilla and Daryl Hackland described aspects of hospital life under the Turners that they were eager to do away with quickly. 'Things were organised in a very old fashioned way that fell in line, in some ways, with apartheid', Priscilla said. 'During meetings, all the whites would sit separately down the side of the hall. That had to change. We got rid of that straight away'. They wanted to avoid the prior system as they saw it, in which 'authority was very much in the hands of the superiors'. Over time, they tried to introduce a system of 'participative management' by, for example, holding open staff meetings on a weekly basis. Whilst it took a long time for people to get used to a new way of doing things, they felt that they were largely successful. Thus, whilst a rigid nursing and medical hierarchy persisted at Bethesda as it did in South Africa at large, Daryl and Priscilla Hackland did, in certain important ways, challenge the assumption of white superiority that was often, even amongst the more 'liberal' ilk of mission doctors and nurses, 'both commonplace and commonsense' (Marks 1996: 147).

Apartheid ideology, therefore, became increasingly at odds with the missionaries who began to challenge explicitly its overt racial discrimination. Ironically this subversive commentary at Bethesda ran alongside the persistence of a dogmatic Christianizing of 'heathen' patients that carried its own profound and deep-seated race assumptions. I turn now to a more detailed consideration of the last decade of mission control prior to take-over in 1982 to demonstrate the ways in which the mission reasserted its own vision of health care in the face of increasing state encroachment and imminent take-over.

'A whole-man type of ministry': the renewal of community health amidst impending take-over

In the years leading up to Daryl Hackland's arrival in 1970, hospital reports suggest that Turner had become tired and frustrated with the hospital's ongoing financial difficulties and with the ever increasing encroachment of the state on hospital affairs. He emphatically states at one point, 'Bethesda was begun as a MISSION hospital, and we are still seeking to make that title real.'[33] Such sentiments were compounded by, perhaps also helped to produce, a feeling of inertia with regard to the spiritual work of the hospital, that was expressed repeatedly through complaints to the board about the lack of a hospital evangelist.

When Daryl Hackland and his wife, Priscilla, arrived – free of the burden of years of frustration and hard work – they seemed to bring with them a new lease of life. In Hackland's first report of March 1970, three months after his arrival, he commended Dr and Mrs Turner for having 'served to their

[33] E114

uttermost', and to the staff for facilitating such a smooth cross over. Yet he wasted no time in laying out his own initiatives and the changes he intended to bring about:

> Conscious that we are not only called to preach and to heal but also to teach we have a concern to commence this programme. We have started in a small way with Occupational Therapy work, but this must be extended to include Health and Hygiene programmes at our Clinics and even basic agricultural projects on the 5-6 acres we have available. The problem is we have no clinics – we must start and we require a further vehicle for this purpose.[34]

Thus began a renewed effort to provide medical outreach and an attempt to widen the breadth of the hospital's work, as well as its geographical reach, with a more holistic approach to health care. This reflected the influence of a wider international shift towards primary health care, which was being publicised and encouraged by organisations such as the WHO. During an interview, Hackland recalled in particular the Alma-Ata declaration of 1978 which was particularly influential and provided a model that he and many other frontline health care workers were trying to replicate.[35]

This focus on providing primary health care through clinics also saw a reinvigoration within South Africa specifically of a vision that had been pushed forward years earlier, if never actualised at the time, by parts of the government and health sector. Following the example set in the UK by the Beveridge Report of 1942, 'a radical blueprint for a visionary welfare state' (Digby 2008: 486), and by the increasing political pressure on the government to address the severity of ill health amongst its African population both rural and urban, the government appointed a National Health Services Commission (NHSC) in 1942 headed by Henry Gluckman, who would later become minister of health between 1945 and 1948. The recommendations of the final report were radical. It suggested the creation of an inclusive National Health Service which would serve, racially and geographically, all areas of society. Linked to this was the central proposition of a shift away from a hospital focused, curative treatment, to an emphasis on preventative care that would be provided through smaller, local clinics and health centres. Gluckman stated it thus: 'our job is to formulate a plan where hospitals would be kept empty' (quoted in Digby 2008: 492). Due, in part, to the new political agendas of the National Party after 1948, most of the report's ambitious proposals were never put into practice. To pursue them, some authors argued, would have involved 'a drastic restructuring of the social order… well beyond the white consensus' (Marks & Andersson 1992: 158). Indeed, most of the small number of health centres that had been created in line with the report's suggestions had closed down by the 1960s due to a lack of funds (ibid.: 158). Marks & Andersson argued that the shift in the 1970s towards a primary health care approach represented a revival of the rhetoric of these earlier aims, but they remained sceptical as to whether, as in the 1940s, this rhetoric would actually translate into implementation (ibid.: 160). More recently, Anne Digby has argued

[34] E134
[35] Alma-Ata was an international conference organised by the World Health Organisation in 1978 that defined and set out recommendations for primary health care as a major international goal.

that under the ANC, 'a national health system predicated on an expansion of primary health care (PHC) in decentralised district health authorities' once again bears similarities with Gluckman's 1944 report. In this section, I will propose that the work of nurses and doctors under the mission's lead in the 1970s laid the infrastructural foundation for the current primary health care network in this district.

In northern KwaZulu Natal, many of the clinics currently in operation, in addition to the main hospitals, were set up by missionaries. Helen Sweet highlights the role of nurses in particular who established outreach clinics in remote areas during the 1930s and 40s at the same time that missionary hospitals were being formed, arguing that this was 'the most significant development' of the time (pg 21). The need for outreach was identified and pursued by missionaries therefore, albeit with very minimal means, from an early stage. Likewise the first medical missionary of the Methodist Church in the region was a nurse called Hanchen Prozesky, who worked alone and allegedly travelled by horseback and on foot to visit people in various parts of the district. She worked at the Kosi Bay clinic of the Threlfall mission, set up by the Methodist Church of South Africa in 1917, and retired many years later in 1940.[36] When Robert Turner began his work in 1939, he visited Kosi Bay amongst other locations on a regular basis. For the twelve months ending in June 1941, a total of 449 patients were seen by Turner on a monthly tour 'embracing a large part of the Ubombo district'. This compared to 129 inpatients and 816 outpatients treated at Bethesda during the same period, so constituted a sizeable portion of Turner's work.[37] Nevertheless, he met with various obstacles that prevented him from setting up permanent clinics able to function in his absence:

> Endemic malaria is present in by far the greater part of the district. While clinics should ever be kept before us as an ideal, it will take many years before much can be developed. Local girls, accustomed to malaria, are not yet at a stage when, after passing Std. V or VI, they are prepared to spend several years getting a nurse's training. Matrimony fills their horizon! To send "high veld" girls down means trouble with malaria.[38]

Nevertheless, in 1943, Kosi Bay clinic moved to a new site which had been granted by the Native Affairs Department, along with a further incentive of £500, to set up a larger clinic called Manguzi which was to become a separate hospital. According to the minutes of a meeting of the Zululand mission in 1946, Dr Gluckman himself – by now the minister of health – commended Manguzi clinic and made it clear that 'his whole-hearted support and enthusiasm…would be forthcoming'.[39] This emphasis shifted fundamentally, however, after 1948 – the year in which Gluckman finished as minister of health and the National Party came to power. Manguzi nevertheless, with the support of the church, developed into a larger hospital under the work of a German missionary, Dr Schwalbe, who began there in 1951.

[36] B22
[37] B10
[38] A54
[39] C44

When Dr Hackland began his work at Bethesda in 1970, therefore, he was building on previous attempts to provide care beyond the site of the hospital itself, yet in a much more systematic way. By 1971, Preventative Medicine programmes were in place across the region, including immunisation of adults and school children against Typhoid, immunisation of under 5s, and Health Education. In addition, a Family Health Clinic had been set up at Bethesda, seeing 256 families regularly. Coupled with these initiatives was a greater focus also on 'spiritual out-reach'. Hackland, who was himself a trained minister, initiated 'a definite evangelical preaching programme by Staff of the Hospital to their areas'.[40]

A year later, Hackland reported: 'Clinics continue to gather momentum and emphasis on prevention [is] particularly thrilling'. Signs were also showing that the government was beginning to take a more active role in supporting the clinics. Hackland mentioned one preventative measure by the State Health department, to which Bethesda had recently been accepted. This was the Kwashiorkor Scheme that involved free provision of subsidised milk powder.[41] By 1973, the hospital was applying to take part in the government's Comprehensive Medical Care Scheme and District Clinics. On 1st May 1973, it was agreed during a meeting that the State Health department would fund an additional doctor's post at Bethesda to make the scheme feasible. This was granted and the necessary funds for the scheme paid to the hospital later that year.

Although Comprehensive Medical Care was a government initiative, there were still difficulties with the financing of the scheme, and it rarely seemed to be prioritised by government. During the following few years, funding for the clinics was sometimes forthcoming and at other times delayed or not given at all. Once again, there appeared a dissonance between professed intentions and effective implementation. Part of this was to do with the confusion around whether accountability lay with the central State Health department or the KwaZulu government. For the state had now begun the process of trying to pass responsibility for health care provision and financing over to the KwaZulu 'homeland' government, as I described in the previous section. At Manguzi Hospital, a report from November 1976 identified the need for more clinics as urgent, and this frustration was compounded by the fact that the KwaZulu government had not so far carried through: 'Permanent clinics run by Kwa Zulu Government show no signs of being established though talking has been going on for years'.[42] Likewise, at Bethesda during the same year, plans for a clinic in Madonela were stalled by the central government's continued negotiations with Kwa Zulu: 'The state is at present holding discussion with the Executive Council of Kwa Zulu re a clearly defined policy.'[43]

[40] E179
[41] E190 Kwashiorkor is a disease associated with protein-energy malnutrition.
[42] E443
[43] E406

Meanwhile, both hospitals continued – within their limited means – to provide outreach, and it is clear that over the course of the decade, this aspect of their work became prioritised by the mission staff themselves as a focus of exciting and innovative change and expansion motivated by an increasingly popular notion within the international medical and nursing professions of holistic, community medicine. In 1977, Bethesda Hospital's outreach work was grouped together under the title 'Go Ye in Christ' and incorporated clinics, immunisation schemes, agricultural projects, health education, a soup kitchen, literacy support at the mission, and evangelising. The new title re-emphasised Christian faith as the driving motivation behind all these initiatives. The hospital report of March 1978 exclaimed:

> 'Go Ye in Christ' 1978 was worked out, and is at present being implemented. The thrilling moments have been to see Jesus preparing ahead of us each step of the way, one jump ahead of us. This has confirmed the reality of His guidance and His tender loving care.[44]

Thus health education was delivered alongside bible study, as in a five day residential course for mothers.[45] Later that year, a further step was taken towards systematising and standardising the community health structure when formal nurse training, leading to a Bethesda Diploma of Primary Health Care, commenced. A meeting with KwaZulu confirmed that a Primary Health Care course would soon receive official recognition.[46]

Whilst it is unsurprising that a mission hospital would use biblical references in the naming of its projects, I suggest that the reassertion of religious language by mission nurses and doctors during this period is revealing in two ways. Firstly, and a point to which I shall return, the use of missionary language – particularly in the naming of projects and official discourse – expressed an attempt to counteract the increasing intrusions of the state. This was most explicit, for example, in the following justification for a constitutional change at Manguzi hospital in 1971: 'It was proposed at the Medical Superintendent's Meeting that in view of increasing Government pressure and identification with the hospitals the name of this hospital be changed to "Manguzi Methodist Mission Hospital".'[47] Words seemed, at times, to carry a symbolic agency, formally reasserting ownership in the face of increasing threat.

Secondly, the archival data repeatedly illustrates an integration of the missionary language of spiritual salvation with that of 'Community Health' and the tropes of an emerging, international field of primary health care. Both of these missionary and medical paradigms rejected the role of health care as a service purely to cure disease, and viewed medical treatment in a wider social and educational context that valued a more holistic understanding of health and personhood. So whilst one was rooted in a religious outlook and the other, in a social and policy-driven paradigm,

[44] E524
[45] E545
[46] E557
[47] E182

nonetheless these similarities – and their shared rejection of a narrow curative approach to medicine – made them compatible. The widespread shift towards a primary health care approach enabled a rejuvenation of missionary ideology through a synthesis of these two ways of thinking:

> The Manguzi Community Programme is one of the ways in which this new concept of Community Health has found practical expression. It aims to provide those components of a *whole-man type of ministry* not fully catered for, at this stage, by Government Health Services'.[48] (my italics)

This synthesis was not only semantic but achieved practically through the activities themselves, of going forth to communities, implied in Bethesda's title of 'Go Ye'; of taking the religious message into people's home, thus evoking the journeying that was central to the missionizing process. The Bethesda Report of December 1977 states:

> Two Health Educators joined our staff from the 3rd of January and this has assisted in a more indepth approach to Preventative Health. Mr. Mhlanga has taken over immunisations, Tuberculosis and school work, and is involved in teaching in the wards, O.P.D. and Clinics. He will penetrate into the individual Kraals and as a committed Christian is happy to be involved with personal and Christian councelling [sic.]… School soup kitchens run by "School Health Evangelists" with World Vision's help with salaries is also a possibility'.[49]

A strong sense prevailed that God's 'calling' was fulfilled, in particular, through outreach work, as in the following quote from a Bethesda report of August 1980:

> We believe that those involved with this aspect of our work are being called by God to support actively on outreach programme. Many lives recently have been touched by the Work and been lead by the Spirit into commitment.[50]

At, Manguzi, nurses and doctors were pursuing similar programmes, despite the KwaZulu Health department's stalling on the financing of clinics. Dr Draper and Dr Prozesky were responsible for pushing forward many of the initiatives, and in particular, for encouraging 'community involvement' through project committees consisting of local residents rather than hospital staff in order to 'decrease reliance on senior hospital personnel'[51], in addition to the training of lay Community Health Workers. At a meeting of the hospital board in August 1980, Hackland commended Drs Prozesky and Draper for their work which, he pointed out, 'was now well known through the country'.[52] This, indeed, was the case. The Buthelezi Commission report of 1982, for example, drew upon what it called the "Prozesky Model", describing the work of Manguzi as a model for future health care delivery in KwaZulu as part of a wider project of 'Total Community Development':

> There [at Manguzi] community workers are being utilised as educators and as the first line of provision for simple medical services, and the screening of patients for referral to specialist attention. Tied in with the provision of primary health care is the provision of safe water, and the hygienic disposal of human and other wastes. This in turn links in with the broader issues of community development and rural development.[53]

[48] E581
[49] E519
[50] E643
[51] E582
[52] E637
[53] Pg 420

Yet, as I have explained, during the development of these strategies in the 1970s, they were continually compromised by funding problems, and whilst clinics did receive some financial support, the state's overall prioritising of curative, hospital-based treatment was clear. The examples of Manguzi and Bethesda support an earlier observation of the report of the Buthelezi Commission, that 'whenever there are financial cutbacks… the outlying clinics providing primary health care are first affected, and the hospitals are kept running as far as possible without cutbacks' (pg393). This was particularly evident in the case of the new Manguzi hospital that was developed immediately prior to take-over, which I now briefly describe.

In 1979, R1 million was provided for the development of a new, larger hospital at Manguzi. Three years earlier, when proposals for this were being formulated, the medical superintendent Dr Allwood made known his opinion on the matter:

> I think the establishment of a huge hospital at Maputa is an ill conceived idea. While certain improvements in our present facilities are clearly needed, the present communication problems and fairly small population hardly make this the place for the proposed 300 bed hospital.[54]

A year later he pointed out the unnecessary demands that a new hospital would place upon the staff, and his strong preference for a community-centred approach:

> Our concern is that this [the new hospital] would unnecessarily increase building and running costs. It would also be a drain on manpower and effort once in use. We also felt that it would commit the staff to a more hospital centred medical care. It is generally agreed that in our area a more community centred medical care should be evolved.[55]

Nevertheless, plans went ahead and the hospital was opened formally on 6th October 1979, with Chief Buthelezi delivering an address that attracted a crowd of 2000. Despite the superintendent's earlier apprehension, the new hospital did bring a status, and more importantly, a significant increase in funding, to Manguzi. Thus over the exciting period of its opening, it was largely commented upon positively in hospital reports. From a position in which Bethesda had been the larger and somewhat more financially secure of the two hospitals, it now seemed to be standing in Manguzi's shadow, experiencing 'critical [financial] difficulties'[56] whilst Manguzi was described as 'entering a new chapter'[57]. However, despite the initial large payment for its construction, and the enthusiasm generated by its opening, by December 1980, Manguzi again found itself with a 'huge deficit'. They were receiving a monthly grant of R52,000, a sum falling nearly R30,000 short of the budget.[58]

[54] E443
[55] E489
[56] E607
[57] E605
[58] E644

A year later, in 1981, attentions turned to Bethesda. Dr Hackland reported that the Department of Co-operation and Development had drafted plans to establish a regional hospital of 600 beds at Bethesda. The board received this news with 'great apprehension'[59], stating that it was 'concerned that development totally unsuitable may take place at Bethesda and at all costs wanted to avoid the situation which is now a fait accompli at our sister hospital Manguzi'.[60] The plan for a regional hospital at Bethesda never came to fruition. Nevertheless, such disputes indicated a repeat of the arguments of the 1940s, in which more radical plans for community health came up against the hospital-centred focus of the state. The fact of an imminent take-over heightened the tensions around this debate, because it was unclear both to what extent the government would continue the community work that the mission had begun, and whether the mission itself could continue medical work in the surrounding district without any longer having control over the hospital. Such concerns were reflected, for example, in the push to achieve official recognition for Community Health Workers at this time, as well as a standardised syllabus for primary health care training for nurses.

However, the biggest concern for missionaries at both Bethesda and Manguzi at this time, once government take-over had become inevitable, was a fear of the discontinuation of spiritual 'witness'. This was expressed by a doctor at Manguzi immediately after take-over:

> On a recent visit to a KwaZulu hospital, where the mission had decided to withdraw completely, I was struck by the total change in the place now run by SADF [South African Defence Force] doctors, totally secularized, having major staff problems, I felt a sickness to the depths of my soul to think of Manguzi similarly changed in a few years' time.[61]

Indeed, such concerns took root several years earlier when suggestions of a take-over were beginning to surface. In 1970, staff at both hospitals requested for chapels to be built on the hospital site. This was around the same time – perhaps not coincidentally – that the possibility of a take-over began realistically to be spoken about. Both requests were met promptly and enthusiastically by the Church and the chapels were completed at Bethesda in 1975 and at Manguzi in 1976, perhaps symbolising a reassertion of Christian 'witness' and spiritual presence in a space perceived as dominated increasingly by external and secularizing forces. At Bethesda, a 'Spiritual Affairs Committee' was set up 'to look after the Chapel', also giving a degree of official status to this aspect of the hospital's work.[62]

In 1981, a 'Christian Work Committee' was set up with the aim of furthering the spiritual work of the hospital by drawing on a wider interdenominational group. In the same year a 'Caring Committee' was established at each hospital and several months later combined to form a single Committee overlooking both hospitals. Its main functions were to 'provide spiritual support' to staff, as well as

[59] E663
[60] E687
[61] E695
[62] E407

to assist in seeking Christian doctors and nurses to fill vacant posts.[63] The government, fortunately for them, seemed forthcoming in allowing them to continue spiritual work in the respective hospitals. Indeed, as the next chapter will explore, certain practices associated with the hospital's Christian-centred past persist formally at the hospital today, long after the departure of mission doctors.

Finally, the stated aim of the Christian Work Committee which was emphasised as essential to furthering the spiritual work of the mission was with regard to pursuing – as far as possible – its programme of community health:

> [To] channel donations of cash and kind to enable the Staff to continue its response to the needs of the whole Community [and to] guide in establishing ways and means of bringing total health to all – for health is harmony of body, mind and spirit.[64]

This quote demonstrates, once again, the way in which deep-rooted missionary theology of physical and spiritual healing is combined with the contemporary language of primary health care, evoking for example the WHO's widely publicised key goal emerging from the Alma-Ata conference of 'Health for All'.

This renewed spiritual emphasis, and the way in which the broad approach of community health fit so easily with holistic missionary conceptions of healing, meant that the contest between hospital-based and community-based approaches to health care delivery seemed to take on a spiritual significance, coming to signify for the missionaries a more existential fight between secularism and religious faith, and between the treatment of physical disease and the attainment of spiritual salvation. Thus it was through maintaining a focus on Community Health that the mission could really leave its imprint. Indeed, the clinics that were set up by the mission hospital during the 1970s are still in operation today and constitute the basic infrastructure upon which Bethesda's current primary health care system is built.

It is difficult to say to what extent the nursing staff and other employees at Bethesda welcomed the take-over or not. Marks points out that some nurses supported the "Africanisation" of nursing, and that others 'had imbibed the language of ethnic difference, which may have afforded them the possibility of a more nuanced sense of identity and cultural continuity than the missionaries had provided' (Marks 1996: 184). Certainly, there are suggestions from the committee reports that over the period of take-over, some nurses rebelled against the mission. At Manguzi, there were complaints that the staff no longer considered their 'Christian responsibilities and responses' as important.[65] At Bethesda, a report described 'a general feeling of antagonism between some of the staff and white families', as well as a 'great concern' that the nurses no longer wished to participate

[63] E701
[64] E704
[65] E706

in Hospital Christian Fellowship.[66] Certainly, such indications raise important issue surrounding the use of archival data and its limitations. Nurses at Bethesda with whom I spoke tended to recall positively and nostalgically the hospital's mission days. As I will discuss in the next chapter, however, many of these sentiments are spoken in reaction to contemporary hospital practice.

Conclusion

In this chapter I have described some of the major themes that were significant in shaping the historical development of Bethesda Hospital, a former Methodist mission hospital in northern KwaZulu-Natal. Began by Dr Robert Turner in 1937, the hospital was run by the missionary society of the Methodist Church of South Africa until its take-over by the government forty-five years later.

From its inception, the hospital was increasingly subject to the labour structures and health care ideas and policies of the state through various forms of funding and legislative control. Yet this process was characterised by an increasingly chaotic delineation of funding responsibilities between different government departments, including attempts to shift control over to the KwaZulu government, with often crippling consequences for front line health care provision because of the resultant lack of funds and accountability on the part of the various departments involved. The struggle between the government's push for hospital-centred, preventative care and the mission's focus on community health was a significant area of conflict. Where the government did support the expansion of clinics, this was often in word more than in deed, reflecting to a large extent its politically strategic, rather than beneficent, motivations.

Yet the state's attempts to enforce control could only go so far. Bethesda continued to provide outreach in the form of clinics, health education and various other projects in the surrounding district. I have argued that such activities, inspired by an international shift towards primary health care, enabled a reinvigoration of missionary ethos through a shared appreciation of holistic care. A doctor at Manguzi, for example, described community health as 'a whole-man type of ministry'. This association was significant in the years leading up to take-over, giving new impetus to the mission's pursuit for community health, whilst the wider rhetoric of primary health care seemed, in turn, to authorise missionary ethos. The government's chaotic and inefficient involvement coincided, therefore, with a resurgence of creativity and energy on the part of the mission, even despite imminent take-over. Hence both the spiritual and community health aspects of the hospital's work were seen, together, to be the most important activities for continuation after take-over. Whilst, undeniably, rural healthcare during this period was vastly inadequate to meet the immense needs of the surrounding population, the advances made by the Methodist mission in

[66] E742

establishing clinics in the district was an important contribution, constituting the infrastructural basis of current primary health care provided by Bethesda Hospital.

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