African demand and missionary charity: the development of mission health services in Kwazulu to 1919.[1]

Traditionally missionaries have been accused of somewhat deliberately using their medical services to remake the African society in the image of the west and in the interest of European imperialism.[2] However, while there was a pre-occupation on missionaries' part with changing the gendered image of the African, missionaries did not deliberately make a decision to give medical care in the first place, nor were they drawn into it merely by imperialistic interests. Rather, their philanthropic feelings were induced by demand for some medical intervention against disease and , to some extent, progress in medical work was assisted rather than caused by shifts in mission thinking.[3] It is not entirely true, either, to argue that medical mission acted simply as a 'bait to catch the souls', though missionaries often hoped to mend not only people's bodies but their souls as well.[4] Nevertheless, the missionaries-Africans interaction in the sick room was more complex than this argument suggests.

This paper maintains that the development of medicine can not be explained only in terms of missionaries' wishes and arguments, rather in terms of the complex interplay between changes in disease incidence (should I say, pattern), African demand for medicine and missionary charity in general, and the development of Western medicine in the background. The widening of

[1] . This paper is part of research work still in progress, so its arguments and claims should seen as only tentative. It was prepared for presentation at the University of Natal in Durban, South Africa, on 15 September 1999. I wish to thank Professor John Iliffe, Drs Paul la Hausse, Jon Lonsdale and Bennett Siamwisa for their comments on the earlier drafts of this paper.

[2] . This argument comes up consistently and strongly in various works. See, for instance, J. Comaroff, 'The diseased heart of Africa: medicine, colonialism, and the black body', in S. Lindenbaum and M. Lock (eds), *Knowledge, Power, and Practice: The Anthropology of Medicine and Everyday Life*, Berkeley, 1993, pp. 305-329.

[3] . Hamilton has recently challenged this stance on colonialism, for instance. See C. Hamilton, *Terrific Majesty: The Powers of Shaka Zulu and the Limits of Historical Invention*, Cambridge, 1998, especially pp. 28 and 74. On missions, see P. Landau, *The Realm of the Word: The Language and Christianity in a Southern African Kingdom*, Cape Town, 1995. See also Zondi, W. S., 'The Making of Gender among Africans in the Natal Wesleyan Methodist Mission, 1850-1880', MPhil., (University of Cambridge, 1998).

[4] . This is a widely spread view. For an example, see Felix, K. Ekechi, 'The medical factor in Christian conversion in Africa: observations from Southeastern Nigeria', *Missiology*, 21 (3), 1993, pp. 289-309.

mission medical practice in the 1850s to 1870s was occasioned by increased African demand for it in the face of changes in their disease environment following colonial penetration and natural disasters like famine, and the resultant confidence in the medical practice among missionaries on the ground. The revolution in mission medicine and its gradual take-over by medical and nursing professionals from the 1890s are seen in the 19th -century context of the greatest advances in biomedicine in the last quarter of the century epitomised by the rise of bacteriology and the subsequent drug revolution in the 1890s. In the same period the incidence of especially epidemic disease seem to have increased considerably for reasons not yet clear, but British colonialism was one. This is not to overlook the change in mission thinking about healing progressively in the second half of the nineteenth century, but it is to argue that was more of an outcome rather than a reason for the development of mission medicine.[5] In this perspective, then, missionaries did not merely decide out of their volition. Advances in mission medical work preceded rather followed its theological justification or rationalization. Africans took the initiative and demanded such help especially as more diseases began to attack them. Noting also that Africans had always valued foreign medical knowledge over their own, Africans actively assimilated western medicine into their pluralistic therapeutic system.[6] It was natural that missionaries should subsequently realise the additional opportunity medicine provided them to get closer to a wide variety of people, material enticements being another; this was but one of the factors exacerbating an already existing essential mission service to Africans.[7] This paper moves from the premiss that Africans-missionary interaction was predicated on a willingness of each party to bargain, i.e. to respond creatively to the needs and the influence of another.[8]

[5] . For a succinct discussion of the changes in mission thinking about medicine in the Metropolis, see Walls, Andrew, 'The heavy artillery of the missionary army: the domestic importance of the 19th century medical missionary', Shiels, W. J., *The Church and Healing*, London, 1982, pp. 277-97

[6] . This is captured in a Nguni proverb, *Imithi ikhendlwa kwabezizwe (Potent medicine is best got among aliens).*

[7] . It has been assumed missionaries, somehow, foresaw this. See footnotes 3 and 5 above.

[8] . For this argument, see Zondi, 'Making'.

Hence, the significance of the African initiative (demand and need) on the one hand, and missionary compassion or charity on the other.[9]

Dr Adams pioneers mission medicine, 1835-1851.

Missionary medicine in Natal began when one of the two missionary parties of the American Board arrived at Ethekwini (Port Natal) on 22 December 1835. This party included Dr Adams, a university-trained medical practitioner. Strangely, Adams like other doctors of the Board were not ordained nor were they trained for mission work, yet they were not sent to provide medical care to anyone but missionaries. The silent policy was that it was left to themselves to treat converts where and when they saw it fit, but not at the expense of conventional mission work. When a contemporary doctor sent with a party to Thailand started medical work among the Thai, he found himself at loggerhead with his superiors.[10] Introducing itself to king Dingane, the party made known Adams' medical skill whereupon he was asked to display it. Not only were his curative therapies sought as sick people in and around the palace were brought in for him to heal, but he found himself involved in a day-long discussion with Dingane and his entourage on what diseases he could cure; how; and which he could not and why.[11] Dingane, then, sought a promise from Adams to be available for medical help when he was asked to provide.[12] He was then given

[9] . I use the concept 'African demand' to stress active initiative in seeking mission medicine as an alternative therapy.

[10] . This doctor did not only open a dispensary, but he treated patients in the open and ran vaccination and obstetrical clinics. This invited a sharp chastisement from Board secretaries in Boston and culminated in his removal from the roll. See Popp, R. L., 'American missionaries and the introduction of western science and medicine in Thailand, 1830-1900', *Missiology*, 13 (2), 1985, pp. 147-57.

[11] . It was common practice in the kingdom for doctors' knowledge to be put to test in public in order to gain royal licence to practice. Dingane and Cetshwayo ka Mpande in particular closely monitored the medical profession which was under threat in the post-Shakan era from quack healers and unlicensed doctors. Mission doctors after Adams and Wilson would have been such threats and Batswana rainmakers were certainly another. See M.V. Gumede, *Traditional Healers: A Medical Practitioner's perspective*, Johannesburg, 1990, pp. 107-8.

[12] . Thus he received, not just a royal licence to practice, but a special privilege to attend to the king himself, a privilege many other therapists would dream of.

a head of cattle and a site for his mission at Umlazi in the south of the kingdom.[13]

Back in Durban being the only medical doctor in Natal then, Adams became responsible for co-ordinating quarantining of a ship that carried suspicious smallpox cases. He treated a lot of Boers and a number of Africans as far as Pietermaritzburg west and beyond Umlazi to the south. He lent his medical books to his colleagues (Revs. Lindley, Grout and Champion) to help them deal with intermittent fevers prevalent. Adams and Lindley continued to provide some medical care till their sudden escape in 1838.[14] The same happened in the 1840s when a virulent small-pox was introduced by another ship, then Adams had a few doctors to work with and his colleagues had enough basic medical skill to help with Africans, especially.[15] These instances raised Adams' reputation as a medical practitioner in Natal, and this was not a pre-planned missionary strategy, nor was it a welcome direction in secular missionary work, yet need called for it.

At Umlazi, however, far from contact with epidemics, Adams found Africans generally in good health. After two years at Umlazi, he reported, 'I have not seen or heard of a case of fever since our arrival'. Nonetheless, people soon came to him with common diseases like eruptions of skin and rheumatic complaints. Typical of doctors of his times, he ascribed these complaints to sudden changes in an otherwise salubrious climate and diet problems; he also advised consumptive patients to relocate for a better climatic environment. His surgery included cutting open tumours and abscesses. However, in 1844 he conducted a more complicated art of removing a cataract. All these were as far as both contemporary medicine and incidence of diseases went[16] Among his

[13] . See Adams' letters quoted liberally in Afrikaans in D. J. Kotze, 'Eerste Amerikaanse Sendelinge onder Zoeloes (1835-1838)', in *Argief-jaaarboek vir Suid-Afrikaanse Geskiedenis*, 1 (1959), pp. 67-73.
[14] . Champion's Journal, in Kotze, 'Eerste', p. 126.
[15] . See H. Davies, *Great South African Christians*, Cape Town, 1951, pp. 40-46; P. W. Laidler and M. Gelfand, *South Africa: Its Medical History: A Medical and Social Study*, Cape Town, 1971, p. 319.
[16] . Although American doctors had just discovered an 'inhalation anaesthesia', they were still

visitors were the healthy ones who accompanied the sick or came to talk and ask questions about medicine and illness. The behaviour of African seekers of medical help- patient and non-patient- is a separate topic of its own, suffice it to say here that among Africans the choice of a form of a therapy, a therapist and the treatment itself fell not on the patient herself, but on a group of relatives and friends.[17]

While Adams tried to subordinate his medical services to conventional missionary works, Africans thronged him for medical care. In his new and more populated station, Amanzimtoti alias Adams, he had so many sufferers visiting that his boys led by Ira Nembula, son of his first convert and patient, built him a hut for their care: the 'sick hut'. That his hands were filled as much by evangelical, educo-industrial and medical work is apparent in the nickname with which Africans addressed him: *umfundisi omajaz'amatatu,* 'a pastor of three coats'. This referred to three different coats he adorned when doing the three tasks.[18] His colleagues also could not undo the reputation as providers of medicine they had earned in the 1830s, so Africans continued to seek their help.

Troubles with the interior party of the American mission in 1837 forced them to join their colleagues in Natal. Thus a second mission doctor appeared on the Natal scene: that was Dr Alexander Wilson. He had no more than a thermometer and chest of simple remedies. These, as Bryant[19] observed, were

---

identified with disease and death rather than health, saws and scalpels rather than the stethoscope and hypodermic syringe. Such were American doctors up to the 1880s according to B. Hansen, 'America's first medical breakthrough: how popular excitement about a French rabies cure in 1885 raised new expectations for medical progress', *The American Historical Review*, 103, 2 (1998), pp. 373-418. See also R. Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity*, London, 1997, pp. 345-50.

[17] . This has been referred to as therapy managing group which makes a choice as to what therapy, of what form to take and which therapist to consult. See J. M. Janzen, (with the collaboration of W. Arkinsall,), *The Quest for Therapy in Lower Zaire*, Berkeley, 1978).

[18] . In isiZulu they called him, *umajaz'amathathu*. See Kotze, 'Eerste', pp. 89-92; J.D. Kotze, *Letters of the American Missionaries, 1835-1838*, Cape Town, 1950), pp. 176, 202-3; E. H. Burrows, *A History of Medicine in South Africa up to the end of the Nineteenth Century*, Cape Town, 1958, p. 198.

[19] . This Catholic missionary wrote a book on indigenous African medical practice in Kwazulu. See A.T. Bryant, *Zulu medicine and medicine-men*, Cape Town, 1966, pp. 7, & 80.

no better than African remedies. The doctors confronted diseases as they were brought to them and in their itinerant preaching which in turn would have exposed their skill to a wider population.[20] However, Wilson and Rev. Venables returned to America in 1840. Champion died after some illness in 1841, leaving Adams, Grout and Lindley to steer forward a missionary work that included responding medically to African illness.[21] Adams was ordained in 1844 which coincided with British occupation of Natal. He was then appointed a member of a Land Commission assembled to locate Africans in which he ceased to be active by 1847.[22] In 1851, after 14 years' service, Dr Adams died prematurely at the age of 45 from a condition arising from overwork.[23] This could be interpreted as an unfortunate outcome of the pressure of mission work worsened by high demand for his medical skill which he was reluctant to use liberally, for which he would later be especially remembered.[24] Clearly the silent non-approval of medical care as a legitimate branch of mission work which forced Adams and Wilson to conceal or subordinate their medical work, is an important factor in this reluctant beginnings of the medical mission in the Adams' era.

Dr Callaway in the midst of pill-box mission medicine

It would not be until 1854 that the next mission doctor arrived in Natal: that was Rev. Henry Callaway of the SPG. He had abandoned a lucrative medical practice in London to become a missionary under Bishop Colenso. This partly explains his tendency to, as Adams and Wilson had done, subordinate his medical work to evangelical work by hiding his medical skill from Africans, but also the recognition of the fact his was mainly an evangelical mission in Natal. Africans were becoming accustomed to the fact that missionaries had

[20] . Kotze, *Letters*, p. 176.
[21] . Kotze, 'Eerste', p. 150-153; L. E. Switzer, 'The problems of an African mission in a white-dominated, multi-racial society: the American Zulu Mission in South Africa, 1885-1910', Ph.D thesis (Universities of Natal and California, 1971), pp. 6-7.
[22] . This assignment worsened his workload which then included being treasuer for the mission so much that he rarely found time to jot some notes down or write and reply letters after 1844. He was not keen on writing letters anyway. See Chapter 4 of Shiels, R., 'Newton Adams, 1835-51', BAHons, (University of Natal, Pietermaritzburg, 1963). NAD Thesis no. 41
[23] . Burrows, *History*, p. 199.
[24] . AZM, 'The golden jubilee, 1909-1959: a report on the McCord Zulu Hospital', p. 3.

this healing skill which they never used unless it really came to a push. It did not take long for Africans to discover that like a real *inyanga* he had a medicine chest packed with an assortment of remedies, bandages, surgical knives and dental forceps.[25] These facilities displayed the significant advances in western medicine of his time[26] and put his medical care on a better footing against a complicating disease environment. Adams had observed skin irritations and diseases of the bowel, and virulent, but low, fevers to have occurred mainly in wet winters. In the 1850s Callaway reported a much more worse disease situation than that, probably given the fact that he was operating in a wet lowland area. He reported colds and influenza, then malarial fever, a lethal diphtheria and a mild dysentery seem to have troubled Natal midlands and Zululand's south coast. Malaria had been introduced by migrant labour, especially for sugar industry, drawn from the malarial lowlands of the northern Zululand and Delagoa Bay.[27] This difference may well be due to the fact that we tend to know better and more about later periods than earlier ones.

Callaway's work included more complicated surgery with the use of recently found American anaesthesia, but his most popular services were the much-practised tooth extraction and treatment of the dreaded dysentery and enteric fever in the 1860s. The more-than-normal incidence of these diseases can be ascribed to some extent to the bad socio-economic conditions in Natal occasioned by severe droughts, general degeneration -an outcome of consolidation of colonial rule, and economic depression which led to a slump in African peasant economy. [28]

Callaway went on to investigate African remedies, medical practice and its underpinnings which took him into the study of African religion.[29] This

[25] . *Mission Field*, 5, 50, Feb. 1860, p. 38; Laidler and Gelfand, *South Africa*, p. 336.
[26] . Porter, *Greatest*, pp. 383-4
[27] . *Mission Field*, 3, October 1858, pp. 221-2.
[28] . *Mission Field*, 5, 50, February 1860, p. 38; 8, 93, September 1863, p. 193. For a good concise account of this and its impact of African household and general economy, see Lambert, J.,'African attitudes to land purchases and ownership in Natal in the second half of the nineteenth century and the early twentieth century', SAHS Conference Paper (1997).
[29] . His researches produced a book published in 1867 in London that was entitled: *A religious*

brought him closer to the people he was working with and made him a popular mission doctor. However, contrary to the view that, like Livingstone, his were times before professional arrogance against African therapeutic practises[30], he refused to recognise the opinions of the sick's relatives and sometimes dismissed them in order to see the patient on his own. He found it ludicrous that patients would often find someone else to say a 'thank you' on their behalf.[31] At the same time he was busy discrediting indigenous doctors which turned some people away from him. This negative part in the development of mission medicine as part of an element of paternalism which characterised the encounters of the West and the Other in the colonial setting especially need not be overlooked.[32] Nonetheless, to stress this alone runs the risk being one-sided and of marginalizing the African initiative in the mission.

Amateurish medical work by non-medical missionaries continued, some complicated cases were referred to Callaway as a qualified man. Lindley remained a key medical provider among American missionaries in southern Natal.[33] The Anglican Robertson distinguished himself with setting broken bones[34]; Johnson was the busiest 'tooth-puller' in Zululand and did much good against common chest complaints in the often wet and cold northern Natal with his modest collection of remedies.[35] Notwithstanding their hostile attitude to medicine and science, Wesleyans found themselves among people asking for medicine and rejecting their tendency to spiritually prepare the sick for their impending death. Soon the courageous, and often rebellious, Wesleyans like John Gaskin and Joseph Jackson caused uproar in London by defying warnings against 'temporal work' at the expense of evangelism by reporting the wonders

---

system of Amazulu.

[30] . This view is made strongly in Etherington, N., 'Missionary doctors and African Healers in Mid-Victorian South Africa', *South African Historical Journal*, 18 (1987), pp. 77-91.

[31] . *Mission Field*, 8, 94, 1 October 1863, p. 230. This tendency has been explained as the work of the therapy managing group among Africans. See footnote 17 above.

[32]. That is exactly what interests the Comaroffs most, that is showing that missionaries did share a condescending attitude to the African and their mode of living and practice. See chapter on Medicine in Comaroff, J & J.L., *Of revelation and revolution*, Vol. 2, Chicago, 1998.

[33] . Davies, *Great South Africans*, p. 47. See also Burrows, *History of medicine*, p. 200.

[34] . *Mission Field*, 9, 99, March 1864, pp. 51-2.

[35] . A. W. Lee, *Charles Johnson of Zululand*, London, 1930, pp. 132-3.

worked by their medicine.[36] To justify this they used practical reasons like the example set by successes of medical missions in China and the incidence of epidemics ravaging their congregations and their own families, but more importantly they argued, with large numbers coming to them for medical care, 'I have sometimes an opportunity afforded of speaking a word for Christ when the heart is open to good impressions', wrote Gaskin.[37]

In Zululand, mission medicine was dominated by Norwegian Lutherans.[38] Bishop Schreuder treated king Mpande of rheumatic fever in public like Adams had done in Dingane's reign. The king suffered from rheumatic fevers prevalent in the northern lowlands.[39] The 1856-7 civil war which had suspended cultivation for at least two planting seasons triggered food shortage and famine which in turn would have lowered body resistance to common diseases among Africans..[40] This was worsened, as pointed out earlier, by drought and economic recession in the 1860s.[41] The Anglican Robertsons reported on arrival in the Kingdom from Natal in the spring of 1860: '*The famine is very severe…both here and in Natal.*' It was still raging on in the summer of 1861. The cause of this dire food shortage was found to be a prolonged drought. As a result some people were starving to death, some resorted to roots and herbs. The situation would have been worse if not for

[36] . J. Allsopp, 10 November 1874; Wesleyan Methodist Mission Archives (MMS), Correspondence, Pearse to Secretaries, 1 December 1860, Pietermaritzburg; Jackson to Dr Hoole, 3 November 1860, Indaleni, Box 16, SOAS.
[37] . See *Missionary Notices*, 21, 1975, pp. 132-3; MMS correspondence, Cameron to Secretaries, 9 Feb. 1871, Edendale, Box 18, SOAS.
[38] . They belonged to the Norwegian Mission Society which had a fair balance between seminary educated and university-trained missionaries. Hence, the clear distinction within NMS between those enthusiastic about science and medicine, and those sceptical of science, but devoted to agricultural pursuits.
[39] . P. Hernaes, 'The Zulu kingdom, Norwegian missionaries, and British imperialism, 1845-1879', in J. Simensen, (ed.), *Norwegian missions in African history*, Oslo, 1986).
[40] . However, industrial progress could have negative effect on health as well. For instance, tooth complaints had a lot to do with the emergence of the sugar industry from 1850s achieving its best productivity in the 1870s. See P. Orange, J.N. Norskin and T.W.B. Osborn, 'The effect of diet upon dental caries in the South African Bantu', *The South African Journal of Medical Sciences*, 1, 2 (Sept. 1935), pp. 57-62.
[41] . *The Mission field*, 7, 82 (1 Oct. 1862), pp. 229-30.

relief provided by Natal mission peasants and colonial government's supply of mealies at a cheaper price. [42]

A similar drought in 1857 had left a bulk of people without means to cope with 'war parties' (involved in the civil war) which swept through the country carrying away all the food they could get. Wars being a largely masculine prerogative in this society, women, children and the infirm were left behind to run households. So they were not only at the receiving end of these invaders' violence, but they were left to starve where help from Natal peasants did not reach. With fatigue, want of food and exposure to bad weather general ill-health set in. Sometimes, more lethal illness mainly the 'Zulu fever'(malaria) and chicken pox among children, broke out. In response to malaria, Norwegian missionaries became openly involved in medical care. In the process they clashed with officials in Stavenger whose thinking about healing within the mission seem to have lagged behind that of missionaries on the ground.[43] Again the incidence of the disease and appeals for health care induced many a philanthropic missionary to think anew about medical work and to begin providing some medical service.[44]

Besides horizontal expansion, mission medicine in the 1870s and 1880s did make forward strides. After a short turn away from actual medical care towards a fact-finding mission on African religion in the mid 1860s, Callaway put before the Natal diocese in 1868 a hospital scheme to cost more than 800 pounds. He had the support of his diocese, but London would not commit any resources to this 'distracting' and expensive venture. Callaway continued to raise the funds on his own with the help of Bishop Wilkinson. But he was appointed Bishop of Kaffraria before the scheme became a reality. Thus the scheme was shelved. Besides a multi-roomed house set aside for patient care

[42]. Mackenzie, *Robertson*, pp. 141,144 & 202.
[43] . J. Simensen, 'Christian missions and socio-cultural change in Zululand, 1850-1906', in Simensen, *Norwegian missions*, pp. 195-6.
[44] . J. Simensen, and V. Gynnild, 'Norwegian missionaries in the 19th century', in Simensen, *Norwegian missions*, p. 40.

at Springvale station, the hospital idea came to nothing.[45] To an extent the idea showed the growing confidence in organised regular western medicine and medical institutionalisation at a time when hospitals were outgrowing their age-old association with death, poverty and misery as they were becoming centres of scientific research. [46] The few state hospitals in Natal were still being shunned by Africans, until all other possibilities had been explored fearing that if they should be admitted they would certainly die. At another level, the fate of the scheme shows that the medical mission was spearheaded without a wholehearted support of the metropolis. This was partly due to reluctance on the part of the mission boards to stretch mission resources any further, and partly because the London's and Boston's lack of touch with the pressing demand for medical care in the mission field. It would gradually commit some resources as benefits of this work come to the fore.

Dabbling in home remedies giving help to the very sick was not necessarily sanctioned by mission authorities abroad and but could continue without their notice, if they did notice it was not easily explained in philanthropy terms. A hospital scheme needed a justification, so Bishop Wilkinson wrote to London*:*

> *'It is surely also a subject for rejoicing that our brother is a member of that noble profession which Christ so especially honoured in this, that while he came from heaven to be the Great Physician of souls, He condescended again and again to be the Healer of the body.'* [47]

Sometimes missionaries, especially Wesleyans, picked out the worst cases they came across when they happened to mention their medical work. To show how unkind the neglect of African medical need, a Wesleyan missionary wrote, 'I found a boy with a cancer in the nose. It had already eaten out the whole of the partition of nostrils. The poor boy was in great pain. But I had not even a medicine chest and no medicine, so I only advised him to pray for his death'.[48] However, the most common justification was to show the benefits of medicine

[45] . *The Net*, 'KwaMagwaza Report', January 1872, pp. 4-5; 1 June 1872, pp. 95-9; *Mission Field*, 13, 153, September 1868, p. 248.
[46] . Porter, *Greatest benefit*, p.306, 380-389.
[47]. *The Mission Field*, 13, 153 (1868), p. 249.
[48]. MMS Correspondence, Jackson to Secretaries, 1 Nov. 1860, Durban, Box 16, SOAS.

to their evangelical work. 'Unohlonga, one of those to be baptised on Christmas day,' reported Robertson, 'was first brought to the station as an invalid.' [49]

The Catholic Oblates of Mary Immaculate's new Vicar-Apostolic arrived in 1874 with nine nursing nuns of the French-speaking Holy Family sisterhood. They opened two Sanatoriums in the feverish Estcourt area and at Ladysmith. This helped priests and the laity concentrate on their agricultural and religious work.[50] The Trappists arrived in 1882 and found a mission complex which included a sanatorium run by the laity and later by their newly created local sisterhood, Sisters of the Precious Blood.[51] They were responding to increased suffering.

In the kingdom, the impact of the 1879 invasion by British forces and the war that ensued went beyond political destabilization. Food production was disturbed and in some cases, if not all, a human-induced famine resulted. The war was preceded by a prolonged drought anyway which worsened the ubiquitous fear of invasion in the kingdom.[52] This further complicated the disease environment.[53] The burden fell on the missionaries. The Anglican Bishop of Zululand wrote:

> *'The poor Zulus are so reduced by famine, 'in consequence of the war, that they can hardly walk, and many are subsisting on roots and herbs which makes poor Zulus dissatisfied, unsettled and dejected; and they seem to be unable to think or talk about anything but their troubles….'*[54]

---

[49] . McKenzie, *Mission life*, p. 141.
[50] . W. E. Brown, *The Catholic Church in South Africa: From its Origins to the Present Day*, New York, pp. 163, 223-4.
[51] . F. Schimlek, *Marianhill: A Study in Bantu life and Missionary effort*, Durban, 1953, pp. 11-13; Brown, *Catholic Church*, pp. 300-302.
[52]. *Paulinah Dlamini: servant of two kings*, H. Filter (compiler), Durban, 1986, p. 66. See also J. P.C. Laband and Thomson, P.S., *War comes to Umvoti: the Natal-Zulu border, 1878-9*, Pietermaritzburg, 1980, pp 26-8
[53]. I am aware of the implications of this assertion. Take it as only tentative.
[54] . See testimonies of missionaries during and shortly after the war: *The Net*, Charles Johnson, 1 June 1879, pp. 88-92; St. Andrews report, 1 January 1881, p. 12. See *Mission Field*, 26, 301 (1 January 1881). In times of dire food shortage Africans in this area would dig up tubbers of

In helping missionaries deal with hunger, wounds and sickness at the same time, women missionaries were useful. 'Some of the wounded were dying, and not to be helped in any way', wrote a missionary wife.[55] With famine and war came diseases as well which missionaries had to deal with there being no organized state medical services for Africans in the kingdom. '[F]amine and the sword, and their attendant diseases', wrote Samuelson, 'will make this year one never to be forgotten by the sufferers'.[56] Conditions continued to deteriorate as droughts and more internal conflict followed in the mid-1880s and as state neglect of medical services for rural Africans continued.[57] The four-year civil war which followed the 1879 war was a humanitarian catastrophe in the sense that it induced famine and destitution over a long period of time.[58] It was fought as much by weapons as by starvation of one group by the other. In this women, children and the infirm were at the receiving end again. During the debacle, one white trader noticed that Usuthu people led by Mnyamana ka Ngqengelele hiding in caves were,

> *'dying in dozens from deprivation and dysentery, children [were] perishing at their mothers' breasts for want of nourishment, and each person [was] covered with the itch and otherwise emaciated…for all the crops were then cut and trodden by Usibepu's forces.'*[59]

Incipient cottage hospitals: medical advances of the 1890s

Disease environment continued to worsen in the 1890s partly to do with natural disasters like drought, locust attack on crops and the rinderpest

---

grass-like *inongwe* and *amadumbe*-like *inkonje* and *izikhwali* for food. See *Paulina Dlamini*, p. 79

[55] . *The Net*, Mrs Carlson, 1 September 1879, pp. 129-130; Mrs Swimmy, 1 November 1882, p. 163.

[56] . *Mission Field*, 24, 282, p. 257

[57] . It has been shown that the state, even after the formation of the health department in 1919, deliberately neglected African health needs even with the outbreak of epidemic diseases as long as they were confined to rural African villages; it only acted when they spread to urban areas thus threatening the white population. S. Marks and N. Andersson, 'Typhus and social control: South Africa, 1917-1950', in R. Macleod and M. Lewis (eds), *Disease, Medicine, and Empire: Perspectives on Western Medicine and the European Expansion*, London, 1988, pp. 257-83.

[58]. For a lucid examination of this rather unfortunate war, see J. Guy, *The destruction of the Zulu kingdom: the civil war in Zululand, 1879-1884*, Pietermaritzburg, 1994.

[59]. Quoted in Guy, *Destruction*, p. 219

epidemic among the cattle. The expansion of medical missions in the 1890s should be seen against that background. But not forgetting that ironically biomedicine was at its best in this disease-ravaged period. In 1892, Adams's successor, Dr Bridgman, arrived in Natal, four decades after his predecessor's death. This young graduate of New York Medical School and a son of a Natal missionary married a newly-graduated nurse just before sailing for Natal. He had learned the most modern medicine at college, the recent surgery and had done his internship in a research hospital in New York.[60] While the old dilapidated house at Adams was being revamped, the Bridgmans took lessons in IsiZulu, but sick Africans would not spare them anymore. In fact even before their arrival at Amanzimtoti, the doctor wrote, 'medical work has, however, been forced upon me from the first day of our arrival in Natal.'[61]

A brick dispensary was built to meet the higher demand for in-house care. The Bridgmans came in a Natal south coast ravaged by epidemics, the most menacing of them being the dysentery. Like most gastro-intestinal infections dysentery was associated with sanitary and nutrition problem, but some epidemics were difficult to explain. It broke out in both forms in the 1890s. 'I am at a loss', wrote the District Surgeon of Umlazi during the 1894 one, 'to comprehend why Dysentery should assume at times an almost epidemic intensity. The epidemic of 1890-1 was attributed to the scarcity of food and water ... the climatic condition then being one of drought. This year it is the very opposite, there being abundance of food and water.'[62] The most lethal and frequent pandemic among children, chicken pox, also baffled missionaries and doctors.[63]

With only his wife as his nurse and a convert, Mqgibelo, as his medical orderly-cum-servant, physical expansion of the institution demanded the

[60]. The same year a special meeeting of the AZM had decided to locate its incipient medical department with a sick house set aside for it at a central station, Amanzimtoti.
[61]. 400 patients were seen by them in four months a Umzumbe. NAD, AZM, Annual Report 1893, A/4/41.
[62]. DS to Res. Magistrate, 5/01/94, Durban. DAR, I/UMB.
[63]. Medical Department Reports, 1893, 5, NAD, AZM, A 608, A/3/41.

increase of personnel. The Bridgmans had modernized the mission medical institution such that surgical work, maternity and medical works were separated, but none of them was adequately staffed. The huge in-flow of patients partly due to a spate of epidemics year after another rendered his work almost impossible without additional staff.[64] Its not clear if he did ask for a reinforcement, but he certainly relied rather heavily on relatives of patients and convalescents for nursing and domestic service at the dispensary.[65] In 1893, history was made when the first African doctor of biomedicine in Natal, John Mavuma Nembula, a grandson of Adams' first convert and patient, was employed at Adams to work with Brigdman.[66] He was a bright young man taken to America by the mission to help in the translation of the Bible in 1883. When that work was done, he used his beautiful handwriting writing visiting cards to raise fees for his education at University of Michigan and Chicago Medical School. On returning to Natal in 1888, he was employed as an acting district surgeon for Umsinga until his appointment to Adams' medical department. At Adams he taught physiology and hygiene to High School pupils, while acting as a surgeon at the dispensary. His acclaimed excellence in surgery justified his taking over that section of the dispensary leaving Bridgman to do obstetrical and medical work. The number of patients almost doubled in his first year and continued to rise in the next five years.[67]

Nembula's exact impact stretched beyond the American mission. As a district surgeon of Umsinga in 1889-90, he had also acted as a visiting doctor in the dispensaries of the Church of Scotland and the Berlin Lutheran. These dispensaries referred serious cases to the government's 'Native Cottage

[64] . *Missionary Herald*, 1892, p. 464; Sheils, 'Bridgman family', pp. 131-3; KCAL, AZM, 'Century of progress in medical work', p. 134.
[65] . For a detailed discussion of this practice, see Janzen, *Quest for therapy*, referred to above. This was a common practice in African medical practice in Kwazulu because there were no medical assistants. See, for instance, H. Ngubane, *Body of mind in Zulu medicine*, London, 1977, pp. 104-5.
[66] . He was the son of Ira Nembula adopted by the child-less Adams family in 1844, who later became the first AZM's ordained African in the 1860s.
[67] . AZM, Shiels, 'John Mavuma Nembula', 1256, Killie Campbell Africana Library (hereafter KCAL); *Natal Blue Book*, 1889, 1890, 1891-2, Royal Commonwealth Society Library (hereafter RCS); *Imvo Zabantsundu*,31 January 1889 and 13 February 1890. I am grateful to Professor John Iliffe for drawing my attention to the *Imvo* references.

Hospital', which he helped to bring about and of which he was a medical superintendent. Even when the Scots received their own doctor, Nembula remained a useful medical visitor, hence, their outcry against his removal from Umsinga. Just how far this relationship went and what kind of things it was based on, remains unclear due to inadequate data.[68]

Nembula's employment at Amanzimtoti was terminated for four months in 1894 and again in 1895 due to want of funds to pay his monthly salary of £ 35. Nembula's absence left Bridgman with an unbearable load of in-patient and out-patient treatment at the dispensary, responding to calls from distant villages and mission stations, health lectures at the American Board mission's high schools and attendance to girls' boarding school. No wonder his relief on Nembula's return in 1896. Early in 1897 Nembula received and accepted a more lucrative job offer as permanent district surgeon of Maphumulo. 'In consequence of this great loss to work,' complained Bridgman, ' practically nothing could be done to maintain and extend our sphere of influence.'[69]

Six months in the job, Nembula died rather prematurely at the age of 37. Circumstances of his death are not clear, Burrows suggests that he died from consumption. [70] Consumption had killed three of his brothers in the 1860s and he luckily recovered from it, but his father succumbed to it in 1882.[71] A few months later, Bridgman himself returned to America to care for his sick wife and resigned the following year.[72]

These doctors had left a legacy of modernized cottage hospitals and professional mission medical practice, but grossly under-staffed. Precisely for the latter reason, the facility had to close temporarily for a year while the

[68] . This is drawn from Magistrates' and District Surgeons' reports enclosed with the *Natal Departmental Reports*, 1889 to 1892, PRO, CO 181/31. Records of the United/ Free Church of Scotland mission were destroyed by fire which guttered the Edinburgh Library.
[69]. Annual Report of the Medical Department, June 1897, NAD, AZM, A/3/41.
[70]. See Burrows, *History*, p. 223.
[71]. Consumption, as Tuberculosis was called, has been one of the deadliest slow killers in the history of Africans' experience of disease. See the history of the disease in South Africa, R. Packard, *White plague, black labour*, Carlifonia, 1989.

Bridgmans were on furlough and permanently when they resigned until another doctor would be found.

1900s to the Influenza aftermath: hospitals, nursing and public health.

The 20th century ushered in an era of pioneer complex mission hospitals staffed with young educated African nurses. No mission doctor deserves credit for this development in Natal and Zululand more than Bridgman's successor, James McCord. He arrived amidst widespread sickness all over the district. But it was his first surgical case that pushed his patience to the limits: an operation on a fractured skull in order to remove debris and damaged brain tissues which took place on a kitchen table in a coal shed at the back of the church. His surgical skills were certainly advanced, but the physical facilities at his disposal were far backward. The long-deserted dispensary needed revamping while he went to England for a medical diploma required for his registration as a doctor in Natal. In his absence in 1900-1901, Margaret, his wife took charge of care for the sick in the repaired three-roomed cottage. The following two years work more than doubled, but the space not. It was the death late in 1903 of a patient on the door-step after travelling a long distance that convinced him that the dispensary work had to be moved to a geographically more central position.

Durban was now reachable by railways from all over South Africa, as a result in 1904 the dispensary was moved to Durban.[73] This physical separation of the medical department from the mission station signified a significant shift in the perception of medicine within the mission; it represented a recognition of medicine as a mission agency on its own.[74]

---

[72] . Shiels, 'Bridgman family', p. 134
[73] . AZM, 'A century of progress in medical work', p. 5, KCAL.
[74]. . It has been noted elsewhere that by the turn of the twentieth century, the idea of medical missions had become widely accepted as a healing ministry of the church. See, for instance, Sheils, W. J. (ed.), *The church and healing*, Oxford, 1982, pp. XXII-XV.

In Durban the dispensary became ‘a substantial brick building.’ The staff composed of his wife, Margaret, as an anaesthetist; Katie Makhanya as his nursing assistant; Mgqibelo as an orderly; and Laura Nyuswa as a domestic servant. The repositioning of the dispensary proved a wise decision and sick people came down to Durban from all over Natal and Zululand. ‘Since coming to town’, enthused McCord, ‘ the department has been more than self-supporting.’ Enough money was being raised for a bigger hospital. Little wonder then four years later a tower of three-storey hospital stood on the Berea after a nail-biting legal battle with white Durbanites resisting a black hospital in a ‘white area’.[75]

In the kingdom, SPG medical advances were a credit to the efforts of Miss Mallandaine, a nursing sister, invited by the new Bishop of Zululand, a believer in the medical mission. In 1906 he wrote, ‘a native hospital will be started in 1907, Miss Mallandaine …has been in England for…a three months course at her old hospital, Guy’s’.[76] In 1914 she opened a second two-storey hospital coinciding with a malaria epidemic in the surrounding lowvelds, as a result it became inadequate from the very outset. It is striking to note that it was the SPG which first planned a hospital in Natal in 1868-1871, but it only built one in 1907 in Zululand. The reason for this was not just the departure of Dr. Callaway, but more importantly it was the replacement in 1871 of the medical mission-enthusiast Bishop Wilkinson with the sceptical Mckenzie. No wonder when Bishop Lee, himself a dabbler in medicine, took over in 1904, a dispensary was opened by the diocese. He vigorously sought support for a hospital in London while Mallandaine took care of logistical planning for the hospital. However, even he was prepared to close them to release matrons and nurses to join the British military medical service in 1915. McCord’s hospital closed as well when America joined the war.[77]

---

[75] . For an account of this battle, see , J. B. McCord, *My patients were Zulus*, London, 1946, pp. 145-57.

[76] . That became Etalaneni mission hospital. See *Mission Field*, LII, 617, p. 143.

[77] . Their patriotism was good news to the British and American military medical corps, but it was a blow to Africans’ fight against rampant diseases where no substantial alternative medical services were available.

Unprecedented in Kwazulu and Natal in this era was McCord's pioneering work of training young African women as nurses. All his predecessors seem not to have realised the importance of recruiting and training an African agency, no wonder Adams died of hard work and Bridgman was overworked even with Nembula working alongside him and he never considered training African assistants. In contrast, at the very outset, McCord employed an African interpreter-cum-nursing assistant.[78] With the removal to Durban, he recruited student-nurses from among patients. One of them, Elizabeth Njapa was entrusted with the charge of a women's ward and Joseph Mgobozi was in full charge of the hospital the first half of 1909.[79] It is crucial to point out that one of the advantages of training nurses which McCord would soon find was that their nursing services while in training would be used for free.

On leave in America, McCord recruited a trained nurse-tutor, Miss McNeill. Rather than looking for candidates from amongst the patients' relatives, she turned her attention to the best girls' high school in Natal, Inanda Seminary. After speaking to the ambitious girls about the nursing profession, out of a large number that came forward she selected three star girls and daughters of the Christian elite.[80] These star girls were to become pioneers of African professional nursing in KwaZulu-Natal. As school girls, they belonged to a generation which aspired regardless of what the society expected of them for independent-income careers of school teaching, dressmaking and nursing.[81] This was contrary to the missionary ideals of female education for domesticity about which scholars have enthusiastically written. For, instance, Edna Mzoneli became a nurse in spite of her parents' cajoles and her teacher's

[78] . See her biography by McCord's daughter, M. McCord, *The Calling of Katie Makanya*, (Cape Town, David Philip, 1995).
[79] . McCord, *My patient*, p. 92; HL, ABC 15.4, Vol. 23, Report of the Medical Department, 30/06/09.
[80] 'Golden jubilee', p. 16.
[81]. They would have been expected to stay in school long enough to reach marriageable age, marry and start their own families. But that often had to wait until they had reached their ambitions and sometimes they never even married at all.

warning that there were no nursing vacancies available.[82] Yet gender scholars dismiss girls' education in the mission as 'education for domesticity' as if missionary expectations determined the outcomes.[83]

The nurses' post-graduate lives do indicate an element of initiative, independence and a wish to do the best for themselves. Julia Magwaza was an excellent general nurse and proved herself competent enough to take charge of the hospital at night. On completion in 1916, she worked as a nurse at McCord's. By 1918 she was employed at the big Durban state hospital as a nurse among 'nurse-maids. She was soon promoted to a superintending sister over blacks' wards. Supervising forty white student-nurses, she confronted racism rampant in state hospitals. Her colleagues took other routes: Nomahluzi Bhengu worked at McCord's for while and resigned on getting married. As a housewife she ran ante-natal clinics and referred complicated cases to McCord's. This became the case with some of the next graduate nurses, thus they created satellite clinics for McCord's, a phenomenon which had not crossed McCord's mind that was soon to be a norm in new hospital systems.[84] This challenges the portrayal of African nurses in South Africa only as victims of their white colleagues by showing ways in which women's future nursing careers were influenced by the nurses' own values.[85]

McCord's training of men as nurses was not equally successful; in fact the scheme was not on the scale of similar schemes in East Africa which laid the basis for a fully-fledged medical profession.[86] Mqgibelo, the oldest male

---

[82] . McCord, *My patient*, p. 93.
[83] . Writing about Inanda Seminary, Hughes treads the same line. See H. Hughes, 'A lighthouse of African womanhood: Inanda Seminary', in C. Walker (ed.), *Women and Gender in Southern Africa to 1945*, Cape Town, 1990, pp. 197-220. For a more detailed review of such gender literature, see Zondi, 'Making', especially pp. 1-16.
[84] . AZM, ABC 38: 29, Cushing, D. P., 'Big doctor "Jim" McCord', Houghton Library, Harvard. See also McCord. *My patients*, pp. 77, 164-5.
[85] . Shula Marks has emphasised this victimization of black nursing to the extent of rendering African nurses simply victims. This view obscures the initiatives of these women to challenge the subordination in creative ways within the limits of their subordinate position. See S. Marks, *Divided Sisterhood: Race, Class and Gender in the Southern African Nursing Profession*, London, 1994.
[86] . For a lucid discussion of this African agency in East Africa, see J. Iliffe, *East African Doctors: The History of the Profession*, Cambridge, 1998, pp. 21-25. Dr Mitchell of Mulago

assistant until about 1915, had a lot of initiative; however, without any schooling and training he could only serve tea, preach and organise patients in the waiting room and like Katie, he was too old to start a training course. Mgobozi had some education and did male nursing in the hospital, but he left for greener pastures.[87]

As a result McCord engaged Jonathan Shabani and Edward Ntuli, former Adams High students and sons of preachers. While Shabani quickly learned symptoms of diseases, remedies and general hospital procedures, he had higher ambitions than the hospital could offer. He was not satisfied with his role and pay. He soon left the hospital job and got a better one in town. Ntuli, on the other hand, proved an intelligent assistant in the surgical theatre and a dedicated male nurse. So like their East African counterpart, these men in their different strategies tried to wedge a social space for themselves to compensate for their positions as Africans in a colonial society.[88]

This experiment proved a fiasco. McCord decided to abandon it after failing to get a 'suitable' replacement for Shabani.[89] This was a blow to male nursing, but a boost to female nursing as McCord turned more towards the training of female nurses and midwives, later with the help of government subsidies. This can be explained in terms of males' inability, in this case, to be assertive without bursting the limited spaces they were operating in. Their old tendency to move between jobs, on the one hand, and the association of caring for the sick with femininity, on the other, also explains this. Not to omit the interest schoolgirls showed in the nursing profession. This also shows the unique ability of these African women to be assertive without irritating their nurse-tutors.

---

hospital in Uganda gave a series of talks in medical missionary gatherings during the World War Two, see *The South African Outlook*, 1 October 1945, 45, p. 156.

[87] . McCord, *My patients*, p. 108.

[88] . Iliffe, *East African doctors*, p. 23.

[89] . It was common practice for African men to work for short periods and return home or move to better ones. No study of this labour behaviour is known to the author of this paper. See examples in D. Child (ed.), *A Merchant Family in Natal: Diaries*, Cape Town, 1979, pp. 67-9, 73-4 and 121.

While McCord abandoned his male nurse-training scheme, he continued to pursue his plan and ambition to start a medical school for African young men. In a society in which the black majority's health was neglected by the white state, the all -white medical profession found an 'el'dorado' in medical practice among Africans and would not let the training of black doctors take it away.[90] It was not until the eve of the Second World War (40 years later) that a scheme along the lines of McCord's began.[91]

The 1918 Influenza epidemic and expansion of mission medical institutions.

'*Unsukumbili usuvimbezele manje lapa e Natal'*, lamented a correspondent of *Ilanga Lase Natal* reporting the spread of *Unsukumbili* (disease lasting only two days), as the Spanish Flu of 1918 was called. Like usual flu, this influenza's infection began with a headache, then pains in the back and on the joints followed, within 24 hours the temperature was high, vomiting and giddiness had set in. Unlike the usual flu, the victim was dead within 48 hours or the flu disappeared, hence its being called, *Unsukumbili* by Africans for it lasted two days. As names listed in every issue of *Ilanga* in October and November show, the victims were mainly young adults, contrary to the norm which was the young and the aged were often the worst victims epidemic diseases and hunger.[92]

---

[90]. I am aware of the implications of this statement.

[91]. For deeper discussions of Africans and the medical training, see Burns, C., ' " A man is a clumsy thing who does not know how to handle a sick person": aspects of the history of masculinity and race in the shaping of male nursing, 1900-1950', *Journal of Southern African Studies*, 24 (4), 1998. See also Shapiro, 'Doctors or medical aids in the debate over the training of black medical personnel', *Journal of Southern African Studies*, 13 (2), 1987.

[92]. See, J. Burman, *Disaster struck South Africa*, Cape Town, 1971, pp. 83-92. No wonder, the Spanish Flu had such adverse effect on the South African economy in general, it walloped the most economic active in society. Its demographic impact has been weighed, its socio- economic impact on Africans as the poorest in South African society awaits a serious study. For an assessment of the local demographic impact of this calamity, see H. Philips, 'Local state and public health reform in South Africa', *Journal of Southern African Societies*, 13, (2), 1987, pp. 210-33

After mentioning a number of victims from principal African families, the correspondent went on to describe the anxiety and terrible fear among the people like this: '*Kungene elikulu ivuso lapa kiti lalo mampenga no Bhememe lomkuhlane u Spanish Influenza… Onke amasonto aselungiselwe ukuba abezibhedlela…oyopila oyixoxisa okwensumo…kahle ngamatshe Spanish Flu!.'*[93] ['There is a lot of anxiety in our land about this menacing virulent fever, the Spanish Influenza. All the churches are preparing to run as hospitals. In government offices smells their charm, Jeyes Fluid…those who will survive will tell it as if it were a myth…Stop!, oh Spanish Flu.]. The mission hospitals still being closed on account of staff serving in the war, Africans had no facility of western medicine to go to. Those in Durban were lucky that the city council converted a beerhall in Umngeni into an Influenza Hospital and engaged Kwa Muhle clerks as paramedics. A number of elated men wrote to *Ilanga* relating their good experiences in the hands of these young men. One James B. Ndlela was impressed by the fact that these paramedics carried stethoscopes around their necks and medicine chests like real doctors. He singled out their courtesy for praise: '*oke waya kona akakohlwa impato nomusa walezensizwa zakiti ezinokwazi nenhlonipo…nempela kuyatokozisa ukubona abantu bakiti bepete izikundhla ezinjengalezi.'* ['All who've been there remember the care and kindness of these young men of our nation who have both the knowledge and respect. It really is pleasing to see our compatriots holding positions such as these men are holding.]. These men were Messrs K. C. Kraft from Isandlwana Mission and Vivian Nembula, of the family of pioneers and the unfortunate of Adams.[94]

Curiously the closure of mission hospitals during the war did not induce the government to take its responsibility for public health. The reason why this was the case was, as Marks and Andersson have shown, as long as diseases of impoverishment were confined to the rural black, the state was not moved. It

[93]. *Ilanga Lase Natal*, 15/11/1918.
[94]. *Ilanga*, 29/11/1918, p.2 . Vivian may have been the son of the first African doctor of biomedicine in Natal, Dr John Nembula, the brother of successful landowners and farmers in the south coast, Hiriam and Harry. Writing a history of this family, which is a story of trials and successes from the 1840s to the 1950s is one of my ambitions.

would only respond decisively in case epidemics that knew no colour bar and threatened the capital broke out. No wonder the 1918 Spanish Influenza epidemic was a turning point in public health and in the development of mission medicine in South Africa. It shattered the complacency of biomedicine and lowered expectations from it heightened by its relative successes since the late 19th century. [95] Even before the state set up a commission leading to the establishment of the first national public health department, most rural Black's health burden fell in the hands of missionaries and, to a less extent, the few district surgeons.

When a lethal pneumonia induced by the influenza hit the feverish lowlands of northern Natal and coastal Zululand, African victims thronged the mission stations. As the above quotation shows, every sort of building in the mission station had to be turned into a makeshift hospital. Evangelical work had to make way for 'a secular ministration to the sick'. Every SPG missionary was equipped with a medicine chest to take the Flu head-on. When a Wesleyan missionary family died as the influenza wiped out the village they lived in, for the first time, they opened a dispensary under a Norwegian missionary nurse. The Church of Sweden missionaries put aside rondavels for accommodation of sufferers to be attended to by district surgeons. Denominational differences were thrown aside as the Catholic Augustinian nursing sisters visited the sick in Anglican, Lutheran and Wesleyan dispensaries. While the epidemic had disappeared in November of the same year, it had lowered Africans' biological resistance to endemic maladies like pneumonia, dysentery and rheumatic fevers that followed it. Thus it further complicated the disease environment.

But the influenza not being necessarily a disease of poverty, exposed the limitations of the march of biomedicine. No previous health control measures could apply with success: that is, quarantine, food relief, disinfecting and vaccination. In the South African context, it exposed the inadequacy of

[95] . Marks and Andersson demonstrate this with regard to the incidence of endemic typhus only eliciting state health intervention when it became epidemic in 1917 and threatened the white settlements at the Cape. See Marks and Andersson, 'Typhus and social control', in Macleod,

medical provisions, especially to Africans. Unfortunately, mission medical institutions had been closed during the war, missionary intervention could have been better. As the legendary, Magema Magwaza urged his contemporaries, the role played by African nurses single-handedly among many helpless people was not (and still is not) fully understood. For instance, Nurse Edna Fihlela (nee Mzoneli) fought hard not only to treat the sick in the south of Durban who were too many for her anyway, but also to counter the heightened fear of the white man's medicine. The people were suspicious: *'Isimangaliso esikulu abantu abaningi abayitatanga leyo miti bati, loku abelungu bayitanda kangaka imali lemiti yanamuhla okutiwa asingayitengi imbala abasiqedeli nje?*[96][The wonder is that a lot of people did not take the medicines provided, saying but whites like the money so much, what kind of medicines are these that we are told we do not have to pay for, are they not finishing us off through it?]. In the end she too succumbed to the flu just after giving birth to a child who also died.

The most modern mission intervention was the extension of hospitals with the assistance of the first state Public Health Department.[97] No less than twenty three major mission hospitals and a plethora of dispensaries were established between 1918 and 1939 with government subsidies.[98] Even more phenomenal was the development of nurse-training in mission hospital made easier for other missions by extra state grants for nurse and midwife-training hospitals. Prior to that only the American Board's McCord, Anglican Kwamagwaza and Trappist's Marianhill hospitals had trained nurses. None of these had more than eight students at a time, but in the 1920s they had an average of twenty girls each, and smaller missions had ten.[99]

---

and Lewis, *Disease, Medicine, and Empire*, pp. 257-283.

[96]. *Ilanga*, 29/11/1918, p. 2.

[97] . In response to the epidemic this act set up the first Public Health department and made possible the state grants to mission hospitals and clinics. See *The report of the committee of inquiry re: public hospitals and kindred institutions*, Cape Town, 1925, UG 30-'25, RCS, pp. 6-7.

[98] . M. O'reagain, *The Hospital Services of Natal*, Natal regional survey, VIII, Durban, 1970, pp. 24 and 39-40. See also MS.HOS., KCAL.

[99] . See a folder of the histories of mission hospitals in KwaZulu-Natal compiled in 1974: MS. HOS, KCAL.

Conclusion

In conclusion, then, the factors in the development of medical missions in South Africa are to be sought in the complex interplay between disease, African initiative, missionary charity and the parallel history of western medicine. To view this simply as a medical or biological cannon for colonialism, or as a bait to the soul is to give missionaries more power over the processes of interaction with Africans than they actually had. The role of Africans pressed by ever more and new diseases in inducing missionaries to provide medical help is a key factor. This development was helped by changes in mission thinking about the medical mission in the form of rationalization which helped justify the investment of resources on the part of the mission and its friends. However, theological justifications themselves do not explain why and how the medical mission developed, rather they rationalised the medical mission as a *fait accompli*, i.e. they followed rather than preceded medical work.