AN HISTORICAL EVALUATION OF THE LUTHERAN MEDICAL MISSION SERVICES IN SOUTHERN AFRICA WITH SPECIAL EMPHASIS ON FOUR HOSPITALS: 1930s-1978

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PIETERMARITZBURG

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DECLARATION

As required by University regulations, I hereby state unambiguously that this work has not been presented at any other University or any other institution of higher learning other than the University of KwaZulu-Natal, (Pietermaritzburg Campus) and that unless specifically indicated to the contrary within the text it is my original work.

RADIKOBO PHILLIP NTSIMANE

29 August 2012

As candidate supervisor I hereby approve this thesis for submission

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PROFESSOR PHILIPPE DENIS

29 August 2012

DEDICATION

I humbly dedicate this work to the millions of South Africans who through no fault of their own have never had the opportunity to see the inside of a classroom. May the day soon dawn when all doors of learning and culture will be opened to everyone.

THEBOLO

Ka boikokobetso lokwalo lono ke lo rebolela bontsi-ntsi jwa batho ba Aferika Borwa ba ba tlhokileng tshono ya go tsena sekolo e se ka go gana ga bona. A letsatsi la go bulwa ga dikgoro tsa thuto le ngwao le itlhaganne.

UKWETHULWA

Ngentobeko lencwadi ngiyethulela izigidi zabantu base Ningizimu Afrika abanga tholanga ithuba lokufunda kunge ngokwehluleka kwabo. Sengathi usuku lokuvuleka kwamasango emfundo namasiko lungafika ngokushesha.

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Radikobo Phillip Ntsimane
August 2012

ABSTRACT

The purpose of this thesis is to show through a chain of events how the Lutheran Mission societies in their quest to provide health care through biomedicine to indigenous people in Southern Africa ended up co-operating with the South African government in the implementation of the policy of apartheid. The question that this thesis will thus seek to answer is the following: If foreign missionaries were motivated to the extent that they left their homes in Europe and North America, why did they allow their hospitals to be subjected to government takeovers without offering much by the way of resistance?

Biomedicine was not introduced to supplement the existing traditional health systems but to replace them. Black people had ways and means to attend to their sick through traditional health systems such as *izinyanga, izangoma,* and *izanusi* among the Zulu, and *dingaka* and *didupe* among the Sotho-Tswana. In Southern Africa, the missionaries saw suffering and great need, and worked as lay medical practitioners to alleviate health problems long before apartheid was formally introduced after the National Party came to power in 1948. Subsequently, they worked with trained medical missionary nurses and doctors. The Lutheran missionaries saw biomedicine as being not far-removed from advancing their mission work of converting the indigenous people to Christianity.

In their provision of basic biomedicine from small structures, the Lutheran missionaries developed their health centres into hospitals by means of assistance from home societies before apartheid became the policy of the government. Financial assistance was also received from the South African government especially in the 1960s to combat the tuberculosis epidemic. However dedicated the missionaries were,

they were condemned to see their influence gradually reduced because they were forced to rely on government subsidies in the running of the hospitals.

In the 1970s, the apartheid government nationalized Lutheran and other mission hospitals. The hospitals were taken over and handed to the newly-established homelands and self-governing states to run. Under this new management, the mission hospitals' quality of service was compromised. The question is: why did the Lutheran missions allow their hospitals to be nationalized? Overall, one can see that the Lutheran missions were influenced by race when they excluded black people from participating in the running of the mission hospitals, despite Blacks having taken over the running of the former mission churches since the 1960s.

In Botswana, nationalization occurred differently. There was no total take-over of mission hospitals and the attendant exodus of white medical missionaries. From the time of independence in 1966, the Botswana government decided to work with mission societies in health care. The government formulated health policies and provided part of the financial needs of the hospitals, while the mission societies provided personnel and ran the hospitals. For example, the Bamalete Lutheran Hospital (BLH) in Ramotswa continues to be run by the Hermannsburg Mission Society. The national Lutheran Church played an important role in the hospital as the Church was part of the governing board.

This thesis has attempted to show that, while the Lutheran missionaries were motivated to develop a health care system for the indigenous people through the introduction of biomedicine and the building of hospitals, they were so dependent on the assistance of the apartheid government, especially in the 1960s and the 1970s, that they could not see that their collaboration with the government in the nationalization of mission hospitals was in fact a collaboration with apartheid. Some individual mission doctors and nurses, especially in the Charles Johnson Memorial Hospital in Nquthu, resisted the nationalization programme, but not the Lutherans. These were paralysed in the face of the pseudo-nationalization programme of the apartheid regime. The interpretation of the Lutheran doctrine of the 'Two Kingdoms', which dissuades Christians from interfering in the sphere of secular governance, may have

had bearing on their reluctance to challenge the apartheid regime to provide better health care.

Key Themes: *Acculturation; African Independent Churches; Africanization; Amakholwa; Biomedicine; Black Nurses; Doctrine; Health care; Homelands; KwaZulu-Natal; Mainline Churches; Medical Syncretism; Mission Doctors; Mission Hospitals; Mission Societies; Nationalization; Personnel; Power; South Africa; Sphere of Influence; Spiritual Healing; Traditional Medicine; Two Kingdoms; Witchcraft.*

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BIBLIOGRAPHY

GLOSSARY

AIC	African Initiated Churches
ALM	American Lutheran Mission
ARCH	Association of Rhodesian Church-related Hospitals
ANC	African National Congress
ATR	African Traditional Religions
ZACH	Association Zimbabwean Church-Related Hospitals
BC	Black Consciousness
BCP	Black Communities Projects
BLH	Bamalete Lutheran Hospital
BMS	Berlin Mission Society
CCSAMM	Consultative Committee of South African Medical Missions
CI	Christian Institute
ELCSA	Evangelical Lutheran Church in Southern Africa
ELCSA-SED	Evangelical Lutheran Church in Southern Africa – South Eastern Diocese
ELCSA-WD	Evangelical Lutheran Church in Southern Africa – Western Diocese
HMS	Hermannsburg Mission Society
NMS	Norwegian Mission Society
LCSA	Lutheran Church in Southern Africa
LKM	Lutheran Church Mission
LMF	Lutheran Medical Foundation

LMS	London Missionary Society
LWF	Lutheran World Federation
MELFC	Mission of the Evangelical Lutheran Free Churches
RCC	Roman Catholic Church
SDA	Seventh Day Adventist Church
TBVC	Transkei, Bophuthatswana, Venda and Ciskei
TCAMH	Transkei and Ciskei Association of Mission Hospitals
TRC	Truth and Reconciliation Commission
UCCSA	United Congregational Church of Southern Africa
UFCS	United Free Church of Scotland
ZCC	Zion Christian Church

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MAP OF LUTHERAN MISSION HOSPITALS

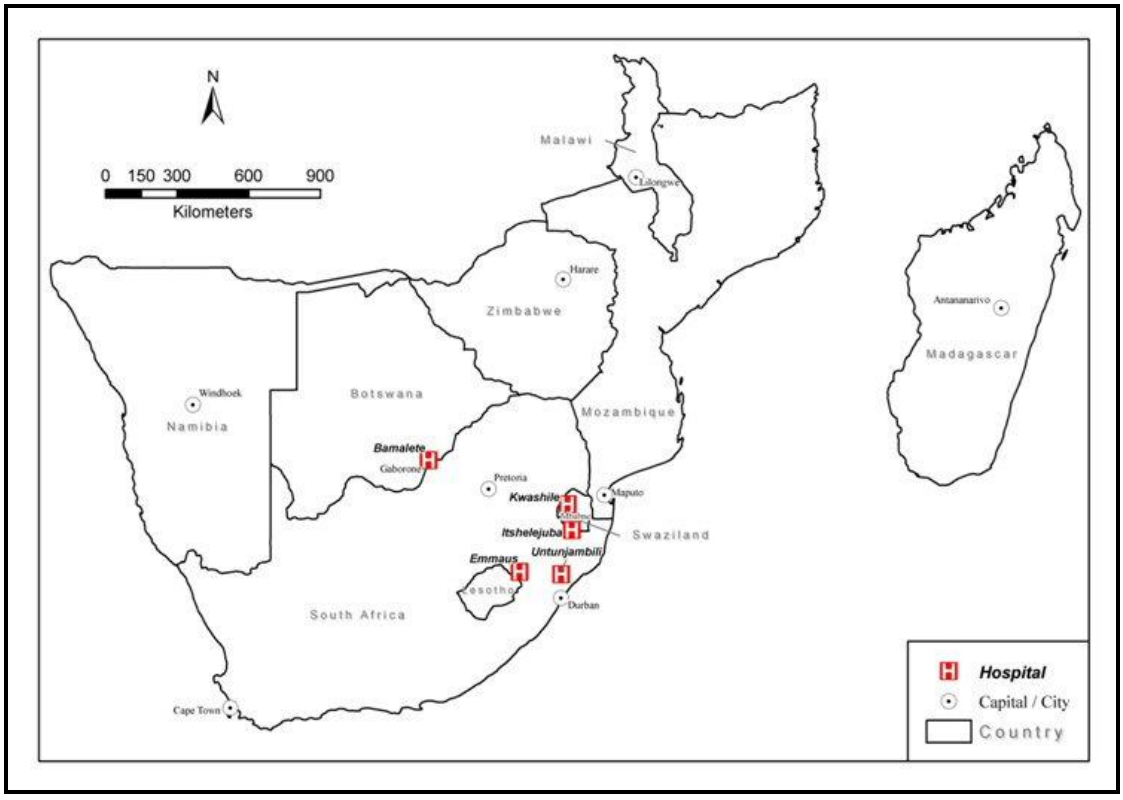

Figure 1

Map of Southern Africa showing the Four Lutheran Mission hospitals in addition to the one in Swaziland

CHAPTER ONE

GENERAL INTRODUCTION

1. Introduction

This thesis is not simply a study that recognizes the importance of the work of the Lutheran missionaries in southern Africa. While one cannot ignore the value of the school education, mission hospitals and agricultural methods introduced by the missionaries, this study goes beyond the recognition of the missionaries' contribution, about which a lot has already been written.[1]

As the title suggests, the thesis intends to look critically at the history of the Lutheran medical missions within a specific historical period in southern Africa. Although the title suggests that Lutheran medical missions in southern Africa will be studied, I chose to focus on four of them in the context of this study. This choice was made because they each represent the four missionary societies, viz.: the Norwegian Mission Society (NMS) and later the American Lutheran Mission (ALM) for Untunjambili Mission Hospital; the Hermannsburg Mission Society (HMS) for the Bamalete Lutheran Hospital in Botswana; the Berlin Mission Society (BMS) for the Emmaus Mission Hospital in Bergville; and the Mission of the Evangelical Lutheran Free Churches (MELFC) for Itshelejuba Mission Hospital between Pongolo and Piet Retief. The choice helps in seeing how the different missionary societies were motivated to start hospitals and how they used medicine as a mission strategy to convert the indigenous people to Christianity.

[1] Lawrence Zikode, "A History of the Emmaus Mission." (Undated and self-published); AEF. Garret (ed.) *South African Methodism: Her Missionary Witness*. Methodist Publishing House: Cape Town. (Undated); Michael Gelfand, *Christian Doctor and Nurse: The History of Medical Missions in South Africa from 1799-1976.* Mariannhilll Mission Press: Mariannhill, 1984; Willem Saayman, *Being Missionary - being human: An Overview of Dutch Reformed Mission*. Cluster Publications: Pietermaritzburg, 2007. Jonathan A. Draper, *The Eye of the Storm: Bishop John Colenso and the Crisis of Biblical Inspiration*. Cluster Publications: Pietermaritzburg, 2003.

Untunjambili Mission Hospital was relevant for this study because it was only established when the mission station was taken over by the ALM after the Mankankanana Mission of Hans Schreuder left the NMS. That was despite the fact that there were already biomedical activities, albeit on a minimal scale, during the time of the NMS.

The Bamalete Lutheran Hospital in Botswana is special, as it was established by HMS, which began in Natal. It was operated independently from the HMS activities in South Africa and unlike others it remained in strong partnership with the national government of Botswana after Botswana's independence in 1966. It provides an opportunity to learn how mission can relate to governments in health care matters.

The Itshelejuba Mission Hospital was established by a mission society that had split from the HMS. It would be interesting to see if there were similarities in how this society approached the medical missions, which were not part of the mission strategy of Louis Harms, the founder of HMS. Although Itshelejuba was the last to be founded among the four, it still provides a valuable opportunity to understand issues of power as one of only two hospitals of the MELFC. Itshelejuba provides a good study subject by being close to the national border, as it benefited people in South Africa and in Swaziland.

The Emmaus Mission Hospital as the only medical facility of the BMS, will help the study to show how this mission society, that initially refused to support the medical initiatives of the missionaries, later fully supported fully these initiatives. Emmaus was the only hospital to have been established in the proper sense through the efforts of a woman doctor, Magdalene Schiele, after World War Two.

Due to the fact that the author can only read English and German among the European languages, the study was limited for convenience sake to those mission societies that used those languages for their administration. The four mission hospitals could show the responses to nationalization from various Lutherans like the MELFC, the HMS in Botswana and the combined Lutheran medical work under the Lutheran Medical Foundation in South Africa in the 1970s. The research sought to establish how the indigenous people who received the hospitals interacted independently with

Lutherans. Due to the fact that in the 1960s the Lutheran mission hospitals operated under one umbrella body in Natal and Zululand, there was no need to choose more.

The research period chosen straddles two eras of the history of the Lutheran churches in southern Africa. The 1930s was a period of renewed missionary activities before the Second World War. Most mission hospitals in southern Africa were founded in the 1930s. Of the four hospitals chosen, only Itshelejuba was properly established after the 1930s, when the first nurse Ruth Bauseneick, arrived. In period after 1960 was when the mission churches were constituted into independent and semi-independent entities with their own constitutions and even with black leadership in some churches. In the 1970s, the mission hospitals in South Africa were nationalized. Although the announcement for nationalization was made in 1974,[2] Itshelejuba and Untunajambili mission hospitals were only formally taken over by the government in 1978.[3]

2. The Research Problem

The takeover of the four Lutheran mission hospitals by the government disturbed the decades-old provision of biomedical help by the medical missionaries. Although the Lutheran medical missionaries developed the hospital work from very humble beginnings, for a number of reasons they could not sustain such hospitals any longer after the government had begun to subsidize them. In this thesis, the author will seek to discover why, when the Lutheran churches became constituted under a national leadership in the 1960s, the mission societies handed over to them their church buildings, schools and seminaries, but not the mission hospitals as well. The mission agencies maintained control of the mission hospitals until the government nationalized them, thereby removing any chance of the national churches running such hospitals. The fact that the Lutheran mission agencies did not object convincingly or make contingency plans well in advance when nationalization was first mooted by the South African government in 1973 is a topic for another

[2] Jon Larsen, "*KwaBaka": A Search for Excellence in Caring; The Story of a Mission Hospital Community in Zululand, 1930 – 2006.* Culster Publications: Pietermaritzburg, 2010, p.184.
[3] Matron Helen Msimanga interviewed by Radikobo Ntsimane in her office at Untunjambili on 27 July 2000. Friedrich Dierks interviewed by Radikobo Ntsimane at Bleckmar, Germany on 29 August 2002.

investigation. The answer may be sought in the doctrine of the 'Two Kingdoms', whose interpretation was emphasized as a call for Christians to obey the State and to dissuade them from challenging its actions. It was not the duty of the Church, according to the doctrine, to impose its teachings upon the State but to instead allow the State to do its duty unhindered.

Were the motivations of the Lutheran mission agencies with regard to health provision purely philanthropic or were there other motives? In light of the responses of the Lutheran mission societies to the nationalization of the mission hospitals, one cannot be blamed for thinking that the Lutheran mission societies abandoned the hospitals after Blacks gained control of the churches and the Bantustans. The thesis seeks to find out whether the responses of the Lutheran missions to the nationalization of their hospitals was unique, or whether the same could be expected from other Churches in a similar situation? Here one thinks of churches beyond the Lutheran circles, such as the Anglican and the Roman Catholic communions.

2.1. The Research Question

This study is interested in discovering why, in their quest to effect conversion among the indigenous people of southern Africa, the Lutheran mission societies introduced biomedical health care to the potential converts. Was it a 'by the way' introduction due to their own needs and their lack of trust in indigenous health systems, or was it to undermine local health systems? Was biomedicine used as a conversion strategy to wean indigenous people away from their culture and to have them embrace Christianity? This study will attempt to determine if it was for conversion purposes and for alleviating a shortage of effective health systems, or if it was for cultural degradation and political conquest by the Western colonial powers. The study will further seek to establish whether the Lutheran mission societies and churches failed to see that their collaboration with the State in health care provision was in fact collaboration in the creation of segregated health care, which left the indigenous people worst off. Through their various histories, I shall attempt to establish if the relationship between the mission societies' personnel—such as doctors and nurses on the one hand, and the indigenous people on the other, especially the church leaders—

was not a fertile ground to nurture the racial discrimination that the government sought to entrench in society in general. I also intend to establish whether the interpretation of the Lutheran doctrine of the 'Two Kingdoms' was not responsible for the passivity of the Lutherans' mission societies when it came to opposing the government segregation of the health system through nationalization. I will consider why the implementation of nationalization had pernicious effects in South Africa, while in other countries such as Botswana, it benefited society.

3. Methodology

This thesis relies heavily on oral history as a key methodology. Despite the fact that this methodology remains contested in some sectors, I want to argue that provided they are handled carefully and critically, oral sources, like any other sources, can be used in history. In this thesis, the oral history method achieved results which standard, archive-based methodology could not have achieved.

All the interviewees welcomed the opportunity when asked to tell their stories of the mission hospitals. We recognize, however, that their stories are subjective. Even if the interviewees told the story of the same hospital, it was highly unlikely that their stories would be identical because each respondent reconstructed the story from their own particular point of view. This needs to be taken into account in the interpretation of oral testimonies.

In the story of Itshelejuba, for example, Weber, Bauseneick and Bergter chose different points to highlight. Weber whose father founded the hospital, emphasized the founding period as told to him by his father. Weber's father also wrote of the founding period in his autobiography. Bauseneick who was the first nurse to work in Itshelejuba, emphasized the struggle she went through as the only nurse at the time. She mentioned the various diseases, the distances she walked to help the sick, and the individual cases she had to deal with like the birth of a boy called Republic. Bergter, the first doctor at Itshelejuba, emphasized his role in the transformation of the hospital as it was being prepared for nationalization.

In all these examples, one can see what Alessandro Portelli, an Italian oral historian, refers to when he wrote that, "The first thing that makes oral history different, therefore, is that it tells us less about *events* than about their *meaning*."[4] The three interviewees tell their stories of Itshelejuba in such a way that their contributions, except in the case of Weber are portrayed positively, as Portelli wrote, "The organization of the narrative reveals a great deal of the speakers' relationship to their history."[5] For interviewees, it is not about the facts and chronology, it is what the story means, often at the time of its narration.

This study relies heavily on the oral history method of research which remains contested in some sectors of the academia. One may ask if such sources are credible. While this question of credibility of oral sources is valid, it is just as valid to be directed to written sources. Portelli responded thus in defence of the validity of the oral sources,

> Oral sources are credible but with a *different* credibility. The importance of oral testimony may lie not in its adherence to fact, but rather in its departure from it, as imagination, symbolism, and desire emerge. Therefore, there are no 'false' oral sources. Once we have checked their factual credibility with all the established criteria of philological criticism and factual verification which are required by all types of sources anyway, the diversity of oral history consists in the fact that 'wrong' statements are still psychologically 'true' and that this truth may be equally as important as factually reliable accounts.[6]

As a researcher, I am indebted to the interviewees who shared their knowledge of the story of the various hospitals. It is clear though that although the interviewees had an agenda in telling the story in a manner that made sense to them, the researcher as an historian was in charge of the discourse by leading the story in a particular direction. Although writing about the role of the working class in the recording of their own history, Portelli's argument is relevant to this study, as he insists that the interviewer shapes the story together with the interviewees.

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[4] Alessandro Portelli, "What makes oral history different" in Robert Perks and Alistair Thomson (eds.) *The Oral History Reader.* Routledge: New York, 1988, p.67.
[5] Ibid.
[6] Ibid. p. 68.

> Nevertheless, the control of historical discourse remains firmly in the hands of the historian. It is the historian who selects the people who will be interviewed; who contributes to the shaping of the testimony by asking the questions and reacting to the answers; and who gives the testimony its final published shape and context (if only in terms of montage and transcription). Even accepting that the working class speaks through oral history, it is clear that the class does not speak in the abstract, but speaks *to* the historian, *with* the historian and, inasmuch as the material is published, *through* the historian.[7]

For ethical purposes, I have followed the standard procedure recommended by the Oral History Association of South Africa (OHASA) in the code of conduct found on their website.[8] The website emphasizes respect and transparency regarding the intention of the research project. It further cautions interviewers to be sensitive to issues of gender and avoid all things that might bring harm or embarrassment to the interviewers and their community. In his chapter in the book, *Oral History in a Wounded Country*, Philippe Denis has given a further discussion on the ethics of oral history, which I follow in this study. He emphasizes that oral history practitioners should take note of four major ethical points that are not dissimilar to the ones made in the OHASA code of conduct: Autonomy and respect for people's dignity; that their projects are non-maleficence to avoid harming the interviewees; that they are upfront in declaring to the interviewees any benefits to them that the project may have; and finally that justice should be seen to be done where the participation of interviewees is rewarded or at least duly recognized in the project's outcomes.[9]

Being responsible for the voices of the interviewees, the historian has to exercise extreme caution regarding what he publishes. Two informants have reacted differently when asked to provide the release agreement for the interview that they provided. One placed an embargo of over ten years on the interview transcript. The other informant specifically asked that certain issues be left out of the transcript because of the names mentioned during the interview. Ethically, I have respected the wishes of the interviewees even if I personally did not think that any harm would come upon them. The advice of Donald Moore and Richard Roberts regarding sensitivity is

[7] Alessandro Portelli, "What makes oral history different" in Robert Perks and Alistair Thomson (eds.) *The Oral History Reader*. Routledge: New York, 1988, p.72.
[8] <http://www.ohasa.org.za/> [Accessed 27 July 2012].
[9] Philippe Denis, "The Ethics of Oral History' in P. Denis and R.Ntsimane (eds.) *Oral History in a Wounded Country: Interactive Interviewing in South Africa.* University of KwaZului-Natal Press: Pietermaritzburg, 2008, pp.67 – 70.

crucial in such matters, where researchers have to decide whether sensitive information, which is important for knowledge creation, should be left out for the sake of the interviewees or should be included. They advised,

> Researchers must also be sensitive to the uses to which their data might be put. For whose benefit is historical knowledge collected, constructed, and disseminated? What effect will the use of historical knowledge have on the community studied? Steven Bunker (1978), for example, chose to wait until after Idi Amin was driven from power before publishing his research on peasant resistance to state marketing boards. While Bunker chose to be silent in order to protect his informants, what should researchers do when confronted with informants' silences?[10]

Some interviewees choose to leave out other information. There are a number of reasons for avoiding or refraining from discussing some matter during the interview encounter. Often interviewees ask for the recorder to be switched off in order to mention sensitive issues off the record. Alternatively, may provide information—according to their judgment—in a post-interview period just before the interviewer leaves the interview location. In this study, I have encountered such situations such as the case Dr. Wilhelm Weber on Itshelejuba Hospital and Dr. Ulrich Schmidt on Bamalate Lutheran Hospital.

4. Hypothesis

This thesis attempts to show that the relationship between the mission hospitals and the government in South Africa, which supported medical mission work financially and otherwise, saw the government taking control of the hospitals and ultimately nationalizing them. Due to the support given by the government to the mission societies, and the Lutheran tradition not to stand in opposition to governments, it was easier for Lutheran hospitals to be taken over than was the case with other mission societies that opposed the take-over. In Botswana, the relationship between mission hospitals and the new government of the 1960s was better managed. This continues to this day with government and Churches working in partnership to provide health care.

[10] Donald Moore and Richard Roberts, "Listening to Silences" in *African Court Records or History in Africa 17* (1990), pp. 319 – 25.

5. Theoretical Considerations

This study does not intend to make a contribution to theory. However, I shall show that subtle forms of power played a role in the relationship between the following: the medical missionaries who were health providers; the indigenous people who were converted and benefited from the mission hospitals; and the government which supported the medical mission work and ended up using it to enforce apartheid. Those relationships which began as assistance towards health restoration of the indigenous people ended up being used to discriminate against them in health matters. From time to time I shall refer to the works of Joan and John Comaroff[11], Paul Ricoeur[12], and Sue Russell[13], all of whom wrote on the power relations between "the haves" and "the have nots."

6. Literature Survey

In southern Africa where the major mission societies and Churches established mission hospitals in the 1930s and after, it is surprising to see how little has been written on the history of those health institutions. Michael Gelfand is credited for having published a large corpus on the mission hospitals in southern Africa. His books cover mainly South Africa and Zimbabwe—where he worked as a medical missionary. With P. W. Laidler, Gelfand wrote a volume covering a period earlier than the scope of this study, as its title suggests: *South Africa: Its Medical History, 1652-1898: A Medical and Social Study.* Though comprehensive, this book of 1971 is more about the activities of the colonial government's health policies. It ends about thirty years before the Lutheran mission societies founded most of their mission hospitals. Gelfand's 1984 book, *Christian Doctor and Nurse: The History of Medical Missions in South Africa from 1799-1976,* is thin on analysis but remains the most comprehensive work on medical missions. However, since Gelfand continued a book which was already started by someone else, he followed a catalogue style with

[11] John and Jean Comaroff, *Of Revelation and Revolution: The Dialectics of Modernity on a South African Frontier*. Volume Two. The University of Chicago Press: Chicago, 1997.
[12] Paul Ricoeur, *Time and Narrative*. Volume One. The University of Chicago Press: Chicago, 1984.
[13] Sue Russell, *Conversion, Power and Identity: the impact of Christianity on the power relationships and social exchanges.* University Press of America: Lanham, 1999.

information on the character of each hospital rather than seeking, like a historian, to know why certain things happened the way they did.

With specific reference to Zimbabwe—as in his 1984 book—Gelfand published *Godly Medicine in Zimbabwe.*[14] In this book, Gelfand provides an overview of how various mission societies founded medical work in Zimbabwe. He went beyond specific mission societies by showing how those hospitals formed themselves into the Association of Rhodesian Church-related Hospitals (ARCH). 'Zimbabwe' replaced 'Rhodesia' after independence in 1980.

Gerrit Ter Haar[15] has also made a major contribution to the study of medical missions. While not specifically dedicated to medical history, his book *In the Shadow of Tradition: Contrasting Health and Healing Concepts in Transkei,* (1999), covers the health-seeking practices of the people living around a Dutch Reformed mission hospital called Rietvlei. As a medical missionary, Ter Haar was also interested in an academic perspective on medical missions and wrote a very useful article on the issues of power in the mission hospitals. Entitled, "Power and Powerlessness in Medical Missions", Ter Haar's article encouraged trusting relationships "founded in the boundless resources of God's forgiving love in Christ Jesus."[16]

Siphamandla Zondi has also contributed to this discipline with a PhD thesis from Cambridge University in 1999. Zondi's thesis, "African Demand and Missionary Charity: The Development of Mission Health Services in KwaZulu to 1919", concentrated on the work of the American Board Mission in Amanzimtoti near Durban. Although Zondi's work covers the period prior to that covered by this current study, the fact that he deals with medical missions in Natal and Zululand is of value to any researcher who wishes to understand the medical missions among the Zulu people.

[14] Michael Gelfand, *Godly Medicine in Zimbabwe: A History of its Medical Missions*. Mambo Press: Gweru, 1988.
[15] Gerrit Ter Haar is one of the interviewees in this study.
[16] Gerrit Ter Haar, "Power and Powerlessness in medical mission", in *Missionalia* Volume 18, Number 1. April 1990, pp.51-60.

For an example of a book with a hagiographical bias, one can mention Märta Adolfson's and Anna Bernsston's 1984 book titled *Ceza: A Roundabout Way to the Goal: Three Decades of Medical Missionary Work in South Africa*. This book was written by former Swedish medical missionaries at Ceza hospital to celebrate the three decades they spent in Zululand. It is more a pat on the back than a critical study. It was in fact originally written for a Swedish readership in 1975 with minor changes in the translation.

The latest contribution on the history on medical missions comes from the Anglican Church Mission. Like Ter Haar who studied Rietvlei in the former Transkei homeland, Jon Larsen wrote a book titled *KwaBaka: A Story of Compassionate Care in a Rural Zulu Community* which he dedicated to the work of the medical missionaries among the people of Nquthu near Dundee in KwaZulu-Natal, where the Charles Johnson Memorial Hospital was built. This work is written in a comprehensive and detailed manner so that one can understand even the finer details of equipment and surgery for various operations. It is bordering on hagiography, especially regarding the contributions of one mission doctor named Anthony Barker.

The Methodists have also published a booklet on their history in South Africa but nothing in depth has been written on the history of their medical work. Although helpful in providing a picture of what medical activities the Methodists were involved in, the chapter titled "Medical Missions" reads like a catalogue showing where and when hospitals were established by mission doctors .[17]

In Botswana, although the country has many mission hospitals currently working in partnership with the government's health department, there is no comprehensive work on the mission hospitals. A recent scholarly publication confines itself to two mission hospitals in Kanye, viz.: the Seventh Day Adventist and the Moffat Hospitals. The publication is but one chapter in a book that attempts to cover the history of the Botswana Church.[18] The author, Part Mgadla, shows how politicians in the early to

[17] A.E.F. Garrett. *South African Methodism: Her Missionary Witness*. Methodist Publishing House: Cape Town, (Undated).
[18]Part Mgadla, "Who Used Whom in the Establishment of Medical Spheres of Influence in the Bechuanaland Protectorate? The Case of the Seventh Day Adventist and Moffat Hospitals in Kanye

mid-1950s manipulated things in order to favour and disfavour one or other mission agency in their struggle to consolidate their work in one area of the then-Bechuanaland.

While this study is not exclusively about the history of nursing in South Africa, the nursing profession plays an important part in the construction of the history of medical missions. There are few authors, mostly women, who have contributed scientific research on the history of nursing. Besides the authors who were themselves nurses, there is one historian, Shula Marks, who has approached the study of the development of nursing history by looking at race, class and gender.

Although her study, *Divided Sisterhood: Race, Class and Gender in the Nursing Profession*, covers the role of religious sisterhoods from the 1880s, it does not focus on the mission hospitals, most of which were established in the 1930s. One can see in this study, focused on mission hospitals, that race, gender and class issues influenced the relationships of hospital personnel. In the mission hospitals, we shall see that the nurses always lagged behind in the development of their profession and had to follow the lead of the state hospitals.

While Marks' study covers a long period from the 1880s to the 1990s, it is important to this thesis as it shows how the government involvement in health provision created discriminatory relationships among health providers and between health providers and health seekers. This thesis confines itself to the period in which the Lutheran mission hospitals were founded in the 1930s to the time when the apartheid government nationalized them in the 1970s. That is an area that the work of Shula Marks did not cover.

Megan Vaughan in her book *Curing their Ills: Colonial Power and African Illness*, attempts to show how what she calls colonial medicine had to struggle for acceptance in colonial Africa. Her study succeeded in demystifying biomedicine as it came into contact with indigenous health systems from the late nineteenth century.

1922-1959" Fidelis Nkomazana and Laurel Lanner (Eds.), *Aspects of the History of the Church in Botswana*. Cluster Publications: Pietermaritzburg, 2007, pp.115-116.

This thesis attempts to show that the introduction of biomedicine by missionaries among the indigenous cultures was not without challenges. In fact, the thesis will show that until nationalization, biomedicine was characterized by struggle to be the preferred health system of African people.

Vaughan's study is geared largely towards the contrasting attitudes of the indigenous people and the British colonial authorities. The book shows how the indigenous populations on the one side and missionaries and colonial official on the other, understood illnesses. The author has leaned towards showing the objectification of Africans by the colonists. For the missionaries and the colonial authorities, as was the case in South Africa at the time of Sir George Grey, the traditions of the indigenous populations were responsible for ill-health and needed to be eradicated in order that in-roads could be made to civilizing them. "The way to health in medical missionary ideology" Vaughan wrote, "lay in part through rescuing the individual African soul from the influences of traditional society."[19]

While Vaughan dedicated her work to showing approaches towards providing health services to the indigenous people in some African colonies, she did not show the different ways in which indigenous people responded to biomedicine.

Unlike the general study of Vaughan, this thesis will focus on four hospitals established by Lutheran mission societies around the 1930s and on how they were lost to nationalization in the 1970s.

7. Sources

This study will use published and unpublished literature and oral sources in the form of formal interviews. Interviews form a fundamental part of the whole study which uses the oral history methodology. Although this methodology was strongly rejected by historians in the past in favour of written records, it has been in use for centuries:

[19] Megan Vaughan, *"Curing their Ills: Colonial Power and African Illness*. Stanford University Press: Stanford, 1991, p.83.

> The use of oral descriptions was integral to the writing of history until the rise of modern historical scholarship a century ago elevated written documents into prominence as reliable historical evidence while devaluing oral records.[20]

Philippe Denis has traced the development of oral history and how its value has been doubted until recently. He and many other oral history practitioners see and use oral history as a fully-fledged discipline in its own right:

> Introducing the *Voice of the Past*, Thompson intimates that oral history should 'provoke historians to ask themselves what they are doing, and why. On whose authority is their reconstruction of the past based? For whom is it intended?' Oral history, in these terms, can be seen as a 'movement.' The authors of this book follow this line of thought. While recognising that oral history is often used in combination with other techniques of historical investigation to develop knowledge about the past, they see it as a fully-fledged academic discipline, with the encounter between the interviewee and the interviewer at its centre.[21]

7.1. Oral Sources

This study depends to a large extent on oral interviews. Not much has been written on the history of the Lutheran missions and the Lutheran churches that they founded in southern Africa. The few articles written were written by missionaries who wrote for a mainly German audience in order to keep the momentum of the mission going and to satisfy the curiosity about Africa that had captivated Europe in the 1800s and the early 1900s. Such literature was largely bordering on the anecdotal rather than on the scientific and critical. The Lutheran newsletters like *Unter der Kreuz*, *die Lutheraner*, and its successor *Missionsblatt*, of both the Hermannsburg Mission Society and other Lutheran mission agencies are a clear evidence of what the missionaries reported to their churches back home. Missionaries like Wilhelm Weber of the MELFC produced some booklets which were not a far departure from the articles written in the newsletters and bulletins. Seldom do missionaries write a critical study of their

[20] Thomas Charlton, *Oral History for Texans*. (Second Edition). Texas Historical Commission: Austin, TX., 1985, p.1.
[21] Philippe Denis, "Introduction," in Philippe Denis and Radikobo Ntsimane (eds.), *Oral History in a Wounded Country: Interactive Interviewing in South Africa*. University of KwaZulu-Natal Press: Pietermaritzburg, 2008, p.3.

sending mission unless they want to be recalled from the mission field. My critique of the literature produced by the Lutheran missionaries through booklets and newsletter articles is that they are to a large extent hagiographical for obvious reasons. It is for the purposes of comparison and complementation that oral sources will be used in order to understand the era that is under research.

7.1.1. Value of Oral Evidence

I have chosen to use oral history as a method of research, aware that there are some circles in the academic camps remaining unconvinced that it can stand its ground as a scholarly discipline.

Instead of trying to establish "the truth", which all historians know to be beyond reach, this study intends to establish by means of interviews how the people who were connected to mission hospitals constructed their stories to tell what they deemed to be "the truth". Interviewees tell their stories from memory and on the basis of their traditions and culture. Like the authors of written documents, the interviewees are prone to bias and prejudice when they tell their stories. As a result of that, no oral history practitioner can claim to have captured 'the truth' from the oral history interviews. Denis wrote thus regarding interviewees:

> They select, adapt, interpret and reconstruct the cultural heritage transmitted by their forebears. In fact, the strength of a cultural tradition is its capacity to be perpetually reinvented. Oral history does not give immediate access to the most ancient traditions. It tells us how these traditions are understood and recreated in a particular community at a particular time. The purpose of the interview is to access the worldview of the interviewee with all its layers of subjectivity. For an oral historian, the manner in which a tradition is culturally and socially represented is no less important than the historical information provided about this tradition.[22]

Simply put, the purpose of this study is not to establish the so-called facts. It seeks to reconstruct from oral and literary sources the history of the Lutheran mission

[22] Philippe Denis, "Introduction" in P. Denis and R. Ntsimane (eds.) *Oral History in a Wounded Country: Interactive Interviewing in South Africa*. University of KwaZulu-Natal Press: Pietermaritzburg, 2008, p.4.

hospitals, in relation to how people and institutional structures with varying powers related to each other in their pursuit of both health-seeking and health-restoring.

For many decades oral history has been contesting for space within the academic arena. Scholars, especially from European countries, have challenged the reliability and authenticity of oral evidence in the academic world. Europe has had alphabets for longer than southern Africa and therefore the scholars doubt oral evidence. As Donald Ritchie has pointed out, oral history can be said to have limitations:

> Oral history can be unconvincing. Some interviewees' remarks are self-serving; they remember selectively, recall only events that cast them in a good light, and seem to always get better of opponents. Interviewers may be too polite or too timid to ask probing questions about events that did not turn out well. Sometimes interviewees honestly cannot remember. They jumble names and dates and confuse people and places. Sometimes they deliberately recast their past to fit their current self and public image. Whole series of interviews can be faulted for paying attention to only one side of the issue, or for interviewing only the people who would speak positively about the individual who was the subject of the people.[23]

Denis has also cautioned against uncritical and naïve face-value acceptance of oral evidence by oral history practitioners. In his article, "The Use of Oral Sources in African Church History", Denis explains that the problem with oral evidence is that it lacks precision, it has a descriptive nature, it has a tendency to reconstruct the past and finally, it has an unconscious use of literary sources.[24]

Authors such as Jan Vansina[25] have made great effort to show that oral evidence has as great a value as literary evidence in scholarly work. The argument of the dissidents is based on a factual matter that memory is undependable, as it is selective and fades with time. They ignore however that even the written sources began as, and depend largely on oral sources for their production. If the origins of written sources can be traced to oral sources, then it goes without saying that written sources have to undergo scrutiny for reliability in a similar fashion to that of oral sources.

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[23] Donald Ritchie, *Doing Oral History: A Practical Guide* (Second Edition). Oxford University Press: Oxford, 2003, pp.117-118.
[24] Philippe Denis, "The Use of Oral Sources in African Church History" in *Bulletin for Contextual Theology in Southern Africa and Africa*. Volume Two, April 1995, pp.32-35.
[25] Jan Vansina, *Oral Tradition as history.* James Currey: Oxford, 1985.

7.1.2. Interviews

How did the interviewees construct their narratives? In the area of gender, one looks at the large number of women working in the hospitals. Due to the caring role assigned to women by most societies, it is therefore not surprising that for this study there are more women interviewees than there are men. Critiquing the gender imbalances in the nursing profession, Shula Marks wrote that the sisterhoods of Kimberley under Sister Henrietta Stockdale did a disfavour to the profession:

> It is difficult to overestimate the significance of Sister Henrietta and the sisterhoods in moulding the very concept of nursing in South Africa in these years – and since. Thus professional nursing in South Africa inherited from the sisterhoods the military notions of duty and the control of nursing staff and patient care could only be entrusted to a 'lady', an educated woman who was usually wealthy and of some social standing – all also characteristics of the British profession.[26]

Obstacles militating against a comprehensive research on Lutheran mission hospitals in southern Africa are mainly of a financial and temporal nature. Many medical missionaries have returned to the countries of origin. Given the limited finances and time-slots in which one could set up interview appointments, one had to settle for those interviewees who could avail themselves for interview. In 2002, while in Germany, I successfully managed to interview nine people previously connected to the medical missions. While some people appreciate to be interviewed for various reasons,[27] others would rather not talk about their past experiences. It is understandable that some missionaries, especially those who returned to their country fearing a revolution or revenge by Blacks after the 1994 democratic elections, refused to be interviewed. Although academic, the research project can be misinterpreted as a Truth and Reconciliation Commission of sorts, to expose the crimes or faults of the missionaries during the colonial and the apartheid eras. There may be other reasons why former missionaries refused to be interviewed.

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[26] Shula Marks, *Divided Sisterhoods: Race, Class and Gender in the South African Nursing Profession*. Witwatersrand University Press: Johannesburg. 1994, p.43.

[27] Radikobo Ntsimane discusses this subject at length in his chapter "Why should I tell my story? Culture and Gender in Oral History" in P. Denis and R. Ntsimane (Eds.), *Oral History in a Wounded Country: Interactive interviewing in South Africa.* University of KwaZulu-Natal Press: Pietermaritzburg, 2008, p.125.

It is of critical importance also to acknowledge the fact that my observations about the interviewees' willingness or unwillingness to be interviewed are based on interpretation rather than facts. I cannot advance my interpretation as fact especially where the potential interviewees did not state their reasons for declining to be interviewed. As a historian, I am at liberty to interpret thereby revealing my bias. Even in the case of my interpretation of the narrative, the whole exercise remains just that, an interpretation. Paul Ricoeur wrote that historians are like judges "placed in the real or potential situation of a dispute, they attempt to prove that one given explanation is better than another." By using the evidence available to them, historians rigorously evaluate the plausibility of each in comparison to others in order to reconstruct a credible story. Simply put, the historian, as in my case, is the one who decides what among the bias sources is credible to be used. While doing that the historian's biasness is undeniable.

In June 2011, I went on a trip to Germany to revisit the Lutheran archives to again look at the documents used in this thesis and to reference them accordingly. On the same trip I asked the surviving interviewees a written consent to append to the transcripts of their interviews within the thesis. It is understandable that the retired medical missionaries living in retirement homes are not trusted by their minders to give interviews any longer due to old age. In similar fashion, principal interviewees living in South Africa refused to give a written consent. Since some of the information that they divulged could cause defamation to others or to themselves they did not allow the transcripts of the interviews to be made public. In his chapter on the *Ethics of Oral History,* Denis wrote about this possibility of refusal:

> In any event, it is recommended not to transcribe and preserve interviews or parts of them when they contain defamatory statements. When a statement is believed to be false or damaging to the reputation or privacy of a third party, the portion of the interview and the transcript containing the statement should not be made available to researchers and certainly should not be published until the subject of the statement is dead.[28]

[28] Philipe Denis, "Ethics of Oral History" in P. Denis and R. Ntsimane (eds.) *Oral History in a Wounded Country: Interactive Interviewing in South Africa.* University of KwaZulu-Natal Press: Pietermaritzburg. 2008, p. 78.

For this reason I have chosen not to append any transcripts to this thesis. It is better to respect the interviewees' wishes rather than to cause irreparable damage to relationships and to block opportunities for other researchers.

Some interviewees were eager to give their consent but were unwilling to append their signature out of ignorance or out of fear of reprisals. Although the interviewees have given permission to use the information gathered during the interviews for this thesis, I do not have written permission to make such information public through appendices for all to see. When a request was made to make the transcripts public by appending them on the thesis, a refusal was received. The caution of Denis to researchers is relevant here:

> In vulnerable communities with high levels of suspicion, as is the case in many communities in South Africa, a signed consent form can be perceived to as a threat. In those communities, some people have a low level of literacy and written document – even if it is in their home language – may intimidate them and even dissuade them from participating in a project. For this reason, it may sometimes be more appropriate not to use a written consent form. If the risk of harm is very low, a recorded verbal statement may be sufficient.[29]

Among those interviewed were missionary doctors (Bergter, Lutkins, Schmidt); missionary nurses (Bauseneick, Gnauk, Sommerfeld); other nurses, (Helen Msimanga, Magdalena Seabo); children of medical missionaries (Solveig Otte, Wilhelm Weber, Richard Schiele); hospital administrators (Jabulani Mdluli and Peter Schildkneckt); committee members (Friedrich Dierks, Nason Danisa, Eli Makhoba); chaplains, (Vivian Msomi, Mookodi Rangongo); other knowledgeable people related to the hospitals (Dean Mthethwa, Titus Dlamini, Sibusiso Xulu, Sindisiwe Zikalala) and; a driver (Simon Dlangamandla). All those who were interviewed were interviewed on the bases of their willingness to be interviewed and on their availability. Elsewhere, this author discusses the reasons why some interviewees were eager to be interviewed.[30] Some of them like Dierks, Schiele and Sommerfeld

[29] Philipe Denis, "Ethics of Oral History" in P. Denis and R. Ntsimane (eds.) *Oral History in a Wounded Country: Interactive Interviewing in South Africa.* University of KwaZulu-Natal Press: Pietermaritzburg. 2008, p. 74.
[30] Radikobo Ntsimane, "Why Should I tell my story: Culture and Gender in Oral History" in Denis and Ntsimane (eds.) *Oral History in a Wounded Country: Interactive Interviewing in South Africa*. Pietermaritzburg: University of KwaZulu-Natal Press, 2008, pp.124-126.

also made more information available by means of letters to supplement on the interviews.

I chose the interviewees based on my prior knowledge of the four hospitals under research. The newsletter *Molaetsa/Umlayeza* published in both Zulu and Setswana was issued four times a year and reported among other things, stories about the Itshelejuba Mission Hospital. As a church newsletter it reported summarized news on hospitals, often when there were church-related functions taking place there. When I studied for the Ministry in the Lutheran Church in Southern Africa (LCSA) in Enhlanhleni in Natal the rector of the seminary Dr. Wilhelm Weber made frequent references to that mission station as the place where he was born. Both from Weber and from reading the newsletters I managed to get prior knowledge of that hospital.

All the medical missions' interviewees mentioned have dedicated their lives to the development of the health institutions. The evidence that they gave about the institutions in which they worked can be biased. The interviewees may want to portray one side in a better light and others may want to portray their opponents in a negative manner. As for medical missionaries like Kurt Bergter, Ulrich Schmidt, Ruth Bauseneick, Evelyn Sommerfeld, and children of missionaries like Bishop Richard Schiele, Dr. Wilhelm Weber and Ms. Solveig Otte, the closeness to the mission hospitals makes them vulnerable to subjectivity. These interviewees have either dedicated a great part of their prime lives to medical mission work or have ancestors who have risked life and limb providing medical care in the mission field.

Although they were prone to bias as a result of their connection to medical mission work, the information provided by the interviewees cannot be discarded. All sources, both written and oral, have a bias; they are written from a particular angle chosen by the author and they are told from a particular angle narrated by the interviewee. That does not suggest that we should discard the stories that sources provide. As Paul Ricoeur wrote, the historian is the judge whose role in the reconstruction of the past is

to discern what is plausible and what is not. To use Ricoeur's direct sentence, "The criterion of his (sic) judgement is the coherence of his construction."[31]

As shall be seen in the following chapters, it would not have been possible to reconstruct the story of the four mission hospitals without their contribution. The fact that the interviewees worked in mission hospitals makes them a source of information of great value, especially with regard to names and dates. Mr. Jabulani Mdluli of Itshelejuba remembered names of the army doctors who served in Itshelejuba as well as the financial details[32] as he worked as an administrator during the transitional period of the takeover of the hospital. While such closeness of the interviewee to the institution can be of importance, it can also cloud the judgment of the interviewee. The interviewees tell only about those things that they can relate to. They relate to things that give meaning to their lives. I want to give a few examples to show how the close proximity of the interviewee to the institution in which they served can influence the manner in which their stories are narrated. How the interviewees tell their stories will help the author judge the value of their evidence, in the reconstruction of the history of the role of the Lutheran medical missions in the development of indigenous people through the mission hospitals.

Dr. Friedrich Dierks worked as the chairperson of the Mission of the Evangelical Lutheran Free Churches (MELFC) hospital committee that oversaw the medical work in Itshelejuba Mission Hospital, Botshabelo Clinic near Lichtenberg in the North West Province and the Dirkiesdorp Clinic in Mpumalanga Province. He told me before the interview that the time he always waited for had come. He said that he knew that one day a Black person from the former mission field would come to seek answers in order to understand how the missionaries worked among the people. It showed a feeling of obligation on his part.

Dierks saw the interview encounter between him and the author as a debt to be paid. He thought that the missionaries from Europe owed to the black people of southern Africa the stories of their experiences during their time as missionaries. As with the

[31] Paul Ricoeur, "The Reality of the Historical past" in Adam Budd (ed.), *The Modern Historiography Reader: Western Sources*. Routledge: New York, 2008, p.367.
[32] Jabulani Mdluli interviewed by Radikobo Ntsimane at Itshelejuba Hospital on 06 July 2000.

Truth and Reconciliation Commission (TRC) in South Africa, Dierks and other missionaries interviewed saw the interview as a way to deal with their past. Referring to the value of telling one's story Denis wrote, "In terms of this perspective, telling the story is more than simply producing knowledge about the past. It is—or at least has the potential to be—a life-changing experience."[33] Dierks was so committed to the interview that he ended up replying later to the remaining questions through a letter, as mentioned above. In the conclusion of the interview, Dierks apologetically mentioned that the information he gave during the interview might be biased because he looked at things on their bright side. Speaking in the Afrikaans language Dierks said that he was a sunflower, '*n sonneblom*.[34]

Sister Solveig Otte, a daughter of a missionary nurse of Untunjambili Mission Hospital near Kranskop, who herself worked in Hlabisa Mission Hospital as a medical technologist for the American Lutheran Mission society, lamented the fact that the contributions of her parents and other missionaries were not appreciated. She would have liked that the Black people for whose benefit the mission hospitals were established, had nothing but praises for the work of the missionaries:

> And you know it is very touching to me because who were any better than anybody else? They were doing their duty as called people. They were doing their duty. And it heartens me to know that the Gospels was ... they were channels and now other people are channels, are continuing the channels of the good news.[35]

7.1.3. Racial Considerations

As a Black person who interviewed White former missionaries, I was always conscious of my race and of how it influenced the shape of the interview. All the missionaries and descendants of missionaries I interviewed lived and worked in southern Africa when racial discrimination was a reality for all to observe. There were mixed motives for the former missionaries and children of missionaries to grant

[33] Philippe Denis, *Oral History in a Wounded Country: Interactive Interviewing in South Africa*. University of KwaZulu-Natal Press: Pietermaritzburg, 2008, p.10.
[34] Friedrich Dierks interviewed by Radikobo Ntsimane at Bleckmar, Germany, on 18 July 2002.
[35] Solveig Otte interviewed by Radikobo Ntsimane in Mayors Walk, Pietermaritzburg, on 8 May 2007.

me the interviews. Dierks confessed that an interview of this nature by a black person from the Lutheran church was long overdue. Somehow he knew that Blacks would be interested in the oral histories and narratives of the missionaries. Of all the missionaries approached, none refused to grant an interview. I am inclined to believe that they felt that they owed it to Blacks to tell their stories since such stories are in fact collective stories with blacks. However, one cannot rule out the possibility that the interviewees told the stories as they thought they should have happened, rather than as they actually happened. Solveig Otte in particular found it challenging when, after the nationalization of the mission hospitals, her Black colleagues accused her and other missionaries of dishonesty[36]. The agreement to be interviewed in the new political dispensation on the leadership role of missionaries can be seen as an effort to defend the missionaries' position. It was like an opportunity to make amends. James Scott would describe this as public action meant to minimize the "punishment" at all costs, even though the willingness to be interviewed by a representative of the historically-oppressed is a hidden transcript:

> Once again, however, it is the show of compliance that is important and that is insisted on. Remorse, apologies, asking forgiveness, and generally, making symbolic amends are a more vital element in almost any process of domination than punishment itself. A criminal who expresses remorse at his crime typically earns, in exchange for his petty contribution to the repair of the symbolic order, a reduction in punishment.[37]

Denis wrote that interviewees who are public figures have a tendency to reconstruct their stories to make them more beautiful. The missionaries and their descendants are not immune to this tendency:

> Consciously or not, informants often try to embellish the past. They distort their narratives in an effort to justify their past actions post facto. Public figures are particularly prone to such self-indulgence. They are careful not to say anything that could tarnish their image. They minimize or even deny the existence of conflicts in their constituencies. Oral testimonies tend to validate the social institutions

[36] Solveig Otte interviewed by Radikobo Ntsimane in her home in Mayers Walk, Pitermaritzburg. 8 May 2007.
[37] James Scott, *Domination and the Arts of Resistance: Hidden Transcripts*. Yale University Press: London, 1990, p.58.

> of the time. They reflect, to quote James Scott once again, the public transcript of the social actors.[38]

The fact that the leadership and management of the mission hospitals were White and that the general workers were Black is not a point that could be missed in the narratives. The boss/worker or even master/slave relationship is prevalent in the narratives in the hospitals setting. Interviewees like Ruth Bauseneick failed to acknowledge the cultural taboos of the Black men in Itshelejuba who had to participate in the burial of a pauper beyond the call of duty. She was shocked by the refusal of the local men employed in the hospital who had not yet overcome the taboo of burying strangers with no guarantee of subsequent ritual cleansing. By virtue of being on the Itshelejuba hospital staff, Bauseneick assumed that they had to honour the call of duty.

As a former lecturer and rector of the seminary which this author attended, Dr. Wilhelm Weber could not extricate himself easily from the fact that at the time of the interview, he was in discussion with his co-lecturer at the seminary. He assumed a position of leadership as he spoke about his passion: the mission. While that is expected in an interview encounter where the interviewer assumes a position of ignorance, Weber clearly wanted to exonerate the mission society run by Whites from possible accusations of wrongdoing. The exclusion of Black church leaders from the hospitals' committee and the appointment of junior White nurses over senior and experienced Black nurses[39] do not feature in Weber's narration. He willingly agreed to the interview as a way to help me towards my studies and narrated the story as if his mission society was incapable of wrong judgements. For instance, he found it justifiable that MELFC did not make major financial commitments to the buildings of the hospital and the hospital personnel from Germany.[40]

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[38] Philippe Denis, "The Use of oral Sources in African Church History" in *Bulletin for Contextual Theology in Southern Africa and Africa,* Volume Two, April 1995, pp.32-35.

[39] In an interview with Radikobo Ntsimane, Lieselotte Gnauk mentioned that when she came from Germany as a junior and inexperienced nurse she was put in charge of Itshelejuba Mission Hospital in the absence of Sister Ruth Bauseneick while there were black experienced nurses. Liselotte Gnauk interviewed by Radikobo Ntsimane in Bleckmar, Germany on 6 June 2002.

[40] Wilhelm Weber interviewed by Radikobo Ntsimane at Enhlanhleni near Pomeroy in KwaZulu-Natal on 8 May 2002.

7.1.4. Age Considerations

Three authors, Krog, Mpolweni and Ratele have cautioned against ignoring the value of age difference between the interviewee and the interviewer. If one does not tread sensitively, issues of age can disturb a potentially rich interview encounter.[41] It goes without saying that the missionaries who were involved directly and indirectly in the mission hospitals which were nationalized in the mid- and late 1970s, were older than me who was born in the early 1960s. During the time of the interview all the interviewees were retired. Ripe age somehow provides the interviewees with a superior position in the interview encounter. That was the case despite the fact that by virtue of their position as interviewees they already occupied a superior position as teachers of the interviewer. All the interviews were long because the interviewees had a lot of experience to relate.

7.1.5. Gratitude and its Complexities

Ms. Solveig Otte born in 1933 portrayed her position and the positions of medical missionaries before her, as having been dictated by historical circumstances. Her narrative shows that she wanted to portray the missionaries in a positive light or at least for their critics to be sympathetic to them. This is how she responded during the interview when asked about the social development that the Untunajmabili Hospital had brought to the local people:

> That is hard for me to say. I do realise every time I go to Untunjambili it actually it heartens me because very often people have said to me, "*Aghh*, the missionaries they just came and they exploited our people and they name the mistakes." And it makes my heart very sore because I know that how much my people, at least the people in my family… my grandfather how they loved the people. They would have died for them…that is how I felt, you know! And to hear all those onslaughts you know: the missionaries, they were selfish and they were just Bible pounding and they didn't do this! And I think of my … but I have never heard that about my…my father and my grandparents. My grandfather used to do a lot of agriculture at Hlabisa and he was

[41] Antjie Krog, Nosisi Mpolweni, and Kopano Ratele, *There was this goat: Investigating the Truth Commission Testimony of Notrose Nobomvu Konile*. University of KwaZulu-Natal Press: Pietermaritzburg, 2009, p.96.

> building churches and he was building schools, you know. He was tireless.[42]

Missionaries and descendants of missionaries have a legacy to guard. In their narratives people like Wilhelm Weber, Friedrich Dierks, Richard Schiele, and Solveig Otte could not distance themselves from the fact that they followed what they believed in to be their calling. An additional factor that affected their narratives is the fact that they honoured their missionary ancestors who came to the mission field before them. Dierks explained that he came from a long lineage of missionaries:

> I was born on 16 January 1939. Here in Lower Saxony, we call it the Lüneburger Heide. This calmer community which was called to mission work by Pastor Ludwig Harms in Hermannsburg in the last century. And five sisters, in fact brothers of my grandparents were missionaries. Two in New Zealand, one in India and the others in Northern America and Southern America. And there is a long, long history of the Dierks family connected with mission work.[43]

Showing her long connection to the mission work through her ancestors Solveig Otte explained that her great grandparents from her father's side came from Norway and Germany respectively and were missionaries in Zululand and Natal. Her mother came from the United States of America as a nurse and Solveig followed her career in the medical mission.[44]

7.1.6. Language

English was the easiest language for the interviewer to use in conducting the interviews as the interviewees spoke languages like Setswana, Zulu, German, Norwegian, Afrikaans and English. As reflected in the interviews, it was difficult to change the language of the interview especially with Ruth Bauseneick. Her command of English was limited and she felt at ease to use both English and Zulu interchangeably depending on the thought she wanted to express at the time. Zulu was the language she used when she was still employed at Itshelejuba. I think she also

[42] Solveig Otte interviewed by Radikobo Ntsimane in Pietermaritzburg on 8 May 2007.
[43] Friedrich Dierks interviewed by Radikobo Ntsimane at Bleckmar, Germany on 18 July 2002.
[44] Solveig Otte interviewed by Radikobo Ntsimane in Mayor's Walk, Pietermaritzburg, on 8 May 2007.

found it easy to speak to a Black person from South Africa in that language. She kept using the "*-ke*" in most sentences as a way of concluding them, even her English sentences. A closer look at the interview's transcript will show that on many occasions Bauseneick mixed German and English when she tried to make a point. Eventually she spoke only German until the end of the interview,

> "You did…*alles* to go to the prayer. You can't believe there were hundred sisters, the nurses. When they were singing, the *Vather Unser*. That was too nice, I was running quickly…should not come [late] to the prayer."[45]

One can understand the strain she endured to speak to me in English. Other interviewees were interviewed in Zulu as that was their first and preferred language. Despite that, the same people who preferred Zulu also included English in their responses.

7.1.7. Letters

Some of the informants for this study chose to reply to my enquiries through letters in instances where a face-to-face interview could not take place. Long distances and the old age of some informants militated against direct oral interviews. For instance, Bishop Richard Schiele of Scottsville where this author studies was prepared for a face-to-face interview but he later sent a letter to add the outstanding information. Similarly Friedrich Dierks who was interviewed in Germany on a Sunday afternoon could not stay on longer as his wife had waited too long for him outside the interview venue. His letter was a response to the remaining questions that I had set for him. The retired Mariane Dumjahn who worked in the 1960s in Thulasizwe and Ehlanzeni Lutheran Mission hospitals as an HMS missionary nurse before moving to Bamalete Lutheran Hospital (BLH) in Botswana in the 1970s, wrote a letter dated 19 June 2000 from Soest in Germany, at the request of her former colleague at BLH, Mrs. Gesa Luetkens.

[45] Ruth Bausenecik interviewed by Radikobo Ntsimane at Bleckmar, Germany, on 5 August 2002.

Shortly before travelling to Germany in order to conduct interviews and undertake archival research, one director of BMS shared with me a letter from a former Matron, Evelyn Sommerfeld who worked in Emmaus Mission Hospital. The letter was a response to the request from the BMS for the former missionaries to share their experiences about the mission field wherever they worked.

7.2. Written Sources

The minutes of synods, mission committees, hospitals committees and church councils form an important resource when one attempts to reconstruct the history of the church or missions. Correspondence in the form of letters compensate for the lack of published material in this study. Reports formed an important aspect of communication between the mission field and the mission headquarters in Europe and America as we shall see, especially in chapter five of this thesis.

7.2.1. Minutes

This study has used minutes where they were the only sources of information, as well as where they corroborated information gathered from both written and oral sources. Minutes are usually taken as stipulated by respective constitutions for meetings of synods, councils, boards, committees and other gatherings related to church bodies, mission societies, and in this study's case mission hospital governing bodies. Although minutes are meant to provide the most reliable information of a particular meeting, some minutes are deliberately aimed at avoiding disputes on certain matters or even to perpetuate disputes within the organization.

It is the duty of the historian to gauge the reliability of the minutes, as is the case with all other written and oral sources used in the reconstruction of events.

7.2.2. Other Letters

There are two kinds of letters used in this study. The first is the correspondence between the missionaries and their colleagues or their mission society officials. The second, which will be discussed later, is the correspondence between particular interviewees and this author.

Although no longer as popular as it was in the nineteenth and twentieth century, letter writing is still used extensively as a form of formal and informal communication. Today, letters reach their destination far quicker than they did between the 1930s and the 1970s, due to improved communication technology and transport system. As will be evident, especially in chapter five, there were many letters going to and from the missionaries in the mission field and their superiors and colleagues in the mission headquarters in Europe and America. Letters form a bulk of the valuable information used in the reconstruction of Lutheran medical mission history. The importance of letters in comparison to that of minutes can be great. We need to keep in mind that the letters were confidential and were supposed to contain information often restricted between the sender and the recipient. Where not much has been written for public consumption, letters provide the only information available on particular subjects. To measure their value, there are whole chapters in books that have relied on archived private and public letters for information.[46]

7.2.3. Reports

Synodical meetings, general assemblies, and diocesan meetings often have reports read or at least handed out, to delegates and participants in formal meetings. This study will make use of such reports where they prove to be relevant to the research. However, I am aware that like minutes, writers of reports also choose a particular way of reporting and leave some issues out. Report writers detail the issues they feel are

[46] Vukile Khumalo, "Ekukhanyeni Letter-Writers: A Historical Inquiry into Epistolary Network(s) and Political Imaginations in KwaZulu-Natal, South Africa," in Karin Barber (ed.), *Africa's Hidden Histories: Everyday Literacy and making the Self*, (ed.) Indiana University Press: Indianapolis, 2006, pp.113-142; Lynn Thomas, "Schoolgirl Pregnancies, letter-Writing, and "Modern" Persons in Late Colonial East Africa", in Karin Barber (ed.), *Africa's Hidden Histories: Everyday Literacy and making the Self* (ed.) Indiana University Press: Indianapolis, 2006, pp.180-207.

important to the particular gathering and leave other things out. As in the case of minute-taking, for the sake of keeping peace and to be seen not to be interested in incessant conflict, the reporters will leave out or at least tone down the controversial matters. As some important annual gatherings, it is discomforting to report a year later on a matter that has since been cleared and in which the conflicting parties have subsequently reconciled.

Where support and funding of the mission society and other stakeholders depends on the success of institutions like schools and hospitals, one expects the reports to be generous with such success stories. It would be counterproductive when the report writer, who still wishes to continue working in a mission hospital, amplifies the negative aspects of the work in the hospital. Reading through the reports from the Hermannsburg Mission Society in Ramotswa, Botswana, one reads about things like witchcraft in the community and the drought that plagued the area in order to justify the continued support to the Bamalete Lutheran Hospital. Similarly, the 1969 report written and read by Friedrich Dierks on the three health institutions of the Mission of the Evangelical Lutheran Free Churches (MELFC) is awash with success stories. I am in no way suggesting that such reports lack credibility as primary sources in historical research. What I am saying is that like minutes these reports are biased and must be recognized as such. A plethora of data will be acquired from such reports to reconstruct the story of the Lutheran mission hospitals that I am attempting to reconstruct.

7.2.4. Archival Documents

The archived material has proved very helpful in this research. I have visited a number of church and mission archives where finances, language and time permitted. While the archives have primary documents of great value, such documents are not necessarily preserved for researchers and often they are not so relevant to a particular study. In Germany where most of the archives were properly organized for official use and outside researchers, the research work went smoothly.

The Evangelisches Landeskirchiches Archiv in Berlin, of the Berlin Mission Wircschaft (ELAB BMW), is in fact the archive of the Evangelical Church but it also houses the archives of the BMS. It is situated in Kreuzberg. I found the work tedious as I had to immediately learn on the spot how to read the old German orthography called *sütterlin*. The archivist, Mrs. Unterhalter, who had taught herself how to read this script, helped to acquaint me with it. However, since the script had developed over many years and because some letters were not standardized, her knowledge was found wanting in the deciphering of the later 1800s script. The script developed over many years and one should appreciate it that it was finally standardized. However, the documents of the mission in the 1800s and the early 1900s remain inaccessible to those unfamiliar with that script.

As with the BMS archives, the HMS archives provided me with an assistant in the form of Mr. Peter Schildknecht who had worked in Bamalete Lutheran Hospital, Botswana for over fifteen years and who was on furlough in Germany. Besides going into the restricted area to fetch folders for my reading, Mr. Schildknecht also helped to speed up my slow reading of the German text. Of all the archives visited, the HMS was the most organized one with properly labelled boxes and folders and with strict written declarations for researchers before written access-permission was granted.

The Archives of the MELFC are housed in the headquarters of the Mission of the Lutheran Church in Bleckmar, Germany. This was the least organized archive. There were many minutes and reports missing or misfiled with regard to the meetings of the Hospital Committee, the Mission Committee and even the church council that met exclusively in South Africa. For instance, the reports that Dr. Kurt Bergter and the representatives of Botshabelo and Dierkiesdorp health centres gave to the Conference on the Hospital were nowhere to be found.[47] That was the situation despite the fact that an undertaking was made during the same conference (*Konferenz der Hospital- und Laienmitarbeiter* 29 April-May 1974) to send future reports on the hospital's work to Germany.[48]

[47] The reports are referred to in items 8, 9, 10 of the minutes written in German of the conference held at the Natal Spa, KwaZulu-Natal from 9 April to 1 May 1974.
[48] Item 18. *Die Berichte über die Hospitäler sollen in Zukunft auch nach Deutchland geschickt werden.*

Despite this, the space provided by the MLC was conducive to research and studying. The large collection of photographs from the southern African mission field was valuable as one could put faces to the many names that passed through the mission field. Here also, there was a South African missionary on furlough, Rev. Christoph Weber, who spent some time helping the present author to translate some of the difficult German sentences into the English language. Since the archive was not yet organized for easy use, there were many extra copies of documents from reports and minutes from where I could extract information for later reference later in South Africa.

The South-Eastern Diocese (SED) of the Evangelical Lutheran Church in Southern Africa (ELCSA) has kept the archives of the many Lutheran mission societies that worked in Natal and Zululand in the head office in Umpumulo near Kranskop in KwaZulu-Natal. The office has a staff member who among many other duties, boxes and files all the documents previously scattered haphazardly in the archives room. The work of finding documents proved quite tedious as the archivist had not completed the task of sorting out all the documents regarding the medical missions.

Private archives have also proved to be valuable in this study. For instance, a short unpublished history of the Kashile Hospital in Swaziland compiled by the retired Reverend Leonora Schiele could only be found from Schiele's archives. Similarly, other people like the Schmidts in Pretoria were the only people who had photographs and copies of their awards while they were working in the BLH in Ramotswa. These bits and pieces of information form an integral part of the entire study because without them, there would be gaps begging to be filled.

8. Overview of Chapters

i. **Chapter One**: This chapter deals with methodology and sources. It shows why the research is undertaken and why some topics that may seem relevant have been left out of the thesis.

ii. **Chapter Two**: This chapter provides an historical overview of the founding and operation of the mission hospitals in southern Africa. It locates the Lutheran mission hospitals within the wide spectrum of medical mission activities from the 1930s to the 1970s. The two graphs, Figure 2,[49] and Figure 3,[50] show how, in 1972, each medical mission society featured with regard to the number of hospitals in the various southern African countries. One should not assume that the Lutherans were the only players in the field of medical missions at that time.

iii. **Chapter Three**: Since the thesis deals with biomedicine as introduced by missionaries from Europe and the USA, this chapter will seek to show that by the time of the introduction of biomedicine and during the founding of mission hospitals, other health systems were used by the indigenous people of southern Africa. Entitled **Conceptions of Disease, Restoration of Health and Dependency,** this chapter looks at the health system practiced by the Nguni group of the Zulus and the Xhosas and the Sotho group of the Sothos and the Tswanas. The other health system considered is the one practiced in churches, especially the Zionist-type and Pentecostal churches.

iv. **Chapter Four**: Entitled **Acculturation and Cultural Assimilation,** this chapter will show that the introduction of biomedicine in southern Africa in the late 1800s and early 1900s cannot be seen as having been parachuted onto the indigenous people. That encounter between the missionaries and the indigenous people was a time of compromise and negotiation as to what was acceptable and what was not. Biomedicine was introduced at the time when missionaries were trying to convert and change the tradition of the indigenous people. The period was also a period of colonialism during which indigenous people were dispossessed of their land by the White people who were similar to missionaries. This chapter shows that the missionary cultures and the cultures of the indigenous people influenced each other to the point that biomedicine was accepted by the indigenous people when the mission hospitals were established in the 1930s.

[49] Page 59.
[50] Page 59.

v. **Chapter Five**: Entitled **The Four Mission Hospitals,** this chapter will look at each of the four mission hospitals, at the circumstances of their foundation and at the challenges they faced in their development. Issues discussed are issues of the pioneers, buildings, doctors and nurses, staffing, expansion, financing, and relationship with the local communities. The chapter leads towards the period where due to expansion and other reasons, the governments of South Africa and of Botswana intervened in the mission hospitals in order to provide subsidies.

vi. **Chapter Six**: Entitled **Mission Authorities and the Nationalization** this chapter will discuss the nationalization of mission hospitals. It describes the events and circumstances that caused both the South African government to nationalize mission hospitals, and the Botswana government to become a major partner in the Lutheran Bamalete Hospital in Ramotswa. Financial, medical, ecclesiastical and political needs caused the two governments to be involved in the running of mission hospitals in the 1960s. In the 1970s, the South African the government's intervention ultimately led to the nationalization of mission hospitals and to the later handing-over of mission hospitals to the newly-created homelands in South Africa. This chapter will show that disproportionate power relations in the hospital setting could marginalize some people and put others at the centre.

vii. **Chapter Seven**: Entitled **The Churches' Responses to Nationalization**, this chapter will analyse the responses to the nationalization of the Lutheran mission hospitals by the various bodies that were directly involved, viz., the Lutheran mission societies and the Lutheran national churches that "inherited" those mission hospitals in the late 1960s. The lack of meaningful response to the nationalization process by the mission societies and by individual doctors and nurses raises questions on the motives which prompted the mission societies to provide health care to the indigenous people in the 1930s.

viii. **Chapter Eight**: Entitled **General Conclusion**, this chapter forms the conclusion of the thesis by showing that health care has been so politicised, that even in cases where effective medication has been invented—such as

ARVs in the case of HIV/AIDS—there are chances that many may still not access it. The fact that the government can nationalize and privatize health care as is the case in southern Africa, indicates that the Poor may be excluded from accessing it. One can argue that local communities living far away from health centres can manage their health with basic health facilities like clinics in their neighbourhood, complemented by traditional health care centres, also in their neighbourhood.

CHAPTER TWO

MISSION HOSPITALS IN SOUTHERN AFRICA: LAYING THE FOUNDATIONS

1. Introduction

This chapter is an attempt to show the extent to which mission societies in southern Africa were involved in providing medical care to the indigenous people, among whom they introduced Christianity. Although this thesis is specifically meant to research the Lutheran medical missions, it is important to appreciate that other mission societies were also involved in the medical work in southern Africa. We shall show a bigger picture of the involvement of non-Lutheran mission agencies in health provision by means of mission hospitals. Where possible, we shall show the numbers of hospitals and clinics established by the various mission societies. Their establishment was, intentionally or unintentionally, a direct challenge to the position of the health agents like *izinyanga* and *dingaka* (herbalists), *izangoma* and *didupe* (diviners) and *izanusi* (soothsayers*)* who were already providing health services to their own people from time immemorial. In 1972, P. H. Coetzee compiled data on mission hospitals for an exhibition that was held in Durban. [1] The data showed that among the mission agencies the Roman Catholic Church had the biggest number of hospitals followed by the Reformed Churches, with Lutherans in third place. This brief chapter seeks to discover what developments took place from the founding of hospitals to the time of the 1972 exhibition which preceded nationalization of mission hospitals in South Africa

[1] P. H. Coetzee (compiler). "Mission Hospitals in Southern Africa," For the 1972 Mission Hospital Exhibition held in Durban, 1972. Pamphlet held at the Killie Campbell Africana Library in Durban.

2. Reasons for Establishing Mission Hospitals in Southern Africa

This chapter will show that there were three reasons for establishing hospitals in the mission fields. Firstly it was to provide medical facilities, both for missionary families and the indigenous communities among whom the hospitals were built. Some tribal leaders requested the missionaries to work among them with the hope that they would reap the benefits that come with the presence of a missionary society in their villages.[2] An example from the 1800s of such a request of a missionary are that of King Shokongo shaKalulu of the Ondonga at whose invitation ten Finish missionaries came to work in Ovamboland in 1870.[3] In Madagascar King Radama I, who ruled between 1810 and 1828, welcomed the Europeans in order for them to contribute to the development and modernising of his country.[4] Closer to home *Kgosi* (Chief) Sechele of the Kwena in Bechuanaland requested the Transvaal President MW Pretorius for missionaries and the Hermannsburg Missionary Society responded positively.[5]

Secondly, the hospital was a way of attracting potential converts to Christianity. Michael Gelfand in his book *Christian Doctor and Nurse* makes mention of this point:

> Through the healing brought by the Gospel, the medical missionary would be the means through which the Faith or Kingdom of God could be brought to the ignorant or unbelievers. When the sick recovered they would be grateful to their doctor, to the mission and to the medicine and above all might turn to Christ and the Kingdom of God. The mission doctor was thus a part the purpose of the mission, which was to bring the Light to unbelievers.[6]

Thirdly and finally, the mission societies sought to acquire a sphere of influence among the communities around the mission station and hospital facility. This point needs to be seen in the light of the colonial interests of the European countries which

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[2] Frants Staugård, *Traditional Healers*. Ipelegeng Publishers: Gaborone, 1985, pp.20-21.
[3] Oliver K. Olsen (ed.) *History of the Church in Namibia 1805-1990: An Introduction.* Gamsberg Macmillan Publishers: Windhoek, 1994, pp.79-81.
[4] Gerard Jansen, "Visualising the Protestant Medical Mission in Madagascar in Patchwork: 1862 – 1900." 2005, p. 3.
[5] Kirstin Rüther, "Social Strategies on African Conversion to Christianity" Unpublished MA Thesis. University of Hannover, 1995, p. 79.
[6] Michael Gelfand, *Christian Doctor and Nurse: The History of Medical Missions in South Africa from 1799-1976.* Marriannhill Press: Marriannhill, 1984, p.20. See also Andrew Walls, *The Missionary Movement in Christian History: Studies in the transmission of faith*. Orbis Books: Maryknoll, New York, 1997, p.213.

took charge of colonies and in which they exercised power and introduced their culture. Their colonies became an extension of their territory. Their presence in a foreign country or territory enhanced their cultural and political influence and domination over the indigenous people. The mission societies' presence could influence the community to change its culture and adopt the culture that would allow the missionaries to influence it to their advantage. The London Missionary Society (LMS) in Bechuanaland, with the help of the British Protectorate government, wanted to build a hospital in the area where the Seventh Day Adventist (SDA) were already working, in order to keep their expansion in check.[7] As we shall see later, a similar scenario unfolded around the same time between the HMS (Bamalete Lutheran Hospital) and the Roman Catholic Church (St. Conrad Roman Catholic Clinic) in Ramotswa, Botswana.[8]

2.1. Expanding the Mission Influence through Biomedicine

Some mission societies credited their medical missions with having had a positive contribution to the growth of their society's work among the indigenous people. The Methodists saw that the growth of their mission was not unrelated to their medical work in southern Africa. Leslie Hewson, a former lecturer at Rhodes University, mentioned this matter when he wrote about the Extension Fund:

> We have added no new mission field except East Africa, and that was evacuated. Nevertheless, an increase in membership from 11, 665 in 1900 to 485, 516 in 1950 shows that real missionary work has been done in our circuits and in our great Missions, South-West Africa, Zululand and Maputaland, Portuguese East Africa, Swaziland, and Basutoland. Of growing importance are our medical missions, which are new ventures of the Twentieth Century. At Mount Coke, Moroka and Bethesda, medical missionaries are bringing the resources of medical science to the service of Africans.[9]

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[7] Part Mgadla, "Who used whom in the establishment of Medical Spheres of Influence in the Bechuanaland Protectorate: The Case of the Seventh Day Adventist and Moffat Hospitals in Kanye 1922-1959," in Fidelis Nkomazana and Laurel Lanner (eds.) *Aspects of the History of the church in Botswana*. Cluster Publications: Pietermaritzburg, 2006, p.107.

[8] Reports to the HMS headquarters in Germany in the late 1930s.

[9] Leslie Hewson, *An Introduction to South African Methodists*. The Standard Press: Cape Town, 1950, p. 99.

Writing about the conflict over who should establish a mission hospital in Kanye—between the Seventh Day Adventist and the London Missionary Society—Part Mgadla saw the founding of a mission hospital in a village by a mission agency as a way of establishing its sphere of influence.[10] The sphere of influence was in fact an issue of authority. The establishment of hospitals, either by governments or by mission societies, was to give those in charge of such establishments some power to influence or control events and life around them. Among the Batswana, the traditional healers had occupied the powerful position of directing the affairs of the village through the *kgosi*, the tribal chief, until Christianity and biomedicine were introduced. The *ngaka*, traditional herbalist and diviner, "was second only to the chief, in some respects his equal and in other advisor."[11] So powerful and influential was traditional healing, – often misunderstood as witchcraft, – that in 1929 the Bechuanaland Protectorate Annual Report (paragraph 22) stated:

> Witchcraft and the influence of native medicine men continue to play a very important part in the lives of most of the native inhabitants and are responsible for much suffering. It is the aim of the Administration to so develop the medical services that these evil factors will be replaced by confidence in qualified medical men.[12]

As this text shows, biomedicine was not generally preceded by the preaching of the gospel for the purposes of Christian conversion. Michael Gelfand gave an example from Zimbabwe:

> The primary objective of the Brethren of Christ was to preach the gospel of salvation through Christ. However, they were not long at their mission before their feeling of compassion made them realize that they could not overlook the physical sickness and suffering that existed. One of the missionaries pointed out that she had to become a physician and nurse to her people in order to bring her into contact with them and relieve them of their suffering, thus paving the way for ministering to their spiritual needs. As the following quotation shows in relation to the Brethren of Christ Church that worked in Zimbabwe

[10] Part Mgadla, "Who used whom in the establishment of Medical Sphere of Influence in the Bechuanaland Protectorate? The case of the Seventh Day Adventist and Moffat Hospitals in Kanye 1922-1959" in Fidelis Nkomazana and Laurel Lanner (eds.) *Aspects of the History of the Church in Botswana*. Cluster Publications: Pietermaritzburg, 2007, p.120.
[11] Frants Staugård, *Traditional Healers.* Ipelegeng Publishers: Gaborone, 1985, p.20.
[12] Frants Staugård, *Traditional Healers.* Ipelegeng Publishers: Gaborone, 1985, p.22.

> from 1924, feelings of compassion in the missionaries led to the introduction of western medicine among the indigenous people.[13]

The introduction of biomedicine was not always an easy decision for missionaries. As was the case with Dr. Livingstone of the LMS, some medical missionaries wanted to avoid being seen only as doctors, in order to wean indigenous people from trusting in *umuthi*[14] and to focus the potential converts' gaze on God. Later, when the value of biomedicine was seen as a gift from God, the missionaries introduced it.[15]

2.2. The Mission Agencies and their Medical Initiatives in Southern Africa

This overview will show that the Lutherans' medical missions were not unique in the mission field, as almost all mission societies working in southern Africa provided medical care to the local people in varying degrees. The Roman Catholic Church, Wesleyan Mission, Anglican Church, Presbyterian Church, Dutch Reformed Church, American mission societies, and the Seventh Day Adventist Church were some of the mission societies and church bodies which were involved in medical mission work in southern African countries.

For one to appreciate the biomedical work done by mission societies in southern Africa, one needs to have a synoptic view of the various mission hospitals established by the mission societies. Many of these hospitals were established over decades, especially in the 1930s. We shall look at the various mission agencies' mission hospitals initiatives in comparison to those of the Lutheran. The Interdenominational Organizing Committee which ran a Medical Missions Exhibition in Durban in 1972 produced a helpful database wherein almost all mission hospitals in southern Africa were captured. Madagascar has been excluded from the database, probably due to its lack of historical and colonial connectedness with South Africa, when compared to other southern African countries of the time. Due to its geographical closeness to South Africa and the fact that it had a strong Lutheran presence, it will be mentioned as one of the countries with active medical missions between the 1930s and 1970s.

[13] Michael Gelfand, *Godly Medicine in Zimbabwe*. Mambo Press: Gweru, 1988, p. 68.
[14] Ibid. p. 62.
[15] Ibid.

This information will help us see where the various mission societies concentrated their efforts regarding the biomedical missions. As a result, it will be possible to see developments in the size and numbers of hospitals until 1972 when the Lutheran churches had the third-most number of hospitals, after the Roman Catholic Church and the Reformed Churches.

Most of the mission hospitals began as very minor initiatives. Missionaries used their own family medicines to help where there was a need among the indigenous people in their immediate surroundings.[16] In some cases, the missionaries used their lay knowledge to help in isolated instances. When the number of patients grew beyond the capacity of the missionary's dispensary, a clinic or a small scale hospital was established. Michael Gelfand, arguably the most published author on the subject of mission hospitals in southern Africa, wrote about this matter with specific reference to the London Missionary Society:

> As a rule, once the mission centre was set up and the missionary began to preach and teach, they realised the need to have a doctor amongst them, not only to guard their own health, but even more important to help the sick African. They found great poverty and disease with a heavy mortality at all ages, but particularly in children. In their desperation the sick often turned to the missionaries, begging them for medicines.[17]

Both the Harmshope Hospital of the Hermannsburg Mission Society (HMS) in the then Bechuanaland, and the Itshelejuba Mission Hospital of the Mission of the Evangelical Lutheran Churches (MELFC) near Pongola, began in rondavels.

Based on the information given in the document compiled by the committee of the Medical Missions Exhibition, most listed mission hospitals were providing maternity services in 1972. One can deduce that, as was the case of the Emmaus Mission Hospital of the Berlin Mission Society near Winterton in Natal, most mission

[16] Solveig Otte interviewed by Radikobo Ntsimane about how her grandmother laid the foundations of what was later to be known as the Untunjambili Mission Hospital of the Norwegian American Lutheran Mission near Kranskop in Natal. Interview held in Mayors Walk in Pietermaritzburg on 8 May 2007.
[17] Michael Gelfand, *Christian Doctor and Nurse: The History of Medical Missions in South Africa from 1799-1976.* Mariannhill Mission Press: Mariannhill, 1984, p.18.

hospitals began to have some sort of building to help in maternity cases.[18] The fact that hospitals provided much needed help for women may have made such hospitals acceptable by the people among whom they were founded. In the case of Emmaus, the hospital was founded when Missionary Schumann introduced maternity services[19] among the Amangwane people in the Drakensberg Mountains. Much later in Botshabelo near Lichtenberg, Missionary Friedrich Dierks began the hospital by introducing family-planning.[20]

Some of the medical mission institutions came about as the result of accidents that illuminated the need for biomedical care. Gelfand wrote of a girl whose stomach was gored by a raging bull in Zimbabwe. The distance separating the injured girl from the nearest medical facility determined the location of the Methodist hospital in Murewa in 1922.[21] A similar story about a bull gorging a child was told by a Mr. Motswaledi, the man who was helped in the Bamalete Lutheran Hospital in Botswana when a beast had ripped open his belly.[22] In his case, the clinic already existed and the help he got confirmed the value of the institution.

Other diseases specific to southern African areas such as malaria, kwashiorkor, syphilis, bilharzias, elephantiasis, etc., were responsible for the founding of mission hospitals in areas affected by these diseases. The various mission hospitals developed and grew as per local needs or the availability of funds, as we shall see in Chapter Five. However, as is evident in the list of mission hospitals found in the document compiled for the 1972 exhibition, tuberculosis also featured predominantly in the services offered by each mission hospital. We shall see in this thesis, when discussing the events leading to the nationalization of mission hospitals, that in the 1960s, when

[18] Lawrence Zikode, "A History of the Emmaus Mission." undated and self-published booklet. As we shall see later, both Itshelejuba Hospital of the Mission of Evangelical Lutheran Free Churches and the Untunjambili Mission Hospital of the American Lutheran Mission had its first rondavel buildings used for maternity cases.
[19] Lawrence Zikode, "A History of the Emmaus Mission". Unpublished pamphlet.
[20] Dr. Friedrich Dierks interviewed by Radikobo Ntsimane at Bleckmar, Germany on 18 July 2002.
[21] Michael Gelfand, *Godly Medicine in Zimbabwe: A History of Medical Missions.* Mambo Press: Gweru, 1988, pp.59-60.
[22] Mr Edward Motswaledi shared his near-death story with the readers of a booklet, Lutheran Medical Mission at Ramotswa Botswana 1934-1984, prepared for the commemoration of the fiftieth year of medical mission in Ramotswa. His story is titled, "I cried for help." In an interview with Radikobo Ntsimane on 8 May 2002, Dr. Wilhelm Weber related a similar story of a bull ripping open the belly of a man.

tuberculosis was so rife that the South African government had to intervene and subsidise all efforts to combat it.

In order to see how the Lutheran mission hospitals in southern Africa operated and when they began their work, we shall look at the activities of other mission societies in other southern African countries. Thus it will be possible to compare their developments and note how the Lutherans who are central to this thesis fared in southern Africa with regard to numbers of mission hospitals before their hospitals were nationalized. Let us begin with Namibia the first country after South Africa, to have mission hospitals.

2.2.1. Namibia

Medical missionary work in Namibia can be understood when the fact that after the First World War that country fell under the direct rule of South Africa is taken into consideration.[23] Most mission societies working in Namibia originated in South Africa, especially when Namibia was under the rule of South Africa on behalf of the League of Nations. The London Missionary Society (LMS) was the first mission agency to work in Namibia and was followed by the Rhenish Mission from Germany and the Wesleyan mission from England.[24]

Biomedicine was formally introduced in Namibia in 1893 by the military,[25] and not by the mission societies. With regard to the medical mission work, the chronology is different. In 1904, the Roman Catholic Church's Franciscan Sisters of Nonnenwerth arrived in Windhoek to help with nursing during the Herero uprising against the Germans. Two years later they built a small hospital called Maria Stern in

[23] Namibia was a German colony called the German South West Africa until the Council of Versailles put the Union of South Africa in charge of it, T. R. H. Davenport, *South Africa: A Modern History* (Fourth Edition), Macmillan Press: London, 1991, p.296.
[24] G. L. Buys and S. V. V. Nambala, *History of the Church in Namibia 1805-1990: An Introduction*. Gamsberg Macmillan Publishers: Windhoek, 2003, p.244.
[25] Ibid.

Windhoek.[26] The Benedictine Sisters arrived in 1923 and renamed the hospital Maria-Hilf Krankenhaus until it was again renamed Roman Catholic Hospital in the 1930s.[27] One can observe that the mission societies were ready to provide medical assistance to the military and to the colonists when they were called upon to do so, even when their mission was targeting the indigenous people. The Sisters who were part of the Roman Catholic Church opened two hospitals, one in Windhoek (Franciscan Sisters) and another in Swakopmund (St. Antonius Sisters), in 1906 and 1908 respectively.[28] Since the Protestant missions were already in the country, the RCC was not allowed to work beyond these two areas.[29] This returns us back to the question of the sphere of influence which we shall discuss in length with regard to Botswana. The missions were adopting territorial tendencies in order to exert their influence unchallenged.

The Finns came in 1908 when Dr. Selam Rainio arrived and the Onandjokwe Mission hospital was established three years later near Oniipa.[30] Apart from being a training centre for nurses, this facility also supported over twenty clinics connected to parishes in the Kavangoland and Ovamboland.[31] The Finns started another hospital in the Kavango and later the provided nurses for the government lepers' hospital in Rundu.[32] Although the Anglicans arrived in Odibo in1924 with plans to build a church, a school and a hospital, it was only in 1936 that the hospital was built.[33] Their second hospital was established in Oshadi in 1948 but accidentally burnt down one year later. After being rebuilt it was later closed in 1974 during the armed struggle for the independence of Namibia.[34]

[26] Ibid. p. 245.
[27] Ibid.
[28]Ibid.
[29] Ibid.
[30] Ibid. p. 245-246.
[31] See *Ondjalulamasiku* 2004, pp.32-43. This is the Almanac of the Evangelical Lutheran Church in Namibia (ELCIN) published in Ondangwa.
[32] G. L. Buys and S. V. V. Nambala, *History of the Church in Namibia 1805 - 1990: An Introduction*. Gamsberg Macmillan Publishers: Windhoek, 2003. p.246.
[33] G. L. Buys and S. V. V. Nambala, *History of the Church in Namibia 1805 – 1990*: *An Introduction.* Gamsberg Macmillan Publishers: Windhoek, 2003, p.246.
[34] Ibid. pp.246-247.

The Dutch Reformed Church began its work in 1957 in Kaokoland and built a hospital in Orumana which the South African government took over in 1974 as it nationalized mission hospitals within South Africa during the same time.[35]

The African Methodist Episcopal from the USA and the Methodists came to work in Namibia but they did not devote energies and resources to the establishment of medical work. The Methodists began their work but stopped and only came back to Namibia in 1919.[36]

The fact that Namibia was close to the Cape Colony made it accessible to mission societies working in South Africa. The disadvantage for the medical missions was that when South Africa took possession of Namibia on behalf of the League of Nations, Namibia was treated as a colony of South Africa with the result that its mission hospitals were affected by the South African government's health policies. The presence of the Rhenish and the Finnish mission societies showed that Lutherans had a presence in Namibia that provided both medical and spiritual support.

The second largest recorded number of mission hospitals in 1972 in Namibia (13%) stand in contrast to the low numbers recorded in Botswana (1%) which also had a low population due to the desert. Mission societies apply many criteria in choosing a mission field, such as: desert area or tropical area; rural area or urban area; remote and unfamiliar population or local and familiar population; easily accessible area or hardly accessible area. Similarly, it is not obvious how mission societies decide which area will have a hospital and which one will not. For instance, how does one explain the fact that a desert area like Namibia had more hospitals than another desert area like Botswana in a given period?

2.2.2. Swaziland

Swaziland has a unique history of Christianization. One of its kings, Somhlolo, is said to have had a vision in his dream in 1836 in which two things were offered to him for

[35] Ibid. p. 248.
[36] Olson, 1994, p. 108.

his nation. Between money and the scroll he was advised to choose the scroll. As a result of that famous dream, Swaziland and its people have been very welcoming to the missionaries and to Christianity.[37] The Swazi King sent a delegation to Thaba Nchu to invite James Allison of the Wesleyan Methodists to speak to the Swazis about Christianity.[38] The Methodists responded to the request by sending men from different tribes along with Allison to preach the Gospel among the Swazis in 1844, beginning in Mahamba[39] where a hospital was later built in 1926 and led by a Dr. Till until it closed in 1934.[40] Mahamba was re-started much later in 1950, but financial and personnel constrains proved insurmountable for the Methodists who discontinued their medical work in Swaziland.[41]

The very first medical mission in Swaziland was in the form of a clinic established by the Church of the Nazarene. The clinic was established in Manzini and was popularly known as KwaHyand after Rev. Hyand, the missionary who used to live there.[42] Later, the clinic grew and a nursing college was built to train local people.[43]

Through the help of a local man by the name of Johannes Mdziniso, the Berlin Mission Society sent a missionary to Swaziland named Bernhard Schiele whose wife Magdalene, was a qualified medical doctor. In 1930, the Schieles established a small clinic in the capital Mbabane on a mission station named KwaShile by the local people.[44] This clinic was maintained with the support of a few friends in Germany but not by the BMS. The clinic closed permanently when World War Two started as the Schieles were interned in then Northern Rhodesia and Rhodesia (present day Zambia

[37] J. B. Mzizi, "Is Somhlolo's Dream a Scandal for Swazi Hegemony? The Christian Clause Debate Re-Examined in the Context of Prospects for Religious Accommodation," in *Theologia Viatorum* 30/1 (2006) pp. 87- 112.
[38] Daryl Balia, *Black Methodists and White Supremacy in South Africa*. Madiba Publications: Durban, 1991, p.35.
[39] Ibid.
[40] Herbert Bennett, "Medical Missions" in A. E. F Garrett (ed.) *South African Methodism: Her Missionary Witness*. Methodist Publishing House: Cape Town, pp.52 & 58.
[41] Ibid. p.58.
[42] A four-page History of the KASHILE Hospital compiled and kept by Rev. Leonora Schiele states that, "*The only existing hospital in the whole of Swaziland was in Manzini (then 'Bremersdorp'), was KaHaynd, the hospital of the Church of the Nazarene under Dr. Haynd*.", p.1.
[43] Rev. Constance Mamba interviewed by Radikobo Ntsimane in Pietermaritzburg on 20 October 2006. Information on churches other than that of the KaShile clinic was gathered during this brief interview.
[44] A four-page pamphlet titled, History of the KASHILE Hospital compiled by Rev. Leonora Schiele, daughter-in-law of the founders of the KaShile Hospital.

and Zimbabwe) because they were German subjects in Swaziland, which was a British protectorate.

The Salvation Army established a clinic in Mbabane and smaller community clinics around the country. The Roman Catholic Church also established a hospital in Siteki called Good Shepherd. Both men and women were trained there as nurse-aids.

Despite the government-established hospitals, the Swazi people benefit much from the mission-established hospitals as they outnumber those of the government. There is a major government hospital in Mbabane which caters for diplomats and the Rich who require special treatment.[45]

Of the recorded southern African mission hospitals in 1972 those from Swaziland accounted for only 1% as shown in the graph (Figure 3).[46] Mission societies with a medical mission agenda also worked in Swaziland but with less enthusiasm to establish hospitals than in South Africa. One of the reasons may be that Swaziland is a small country and was governed as a British Protectorate until its independence in 1968.[47] Its size and its geographical proximity to South Africa meant that Swazi people could easily reach South Africa to satisfy their medical needs. In fact Itshelejuba Mission Hospital of the Mission of the Evangelical Lutheran Free Churches (MELFC) between Piet Retief and Pongola is situated adjacent to the Swazi border and served people on both sides of the border without discrimination.[48]

2.2.3. Botswana

As a British Protectorate, Bechuanaland stood in a good position to receive various benefits from Britain and other European countries. These included medical facilities. Over and above the government benefits, the mission societies also made important

[45] Rev. Constance Mamba interviewed by Radikobo Ntsimane in Pietermaritzburg on 20 October 2006. Information on churches other than that of the KaShile clinic was gathered during this brief interview.
[46] Page 59.
[47] T. R. H. Davenport, *South Africa: A Modern History* (fourth edition). The Macmillan Press: London,1991, p.451.
[48] Ruth Bauseneick in an interview with Radikobo Ntsimane at Bleckmar, Germany on 05 August 2002 mentioned patients who came across the border to Itshelejuba.

contributions to education[49] and health care. Part Mgadla, a historian from Botswana, aptly put it when he wrote:

> Besides education, which was sine qua non if evangelization was to take root, other aspects that were seen as beneficial to the communities were introduced. These included, among others, medical services. These were viewed, not only as being complementary to education, but also strengthening the conversion process as the would-be converts would be healed spiritually, physically, and perhaps mentally as well.[50]

In Kanye in the south of the country the Seventh Day Adventist opened a clinic in 1922 with subsidies from the Protectorate government.[51] Another initiative was in Moshupa not very far from Kanye. In 1933, the United Free Church of Scotland (UFCS) and the LMS co-operated in the establishment of the hospital in Molepolole called Scottish Livingstone Hospital. Mgadla discusses at length the complex situation around the establishment of a second mission hospital in Kanye called Moffat, in the early 1950s.[52] In order to spite the Seventh Day Adventists, the Protectorate government officials encouraged the UFCS in partnership with the LMS to establish an alternative hospital called the Moffat Hospital. That hospital lasted for only eight years.[53]

The number of mission hospitals did not increase significantly in Botswana, as the 1972 graph (Figure 3)[54] shows below. The facts need to be considered that Botswana for centuries had low populations. Most of its vast land is the Kalahari Desert and that explains the lack of mission initiatives among the Khoi-San tribes that live on the desert. Mission work was mainly concentrated in the eastern part of the country that borders South Africa.

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[49] Obed Kealotswe, "The Church and Education in Botswana 1966 – 2004: Implications for Vision 2016," in Fidelis Nkomazana and Laurel Lanner (eds.) *Aspects of the History of the Church in Botswana*. Cluster Publications: Pietermaritzburg, 2007, p.240.
[50] Part Mgadla, "Who used who in the establishment of Medical Spheres of Influence in the Bechuanaland Protectorate? The case of the Seventh Day Adventist and Moffat Hospitals in Kanye 1922 – 1959," in Fidelis Nkomazana and Laurel Lanner (eds.) *Aspects of the History of the Church in Botswana*. Cluster Publications: Pietermaritzburg, 2007, p.117.
[51] Ibid.p.79.
[52] Ibid. p.80.
[53] Ibid. p.154.
[54] Page 59.

We should mention, however, that the Dutch Reformed Mission saw a mission opportunity in Botswana and initiated biomedical work among the Bakgatlha people north of Gaborone in Mochudi.

2.2.4. Zimbabwe

The geographical and political proximity of Zimbabwe (previously called Rhodesia) and the Union of South Africa makes the medical mission history of the two countries inseparable. As long ago as the 1800s, medical personnel such as nurses and doctors went to Zimbabwe from South Africa or via South Africa from European countries. Michael Gelfand in his book *Godly Medicine in Zimbabwe,* provides information on the history of mission hospitals in that country. It is interesting to note that there are some similarities with South Africa on how the mission hospitals developed in relation to the State and how they were also nationalized, as we shall see in the next chapters. One can see in the pie graphs below that, in comparison, Zimbabwe came third in the numbers of mission hospitals after South Africa and Namibia. Besides the distance mentioned above, one can also note the fact that Zimbabwe was the nearest colony of the British and like South Africa in the 1800s, it was open to various mission societies in addition to commerce. The various mission societies entered Zimbabwe to provide medical care while others like the Brethren in Christ Church entered for evangelization purposes and provided medical care when they saw the need for it.[55]

The Dominican Sisters began nursing work in Zimbabwe through the Chartered Company under Cecil Rhodes in the late 1800s around Bulawayo. Due to the inability to provide certified nurses as required, the Dominicans discontinued their work as nurses in Zimbabwe in 1898.[56] The Dominican Sisters could not provide such nurses as they were not a medical religious order. Earlier, in 1895, the Anglicans sent a Dr. Jameson who worked in Mutare with the financial support of

[55] Michael Gelfand. *Godly Medicine in Zimbabwe*. Mambo Press: Gweru, 1988, p. 62.
[56] Michael Gelfand. *Godly Medicine in Zimbabwe*. 1988, pp. 30, 48.

Cecil Rhodes.[57] That was an indication that churches and mission societies sometimes do need to raise funds from external bodies in order to sustain medical provision.

One mission that worked in many southern African countries was the Dutch Reformed Church Mission. In Zimbabwe this mission society started work in 1891.[58] Dr. John Helm established the lepers work at a mission station called Morgenster in 1907 and managed to get the government of the then- Rhodesia to pay for it. As we shall see in the selected hospitals under this research, it happened in Zimbabwe that the government took over the lepers work and relocated it to Ngomahuru where other doctors succeeded Helm.[59]

The Americans came to Zimbabwe in two mission societies, viz.: the American Board of Commissioners for Foreign Missions in the early 1900s to Mount Selinda and in Chikore districts and the American Methodist Episcopal Church Mission in 1903 to Mutare.[60] The two mission societies provided trained nurses and medical doctors to preach and to provide medical and maternity services. In 1924, the Brethren in Christ Church established a hospital at Mshabezi Mission Station not far from Gwanda.[61]

From among the Scandinavian countries, the Church of Sweden Mission came to Zimbabwe in 1916 and began medical work in Mnene which culminated in the establishment of a hospital in Mnene in 1927. The Mnene Hospital treated leprosy and sexually transmitted (venereal) diseases among others.[62]

Finances play an inevitable role in any health provision initiative. The construction of buildings, salaries of personnel and procurement of medical and other supplies all need financial muscle for the sustainability of the medical facility. Michael Gelfand writes that pressure was put on the government for hospital subsidies by missionaries:

> The Government was made aware of the need for aid in medical care to rural Africans by the missionaries themselves. The appeal was strong

[57] Ibid. p.45.
[58] Ibid.
[59] Ibid. p.48.
[60] Ibid. p.49.
[61] Ibid. p.62.
[62] Ibid. pp.65-66.

> and sustained by lay missionaries who were not slow to inform the Medical Director of his Department's responsibility in the health care of rural Africans. The Southern Rhodesia Missionary Conference also passed resolutions calling on the Administration to provide the means whereby the health of the Africans could be bettered.[63]

Two Government Notices hold historical importance, as they changed the perception on medical missions in Rhodesia. The government bent under pressure and made provision for the health of Africans in Rhodesia. Government Notice 335 of 1927 made financial provisions towards missionary bodies for staff salaries, staff training, maintenance and stock.[64] Government Notice 543 of 1928 made provision for mission societies to train nurses of both sexes. Like the South African government, as we shall see in later chapters, the Rhodesian government set two conditions for the grants, which fundamentally changed the relationship structures in the mission hospitals, "Firstly, the payment of these grants in every instance was subject to the approval of the Colonial Secretary. Secondly, the acceptance of any grant or portion thereof would *ipso facto* give the Government the right to inspect all hospitals, training schools, etc."[65]

Training schools for nurses were sustained through government grants. However, the government of Rhodesia started to nationalize mission hospitals by taking over the Makumbi Mission of the Dominican Sisters in 1959, as one of its rural hospitals.[66] Although outside the time frame of this present thesis, it is important to note that like the South African government in 1973, the newly-independent Zimbabwean government took over the Martin Tuberculosis Sanatorium of the Dominican Sisters in 1981. The combating of tuberculosis led to the direct intervention of the government in the mission hospitals.

In 1974, the mission societies in Zimbabwe organized themselves into the Association of Rhodesia Church-Related Hospitals (ARCH) but after independence they changed their name to the Zimbabwean Church-Related Hospitals (ZACH) in line with the

[63] Ibid. p.73.
[64] Michael Gelfand, *Godly Medicine in Zimbabwe*. 1988, p.76.
[65] Ibid. p.77.
[66] Ibid. p.106.

new name of the country.[67] The new body wanted to be at the forefront of the co-operation with the government in order to receive subsidies for the provision of medical help to the rural people.[68]

2.2.5. Mozambique

The Swiss Mission worked in the northern Transvaal, today's Limpopo province, at the end of the 1890s and crossed over in to Mozambique. Similarly to the Transvaal, there were Tsonga-speaking people in Mozambique who the Swiss Mission was probably planning to convert. They established mission stations in Lourenço Marques, today's Maputo, and in Anthiok.[69] Soon after their arrival, the Swiss Mission established hospitals in Maputo in 1905 and at Chikumbane in 1908.

The Anglicans established St. Luke's Hospital in Augusto Cardoso in Vilacabral, which in 1972 had forty beds.[70] The mission hospitals received no assistance from the government, [71]which is recovering from a long civil war.

The small percentage of mission hospitals in Mozambique can be explained in two ways. Firstly, Mozambique was Portuguese-speaking and did not attract mission societies that had experience of working in British colonies. Portugal conquered Mozambique in the 1600s and the war of liberation that began in the 1960s, destabilized rural mission work which supported mission hospital initiatives. Even after the independence in 1975, the country could not recover sufficiently, as a result of the South African-fuelled civil war.[72] Secondly, Mozambique was supported by mission hospitals in northern Zimbabwe (St. Alberts Mission Hospital),[73] in southern

[67] Ibid. p.282.
[68] Ibid. p.283.
[69] Ancestry24.com/swiss–mission-in-south-africa/
[70] P. H. Coetzee, "Mission Hospitals in Southern Africa", Durban, 1972.
[71] Ancestry24.com/swiss–mission-in-south-africa/
[72] Gill Walt and Julie Cliff, "The dynamics of health policies of Mozambique 1975 – 1985" in Health Policy Planning. 1986; 1(2): pp. 148-157. Available at: <http://heapol.oxfordjournals.org/> [Accessed 27 April, 2010.
[73] < http://www.stalbertsmissionhospital.org/> [Accessed 28 August, 2012].
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Malawi (Mulanje Mission Hospital)[74] and in Angola, which were not far from the borders.

Although referring to the period after the 1972 Mission Hospitals of Southern Africa exhibition in Durban, the following quotation helps to show the devastation caused to medical mission work in Mozambique by the war:

> Health services were nationalized in July 1975, a chaotic year for the newly-independent country. Over 85 per cent of the 550 doctors left; rural mission hospitals and health posts were abandoned. A few were kept going by untrained health orderlies who administered what aid they could from experience. In the liberated zones of the northern provinces first aid assistants continued to provide simple care, although many were sent on retraining or refresher courses. No-one knew how many health workers there were, or how many services had been abandoned. Poor communications and transport made information gathering a nightmare.[75]

The scanty information in Coetzee's compilation can be attributed to the war situation in Mozambique which according to the quotation above made the gathering of information a nightmare.

2.2.6. South Africa

Many missionary societies have worked among tribal groupings of South Africa. In each province, a substantial number of missionary societies established hospitals. I shall follow the example of Michael Gelfand who used the categories of the former Republic of South Africa's provinces to discuss the different hospitals and their mission societies in his book, *Christian Doctor and Nurse*. Since this thesis deals with the medical mission work of the Lutherans, I shall not go into details on the non-Lutheran mission hospitals. The aim is to show how the Lutheran fared in comparison to other mission societies with regard to establishing and sustaining their mission hospitals before they were nationalized in the early 1970s.

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[74] <http://www.directrelief.org/> [Accessed 28 August 2012].

[75] Gill Walt and Julie Cliff, "The dynamics of health policies of Mozambique 1975-1985" in Health Policy Planning. 1986; 1(2): pp. 148-157. Available at: <http://heapol.oxfordjournals.org/> [Accessed 27 April 2010].

As a former British Colony, Natal has been a mission field to many missionary societies. The desire to convert the Zulu nation and the welcoming nature of the British colonial government were probably responsible for the many societies that came to Natal in the nineteenth century.[76] All the Lutheran missionary societies except the Rhenish and Finish, worked in Natal. As we shall see later in this chapter, all the Lutheran societies which worked in Natal also established mission hospitals. Besides the Lutherans, other missionary societies also established hospitals and clinics of varying sizes.

2.2.6.1. The Methodists

Although some unstructured low-key medical assistance was rendered to the indigenous people by Methodist missionaries as far back as 1826, the first structured initiative began in the Zululand and Maputaland area between 1916 and 1924.[77] Mount Coke hospital, which was built in 1933, seems to get historical prominence as the first Methodist medical work in South Africa, followed by two others in Ingwavuma (Zululand) and in Maputaland (Kosi Bay) where Rev. Carr started to work.[78] The biomedical influence of the Methodists extended to the Free State and the Eastern Cape, and to northern Natal when they opened a hospital at Manguzi in 1947.[79] As illustrated in the Figure 2[80] graph below, the Methodists were not much into medical mission work.

[76] Norman Etherington, "Kingdoms of this World and the Next: Christian Beginnings among the Zulu and Swazi" in Richard Elphick and Rodney Davenport (eds.) *Christianity in South Africa: A political, Social and Cultural History*. David Philip: Cape Town, 1997, pp.89 – 106.
[77] Herbert Bennet, 'Medical Missions" in A. E. F. Garrett, (ed.) *South African Methodism: Her Missionary Witness*. Methodist Publishing House: Cape Town, (Undated), pp.50-51.
[78] A. E. F. Garrett, (ed.) *South African Methodism: Her Missionary Witness*. Methodist Publishing House: Cape Town, (Undated), pp. 50-51.
[79] Michael Gelfand, *Christian Doctor and Nurse: The History of Medical Missions in South Africa from 1799-1976.* Mariannhill Mission Press: Mariannhill, 1984, p.25.
[80] Page 59.

2.2.6.2. The Roman Catholic Church

Joy Brain's summary of the Roman Catholic Church medical mission activities in southern Africa is helpful:

> The foundations of the Catholic hospital movement in Southern Africa were laid towards the end of the nineteenth century when, at the invitation of their bishops, religious sisters from Europe opened hospitals and nursing homes. This was followed by dispensaries and clinics set up in the rural areas. By 1950 there were 73 hospitals and 18 dispensaries run by religious sisters in the Union of South Africa, Basutoland, Swaziland, South West Africa and Southern Rhodesia. In addition several of the Catholic hospitals were providing facilities for the training of nurses.[81]

The Mariannhill Hospital, which still exists, deserves special mention as it started to function long before others when a resident Catholic doctor, K.F. McMurtie, arrived on 13 February 1925 from the Eastern Cape.[82] The Missionaries of Mariannhill established St. Mary's Hospital near the Mariannhill station during the influenza pandemic of 1915.[83] The hospital was completed in April 1927 and the doctor and staff moved in one year later.[84] The fact that the local people had not seen anybody die at the hospital until that time, according to Gelfand, made the hospital popular among the local people, who initially were suspicious of it.[85] This developed trust of the biomedicine and later created a dependence on its providers.

The Roman Catholic Church had the biggest number of mission hospitals in South Africa in 1972, largely because various Catholic sisterhoods and orders responded to the health needs of the indigenous people by building hospitals.

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[81] Joy Brain, "Charitable Works and Services," in Joy Brain and Philippe Denis (eds.) *The Catholic Church in Contemporary Southern Africa.* Cluster Publications: Pietermaritzburg, 1999, pp.98-99.
[82] Francis Schimlek, *Medicine versus Witchcraft*. Mariannhill Mission Press: Mariannhill, 1950, p.35.
[83] Michael Gelfand, 1984, p.121.
[84] Francis Schimlek, *Medicine versus Witchcraft*. Mariannhill Mission Press: Mariannhill, 1950, p.39.
[85] Michael Gelfand, *Christian Doctor and Nurse*. 1984, p.122.

2.2.6.3. The Anglicans

The Anglicans began their medical work in the Ciskei, the Transkei, KwaZulu, Lebowa, Bophuthatswana, and Cape Town.[86] Their first mission hospital was started in the Eastern Cape with the arrival of a qualified nurse called Sister Dorothy Kingspark in 1916.[87] After establishing medical centres in the Transkei, the Anglicans focused on KwaZulu in the late nineteenth and in the twentieth century.[88] A missionary called Charles Johnson established a small dispensary among the Ngobese people near Isandlwana Mountain, which grew into the sophisticated Charles Johnson Memorial Hospital after it moved to Nquthu.[89] In 1932, the Anglicans began medical work among the Tswanas living on the borders of the Kalahari Desert among the Batlharo tribe.[90]

In Durban, the Anglicans established St Aidan's for Indians and Umlazi (now Prince Mshiyeni) for Africans. Those were the few mission hospitals established in an urban areas. Mission agencies chose to concentrate their efforts in the rural areas for a number of reasons. Firstly, the government was neglecting rural areas as far as medical care provision was concerned except for an occasional District Surgeon who had to cover a large area. Secondly, most mission societies began their work in rural areas before the rapid industrialization of South Africa through the discovery of diamonds and gold. The need was therefore glaring in the rural areas. The Anglicans touched many tribes with their medical mission work. As mentioned earlier, the need and the available funds determined how far each mission agency could go with its health provision.

2.2.6.4. The Lutherans

The following Lutheran and Lutheran-related mission agencies contributed to the establishment of medical centres in southern Africa: Berlin Missionary Society,

[86] Michael Gelfand, *Christian Doctor and Nurse*. 1984, p. 26.
[87] Ibid.
[88] Ibid.
[89] Ibid. pp.118-119.
[90] Ibid. p.166.

Norwegian Mission Society, American Lutheran Mission, Hermannsburg Mission Society, Church of Sweden Mission Society, Finish Mission Society, Mission of the Evangelical Lutheran Free Churches, Rhenish Mission Society, and Moravian Church. The large number of Lutheran mission hospitals was the result of the individual initiatives of the various Lutheran mission agencies in southern Africa. More will be said on the work of the Lutheran hospitals in Chapter Five of this thesis.

2.2.6.5. The Dutch Reformed Churches

The Dutch Reformed Church family, whose earlier colonial leaders refused that other denominations and mission societies conduct mission work in the Cape Colony,[91] came late into the mission field with regard to direct evangelization and medical mission.[92] In the 1920s the Reformed Church missions began to grow rapidly and moved mostly to the northern Transvaal among the Venda peoples and the Pedi peoples.[93] The missions went to Bophuthatswana in 1938 to open George Stegman Mission Hospital[94] in Rustenburg and Gelukspan near Lichtenburg.[95]

The Dutch Reformed Church moved to Botswana and completed a hospital building in 1957 called Derdepoort,[96] thereby increasing the church's sphere of influence among the Tswana-speaking people. Other mission hospitals established by the Reformed Church family were spread in today's Limpopo Province among the Venda (Tshilidzini Mission Hospital), the Pedis (Bourke's Luck Mission Hospital and Meetse-a-Bophelo) and the Shangaan (Groothoek Mission Hospital).[97]

[91] George Schmidt of the Moravian Mission had to confine his mission in the Cape to the Khokhoi and was expelled when he began to perform baptisms.
[92] Michael Gelfand, *Christian Doctor and Nurse*.1984, p.27.
[93] Ibid.
[94] Ibid. p.240.
[95] Ibid. p.28.
[96]Ibid. p.239.
[97] For more information on the Reformed Churches medical work see Michael Gelfand's *Christian Doctor and Nurse*. 1984, pp.239-243.

2.3. The Position of the Lutherans in the Medical Mission's Landscape

According to the pamphlet published for the Medical Missionary Exhibition in Durban in 1972, [98] there were more Lutheran medical centres than the other denominations and mission societies at that time, except for the Roman Catholic Church. Among the other denominations were the Anglicans, Dutch Reformed, Roman Catholics, Seventh Day Adventists and the Methodists.[99]

While the information gathered for the Durban exhibition is valuable as an overview of the mission hospitals and medical missions in southern Africa, it has limitations regarding the understanding of the depth of the medical mission landscape from the establishment of mission hospitals to their nationalization. Since our study deals with the four Lutheran mission hospitals, the information given in the document on other agencies' medical mission initiatives is sufficient for the purpose. According to P. H. Coetzee, the chief compiler of the pamphlet:

> An endeavour was made to contact every mission hospital in order to compile this interdenominational booklet of mission hospitals. In such a compilation errors and omissions are almost unavoidable. We trust that future editions will have these corrected.[100]

The omissions referred to by Coetzee are due to the fact that each denomination chose how much information to give rather than following the instructions by the organizing committee. Some denominations gave more information than others. The following graphs are based on the information provided in Coetzee's pamphlet.

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[98] The publication is a 65 A4 pages document titled "Mission Hospitals in Southern Africa" with names of mission hospitals, their denominations or mission societies, the nature of services they provided, the number of beds, their locations and their needs at the time of the publication. The document is a valuable resource held at the Killie Campbell Africa Library in Durban. The document was a once off effort published by the ad hoc Interdenominational Organizing Committee, Medical Missions Exhibition. While not complete, the document gives useful information and helps to compare the contribution of the various denominations in the area of health care provision.

[99] P.H. Coetzee, "Mission Hospitals in Southern Africa." Durban, 1972. Unpublished pamphlet held at the Killie Campbell Africana Library in Durban.

[100] P. H. Coetzee, "Mission Hospitals in Southern Africa." Durban, 1972, p.1. Pamphlet held at the Killie Campbell Africa Library in Durban.

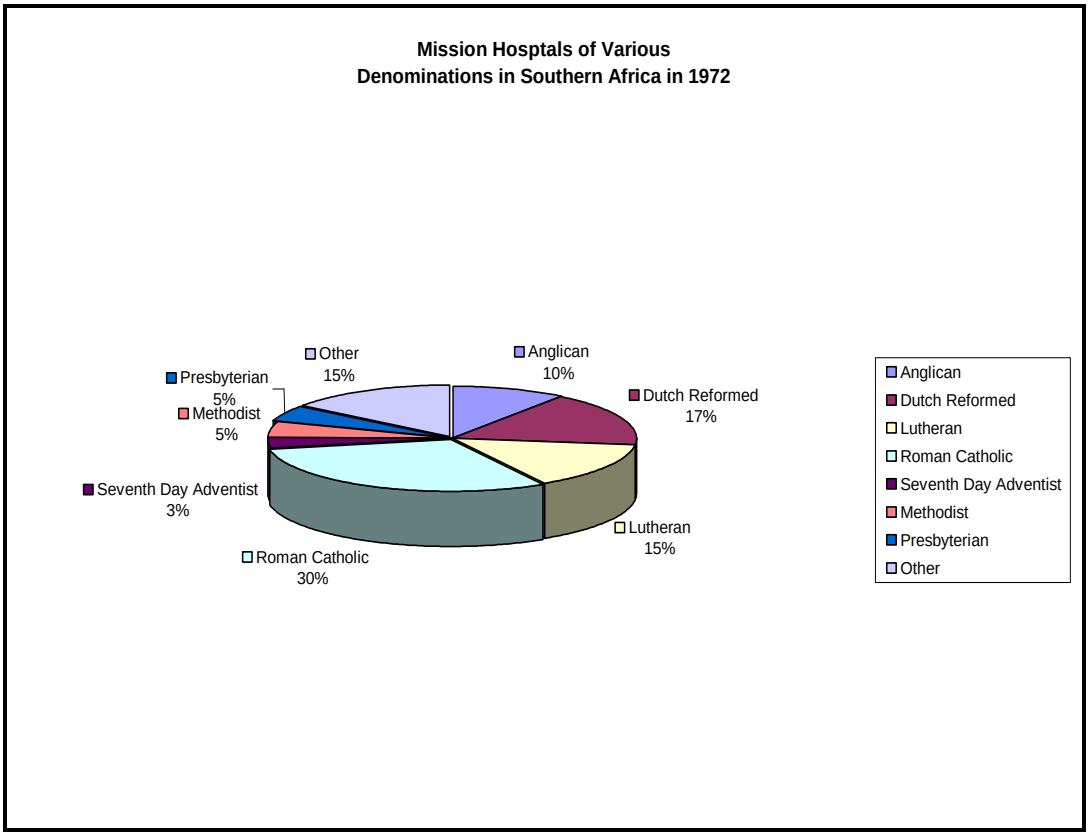

Figure 2

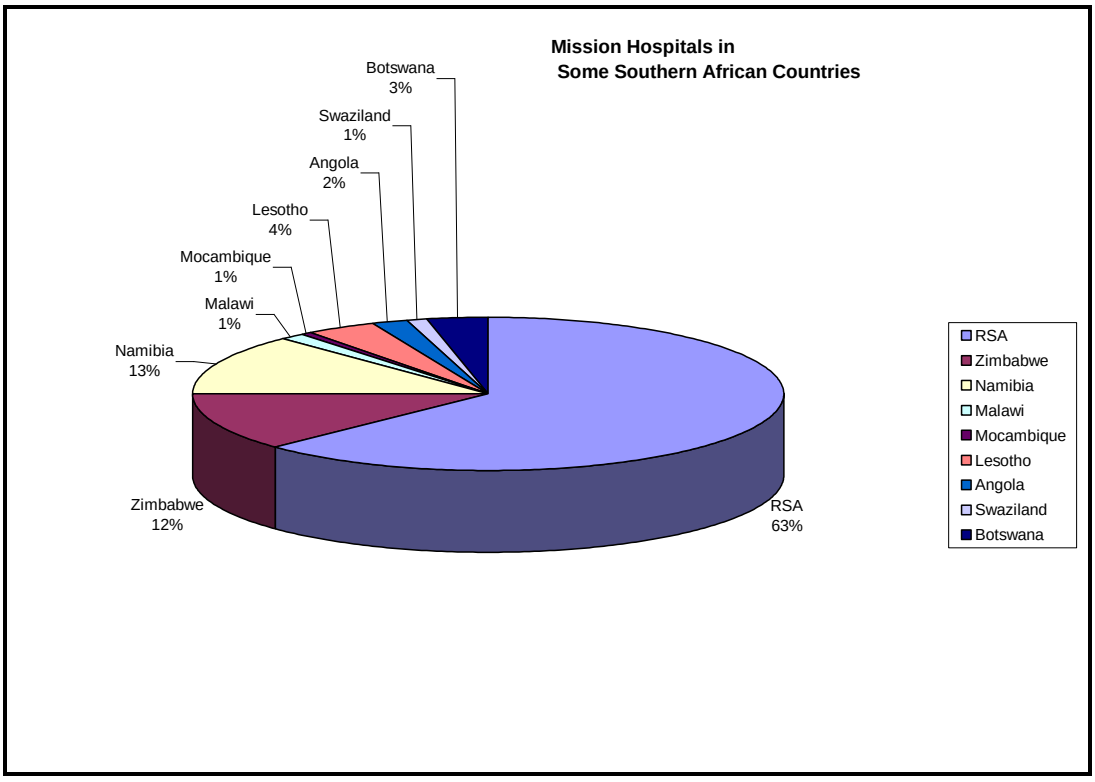

Figure 3

From the information provided in this document, one can see that the Lutherans established many mission hospitals in southern African. It may be asked, what was special about the Lutherans? The chief reason for having founded many hospitals is that they came to southern Africa under the auspices of diverse mission societies which only started to co-operate long after the mission hospitals were established. Although Coetzee's survey does not specify it as it was only compiled in 1972, there were nine Lutheran mission societies in southern Africa between the 1930s and 1970: the Berlin Missionary Society, the Norwegian Mission Society, the American Lutheran Mission, the Hermannsburg Mission Society, the Swedish Mission Society, the Finish Mission Society, the Mission of the Evangelical Lutheran Free Churches, the Rhenish Mission Society, and the Moravian Church. In the then-Natal Province and Zululand the following Lutheran mission societies had already formed themselves in the 1960s into a loose structure called the Co-operating Lutheran Missions where ventures like ministerial training, teachers training, mission hospitals, and literature publication were jointly undertaken. This structure included the Norwegian Mission Society, the Swedish Mission Society, the Hermannsburg Mission, the Berlin Mission Society and the American Lutheran Mission.[101]

While being the last on the scene, the Roman Catholic Church managed to establish the biggest number of mission hospitals. The second last on the mission scene were the Reformed family of Dutch Reformed Churches.[102]

The graphs in Figure 2,[103] and Figure 3,[104] on the presence of the various mission hospitals in most southern African countries show that although the Lutherans had a strong presence overall, they were not the major players in the health field. Despite the fact that the Roman Catholic Church only established mission hospitals in southern Africa much later than the mission societies such as the Lutherans, the Roman Catholic Church had the majority of mission hospitals.

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[101] Hans Florin, *Lutherans in South Africa*. Lutheran Publishing Company: Durban, 1967, p.95.
[102]The large numbers of mission hospitals under the Roman Catholic Church and the Reformed Churches should be seen as independent efforts of the various religious orders in the case of the Roman Catholic Church and as independent efforts of each denomination in the case of the Reformed Churches. The case of the Lutherans was not different.
[103] Page 59.
[104] Page 59.

When mission agencies that had fewer mission hospitals than those who had many in southern Africa are compared, one may arrive at different conclusions. Firstly, the mission agencies worked in other parts of the world and not only southern Africa, with the results that their human and financial resources were stretched. Secondly, the Roman Catholics and the Lutherans who each dotted large areas with health centres were not united bodies. The Roman Catholics came from various European countries to southern Africa in different monastic orders and sisterhoods. The Lutherans came from Europe and America under the auspices of individual societies which in the beginning had no inclination to co-operate. For instance, in Germany the mission headquarters of the HMS and the MELFC were, and are still situated less than thirty kilometres apart. Doctrinal and selfish interests played a role. Seen individually, it becomes obvious that no single mission society established more than five hospitals in southern Africa before 1972, except the Finnish Lutheran Mission that worked almost exclusively in the north of Namibia.

3. Chapter Summary

This chapter gives an overview of the involvement of the various mission societies in biomedical work and their establishment of mission hospitals in southern Africa. It is clear that the Lutherans were by no means the only denomination active in health provision between the 1930s and 1976. We have seen that the reasons for the establishment of health institutions by various mission agencies were not dissimilar. Except for Botswana, where the SDA clashed with the LMS over the establishment of a mission hospital in Kanye and the HMS clashed with the Roman Catholic for the St. Conrad hospital in Ramotswa, no mission agency attempted to establish a hospital where one already existed.[105]

That point shall be discussed in the next chapter when we shall look at the various concepts of illness and health restoration. We also need to be aware, as shall be discussed in the fourth chapter, that the indigenous people of the sub-continent of

[105] Harmshope Mission Station annual Report of 1931 written by Missionary Fitschen to the Hermannsburg Mission Society headquarters in Germany.

southern Africa challenged the introduction of biomedicine amongst them when they deemed it to be an imposition of a foreign culture.

CHAPTER THREE

CONCEPTIONS OF DISEASE, RESTORATION OF HEALTH AND DEPENDENCY

1. Introduction

To have an understanding of the mission hospitals and the way they operated in southern Africa, one needs to know the major forms of health systems practiced by the people for whose benefit the hospitals were established. Each health system was conceived from within a specific cultural milieu and biomedicine was no exception. We shall see that they operated differently as far as disease conceptions and health restorations are concerned. It shall be noted that largely the health seekers did not adhere to one health system but used each system as they deemed fit.

Disease and health are conceived differently within various cultural milieus. What is conceived as disease in one culture may not necessarily be conceived as such in another culture. What is regarded as disease in one culture can be dismissed and frowned upon in another culture. We can conclude that disease is largely culturally constructed and therefore culturally located. Similarly, what is perceived to be the cause of disease differs from one culture to the next. In her book, *Healing Traditions: African Medicine, Cultural Exchange, and Competition in South Africa, 1820-1948,* Karen Flint explained these differences tin the following way:

> This is because concepts of health, wellness, and the body, like tradition, are informed by our own experiences and the culture and era in which we live. Different communities often have various ways of understanding the body and illness and consequently diverse approaches to health and healing. For instance, biomedical conceptions of the body privilege a fairly mechanistic understanding of our selves, whereas Ayuverda (what is construed as "traditional" Indian medicine)

> views the body as consisting of five elements whose make-up determines one of three major body types.[1]

To understand how one's culture understands illness and healing, one has to undergo a mind shift of some sort. To prove this point, Megan Vaughan dedicated chapter eight of her book *Curing their Ills: Colonial Power and African Illness*, to the difficulty of teaching Blacks about the causes of diseases even through the use of audio-visuals of cinematography.[2] Even the terminology of disease is dissimilar in various cultures. Later we shall see that in the hospital setting White medical missionaries and their Black patients faced challenges in understanding diagnosis and prognosis as a result of coming from different medical-cultural backgrounds.

Blacks in southern Africa had a worldview that apportioned the responsibility of the prevalence of diseases largely to sorcery and the ancestors while White missionaries understood disease to be largely caused by germs, as early as the mid-nineteenth century.

Hospitals were not established in a vacuum. It was not a matter of health care economics where one provides supply when a demand is detected. A demand existed, long before the arrival of missions in the mid-1800s, and the supply of such care was provided by indigenous health providers. Later when dispensaries, clinics and hospitals were established by mission societies, another healing practice appeared. It was the Afro-Christian spiritual healing, practiced largely by the Zionist-type of the African Initiated Churches. We include it in this study since African health seekers would use all three modes of healing concurrently or individually depending on their type of illness or its duration. This chapter will look at how, around the late nineteenth century and the early twentieth century, concepts of illness and healing differed between Africans in southern Africa and the European missionaries. However, let us note that the arguments are to be understood in relation to health in colonial southern Africa on the body of indigenous Africans.

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[1] Karen Flint, *Healing Traditions: African Medicine, Cultural Exchange, and Competition in South Africa, 1820-1948*. University of KwaZulu-Natal Press: Pietermaritzburg, 2008, p.19.
[2] Megan Vaughan, *Curing their Ills: Colonial Power and African Illness*. Stanford University Press: Stanford, 1991, p.185.

2. Concepts of Illness and Healing

The three concepts of health and healing which manifest skewed power relations between the health providers and the health seekers shall be considered. Arguably, as we have seen in Chapter One, those who have knowledge and resources inevitably posses some control over those who are in need of those resources. It has happened though, that those who needed health-giving resources exercised a subtle form of power over those who were in control of those resources. An example is when political or traditional leaders call upon a doctor or a healer to restore health to someone.[3] At the end of this chapter I will argue that power is exercised in a similar manner in all three forms of health provision. Since disease and healing are culturally located, we shall establish how the Western concept of illness and healing influenced the indigenous people and how the indigenous people transformed the Western concept of healing to their advantage. Although the practitioners of Western medicine continued to dominate after the establishment of hospitals, they were forced to integrate the indigenous responses to illness and healing in order to be relevant in southern Africa.

As we shall see in the chapter on acculturation, the Blacks had to learn how to become ill in the Western ways in order to benefit from biomedicine. Simply put, blacks had to adopt Western culture which included a Western economy, Western education and Western religion—in this case, Christianity. An interpreter always had to be present during consultation in order for a White medical missionary to understand, in their cultural terms, what the condition of the patient was.

It is of paramount importance to have a background on what constitutes illness before attempting to find out the prognosis. What causes someone to be declared ill? At least two answers can be found. The first is that something has gone wrong, either in

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[3] Sister Liselotte Gnauk related a story during an interview with Radikobo Ntsimane in her home in Bleckmar, Germany that under the cover of the night one Zulu Prince from KwaNongoma palace came to Itshelejuba Mission Hospital demanding a specific injection for his gonorrhoea. Without knowing the patient, Sister Gnauk sent the nurse on duty to advise the patient to come back the following day. Fearing the consequences, the nurse informed Sister Gnauk that there is no way they can deny the prince the medication he required. The interview took place in Bleckmar, Germany on 6 September 2002.

the physical or psychological make-up. The physical or the somatic illness involves the tangible body of a patient. The illness means that the body is not functioning in the way that its owner is used to. When this condition is felt or observed, one concludes that one is ill. Some people are born with physical limitations, for example, dysfunctional limbs, and others suffer amputations in accidents or after accidents. In such cases it cannot be said that they are ill. They are said to be disabled. The Ngunis refer to such people as *isixhwala* or *inyonga* (cripple) while the Batswana refer to them as *segole* or *setlhotsa.*

The second answer regarding what causes a person to be declared ill, would be that something is disturbed in the mental faculty of that person. Mental ill-health means that the person in question manifests behaviour that does not fit their level of maturity or the circumstances prevailing at the time. Examples are when the person undresses in view of the public, speaks incoherently, or attacks people without provocation.

This chapter looks at the different perceptions of illness by the indigenous people of southern Africa and by Western missionaries. How did the two cultures diagnose illness during the late nineteenth and early twentieth centuries? Looking at these perceptions will foster a better understanding as to the role of hospitals as centres of healing in an African context. Since this thesis does not just deal with broad categories of Africans, as well as Western missionaries but with specific groups within such categories, it is necessary to divide the approaches to illness into two major categories, namely the spiritual and the scientific. When dealing with the spiritual approach to illness, the African traditional religions, the mainline churches, the African independent churches, and the Pentecostal churches shall be discussed. The scientific approach is about the health system that dominated hospitals and clinics from the 1930s and was gradually supported and promoted by governments from the 1960s. The sources available to me are mainly secondary. Because of that handicap, this chapter will rely largely on written sources.

2.1. The Spiritual Approaches to Illness

For those who understand illness in spiritual terms, bad health is understood to be of a spiritual origin and can be healed by means of spiritual interventions. Various cultural groups have various understandings of the causes of disease and of the healing process. There are those who believe that God is responsible for diseases and healing, and those who believe that the ancestors and other forces are responsible. Among the spiritual approaches one finds the African traditional approaches, the mainline Churches' approaches, the African Independent Churches' approaches and the approaches of the Pentecostal Churches in their various forms. All these understandings of illness have relied to varying degrees on the scientific approach to illness to which we shall return later.

2.1.1. The African Traditional Religions' Approach to Illness

Among the practitioners of African Traditional Religions (ATR) are the Bantu of southern Africa who believe that the ancestors play a significant role in health—or lack of it. All the ATRs are inextricably connected to the spiritual realm, where some major causes of diseases and their cures are supposed to originate. Since this thesis is focussed on the Lutheran mission hospitals in southern Africa, we shall confine this subsection to both the Nguni and the Sotho Bantu-groups, among whom the hospitals were established.

In the context of this thesis, "traditional" does not refer here to what is outdated and of no current value. It refers rather to what has been practiced for a long time and which is still in use today, although with notable modifications. "Traditional" is contrasted with that which was introduced from the West in the field of healing. It does not in any way mean that the West has no traditional health concepts of its own, nor does it mean that "traditional" is that which has remained unchanged for ever. As part-and-parcel of culture traditional health systems are never stagnant. The term is problematic and I concur with Anne Digby that we should use it for lack of a better

one. She disentangled herself from the ambiguity of the term "traditional healing" when she wrote:

> Yet even a brief review of traditional or indigenous healing in southern Africa suggests the malleable and flexible nature of tradition, and the way that healing could both reflect and strategically respond to a range of needs in the present. So I have preferred in this chapter to use the term 'indigenous' rather than 'traditional' because of this fluidity of healing. To the extent that healers also appropriate elements of 'western' medicine in the form of pharmaceuticals or patent medicines the term indigenous is also not an ideal term but, at present, we lack a more apposite alternative.[4]

There is a glaring gap in the literature on the development of traditional practice in health and healing. The early anthropologists were biased against indigenous health systems due to their negative views on African indigenous people. Instead of opting for an informative phenomenological approach in explaining early African traditional health systems, they portrayed indigenous health agents as "witchdoctors" and their profession as fraudulent.[5] For a better understanding of this health system, I shall make reference to the history of its development.

Given the fact that the hospitals chosen to be researched are found among the Zulus (and partly the Swazis)[6] and among the Batswana, this thesis will concentrate on these groups rather than on the Nguni groups and the Sotho groups as a whole. It is understood that Nguni and Sotho traditional health systems are not necessarily identical. I have chosen to discuss them under one sub-heading because of their similarities. Karen Flint in her recent publication on healing traditions in South Africa concurs with this point as she wrote:

> African medical beliefs and local therapeutics currently practiced in KwaZulu-Natal show remarkable similarities with wide regional beliefs and practices, evincing a long history of interaction and some common origins. Though medical practices and *material medica* may

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[4] Anne Digby*, Diversity and Division in Medicine: Health care in South Africa from 1800s*, Volume 5. Peter Lang: Oxford, 2006, p.278.
[5] Karen Flint, *Healing Traditions*: *African Medicine, Cultural Exchange, and Competition in South Africa, 1820 – 1948*. University of KwaZulu-Natal Press: Pietermaritzburg, 2008, p.27.
[6] Before the Berlin Mission Society stationed Missionary Bernhard Schiele in Emmaus, Bergville, his wife Doctor Magdalene Schiele was running a small hospital, KaShile, in Mbabane, Swaziland.

> vary among different cultural groups, southern Africa's local medical cultures share many key attributes. These include similar herbal remedies, surgical and non-invasive therapeutic techniques, and an occupational division between healers who use only herbs and those who heal through clairvoyant means. The area's culture also historically shared the no-cure, no-pay, a practice that has largely disappeared in the face of colonial and post-colonial changes. [7]

It will be incorrect to assume that indigenous health systems have remained the same and have been inherited unadulterated from their early conceptions. Flint showed that such concepts have undergone changes with time.[8]

Writing about the cosmopolitan Soweto, Adam Ashforth does not acknowledge differences between the Nguni and Sotho understandings of disease. His book *Witchcraft, Violence, and Democracy in South Africa*, showed how Sowetans understand the causes of disease:

> The foundational distinction in everyday understandings of health in Soweto, as in the rest of black South Africa, between "natural" illness (*umkhuhlane*, Zulu; *mokotlane*, Sotho) and "man-made" or "African" diseases (*ukufa wa* [sic] *Bantu* or *imisebenzi yabantu*; *mesebetsi ya batho*), or, in the manner of Sowetan English, between "a natural sick" and "things of we blacks." Sometimes a further distinction among natural ailments is made between diseases of "whites" and other natural ones known to Africans of old. As an everyday rule of thumb, natural illnesses are thought to be responsive to treatment by Western medicine, and man-made afflictions are immune to such treatment and require the intervention of healers deploying spiritual powers. Natural afflictions are also typically spoken of as "God's will", particularly when they prove terminal. African diseases, on the other hand, are spoken of as involving "evil forces" – typically either the man-made forces or *muthi* or the ill effects of encounter with pollution.[9]

Ashforth and the Christian anthropologist Harriet Ngubane are in agreement that natural diseases can be cured using Western medical interventions. These diseases have not come upon a patient as a result of witchcraft, sorcery or malicious intentions of a human being. There are illnesses, though, that have been "fabricated" by human

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[7] Karen Flint, *Healing Traditions: African Medicine, Cultural Exchange, and Competition in South Africa, 1820-1948*. University of KwaZulu-Natal Press: Pietermaritzburg, 2008, p. 40.
[8] Ibid. pp.9–14.
[9] Adam Ashforth, *Witchcraft, Violence, and Democracy in South Africa*. University of Chicago Press: London, 2005, pp. 44-45.

beings to cause harm or to kill other persons. In Zulu cosmology, dead ancestors are powerful and look after their living descendents and protect them from the malice of witches and sorcerers. The same ancestor, ironically, can also use illnesses to communicate their displeasure about bad actions or lack of good actions on the part of descendants, family and clan. Invariably, any afflicted person or their loved ones will seek help to restore him/her back to a state they regard as normal. For what is deemed natural illness, *umuthi*—traditional medicine, or biomedicine will be used to counter the affliction. This form of intervention will also be used to restore 'normality,' as man-made diseases are not regarded as such until several attempts have been made to counter them.

Christian anthropologists who have written about illness are not without limitations. They wrote about something they had not experienced closely. An LMS missionary, William Willoughby, for instance wrote his book *The Soul of the Bantu* in 1928, before the proliferation of the mission hospitals. It was while Willoughby worked among the BaNgwato of Botswana, that Kgosi Khama appointed wise men of his tribe to instruct him on subjects of law, religion, custom and folklore.[10] Another pitfall experienced in relying on Christian anthropologists is that they were not trained in the academic discipline of anthropology as they would probably be if they were operating today. Their chief aim was mission work with the intention of converting indigenous people. They pursued interest in subjects relating to Africans and wrote as best as they could with the aim of helping interested parties to understand Black Africans. Obviously, those who wrote earlier, like William Willoughby, are closer to the source than those who wrote later, like Ngubane whose book appeared in 1971. Let us bear in mind that most mission hospitals in southern Africa were established around the 1930s. Willoughby's categorizations imply that the "Bantu" regarded their dead ancestor as capable of bringing illness upon their living relatives. He also pointed to

[10] Willoughby studied Bantu tribes between the Zambezi and the Vaal and from 1919 after retirement from Africa had frequent meetings on these and other subjects with missionaries who came to the Kennedy School of Missions in England for furlough. See W. C Willoughby, *The Soul of the Bantu: Sympathetic Study of the Magico-Religious Practices and Beliefs of the Bantu Tribes of Africa*. Student Christian Movement: London. 1928, pp.ix-x. (preface).

the ancestors as sources of healing for such illness as they have brought upon their relatives.[11]

We shall now look at how Africans themselves understood illness and its healing before we look at how their understanding impacted on the missionaries' strategies of making converts and starting hospitals.

In Zulu, the first attempt to counter any illness is referred to as *ukwenza izaba*. This intervention uses whatever relevant *umuthi* is available in the household of the afflicted member. Often emetics or purgatives are used to induce vomiting (*ukuphalaza),* or to loosen bowels (*ukuchatha*). In both cases water mixed with herbs, or other items of a medicinal nature are used. These methods are used if the cause is suspected or known to be within the body cavity, viz., chest, stomach or intestines. They are not employed when ancestors' wrath or witchcraft is suspected.[12] If the *ukwenza izaba* fails as the first line of intervention, just like first aid in Western biomedicine, the second line is put into operation.[13] Digby noted in relation to biomedicine that sometimes the family adhere to the family medication until it is too late to find help outside the home:

> Reinforcing this process was the tendency of patients to delay [biomedical] treatment until the case was acute, either because of the distance and expense involved [in reaching biomedical practitioner], or because of their strong cultural reliance on household remedies.[14]

While *ukwenza izaba* takes place within the household of the afflicted member by family members or close relatives, the second intervention is conducted by an expert from outside but within the same village or neighbourhood. The expert chosen will either be a *sangoma* (*sedupe* in Tswana),[15] —one who divines, or an *inyanga*—one

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[11] William Willoughby, *The Soul of the Bantu*: *A sympathetic Study of the Magico-Religious Practices and beliefs of the Bantu Tribes of Africa*. Student Christian Movement: London, 1928, pp.193-195.
[12] Karen Flint, *Healing Traditions*: *African Medicine, Cultural Exchange, and Competition in South Africa, 1820-1948*. University of KwaZulu-Natal Press: Pietermaritzburg, 2008, p.57.
[13] Karen Flint, *Healing Traditions: African Medicine, Cultural Exchange, and Competition in South Africa, 1820-1948*. University of KwaZulu-Natal Press: Pietermaritzburg, 2008, p.54.
[14] Anne Digby, *Diversity and Division in Medicine: Health care in South Africa from 1800s*, Volume 5. Peter Lang: Oxford, 2006, p.219.
[15] When not using tangible items in divination, a Tswana diviner is said to "*dupa*" = smell out the cause, hence the name *sedupe* = the one who smells out.

who uses herbs to restore health. A *sangoma* will either use "the bones" to divine the cause of affliction and to determine the manner of treatment or the *muthi* for treatment. Alternatively, the *sangoma* will use a trance-channelling method in order to be the medium through which ancestors may communicate regarding the affliction. Let me add that the appearance of traditional healers during consultation is exaggerated in the regalia that are supposed to emphasize the supernatural power that the individual healer has. The combination of non-mundane colours and animal skins, as well as parts of their anatomy like heads and feet enhance the strangeness and illuminate the display of power. In his book, *Africa in my Bones: A Surgeon's Odyssey into the Spirit World of African Healing*, David Cumes, who is both a *sangoma* and a Western-trained surgeon, explained how *sangomas* work:

> In contrast, in other indigenous African traditions, the ancestral spirit of the *sangoma* or *inyanga* comes down from the cosmic field and possesses the healer. The spirit occupies the *sangoma's* body while the ego or the persona steps aside. In this way, healers can access information that is not localized in space and time, information that is not readily available to those who are not trained as *sangomas*. A *sangoma's* ancestor is able to speak directly through the healer to the patient, and the information is highly specific to the individual. We describe this process in the West as channelling or trance- channelling. *Sangomas* may speak in tongues; it is not unusual for a healer who speaks Zulu to speak in English or for another who speaks Sotho to heal in Zulu. *Sangomas* speak the language of the ancestor concerned.[16]

To present the use of bones in divination in the Tswana culture I shall use the writings of Isaac Schapera and John Comaroff. They describe the use of divination in this manner:

> Most doctors, in addition to their other activities, practice divination (*go laola*). This features prominently in Tswana life; people use it to discover the nature and causes of sickness, the reasons for a person's death, the whereabouts of missing stock, the prospects of a journey, the meaning of unexpected objects seen about the compound, and in all other situations where they are baffled by some occurrence or wish to ascertain what future holds in store. In the old days, similarly, the chief

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[16] David M. Cumes, *Africa in my Bones: A Surgeon's Odyssey into the spirit world of African healing.* Spearhead : Claremont, 2004, p.7.

> consulted diviners officially before holding any tribal ceremony, in time of war and drought, when selecting the site of a new village, etc.[17]

In her quest to discover how people become ill, Harriet Ngubane established that there were three major sources or causes of illness among the Nyuswa-Zulu people of Bothas Hill in KwaZulu-Natal. These were: natural causes, sorcery, and through ancestors' wrath.[18] She uses the generic term *umkhuhlane* to refer to illnesses which just come about—such as common colds and serious epidemics like influenza and smallpox.[19] Sorcery is witchcraft with an intention to harm or gain an advantage over one's enemies.[20] Ngubane divides sorcery into night and day sorcery, the former using familiars like baboons, and the latter using substances like noxious medicines in the food of the competitor.[21]

An Anglican Church missionary, Henry Callaway, wrote on religio-cultural themes such as ancestors, spirits and healers. He wrote the religious system of the Zulu people in same manner that such systems were narrated to him. Throughout a volume of over four hundred pages, Callaway wrote in Zulu in one column and translated in English in another column the narratives in verbatim. He largely wanted to show what in their own words the Zulu people believed with regard to health-related subjects including: *uNkulunkulu* (God), *uTixho* (God), the Lord of Heaven, *Amatongo* (ancestral spirits), dreams, diviners, magic and witchcraft. His informants told him that diseases were caused by ancestors they named *amatongo*.[22]

Willoughby on the other hand maintained that sickness was not always caused by witchcraft or sorcery.[23] Ancestors may wish to be appeased and thus show their displeasure by placing a calamity of diseases upon someone or their relative in order

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[17] Isaac Schapera and John Comaroff , *The Tswana* (Revised Edition). Keegan Paul International: London, 1991, pp.57-58.
[18] Harriet Ngubane's *Body and Mind in Zulu Medicine*. *An Ethnography of health and disease in Nyuswa-Zulu thought and practice*. Academic Press: London, 1977, chapters 2, 3 and 4.
[19] Ngubane, *Body and Mind in Zulu medicine*. Academic Press: London, 1977, p.23.
[20] Karen Flint, *Healing Traditions*: *African Medicine, Cultural Exchange, and Competition in South Africa, 1820 – 1948*. University of KwaZulu-Natal Press: Pietermaritzburg, 2008, p.59.
[21] Ngubane, *Body and Mind in Zulu medicine*. Academic Press: London, 1977, p.35.
[22] Henry Callaway, *The Religious System of the amaZulu*. Struik: Cape Town, 1970, p.5.
[23] William Willoughby, *The Soul of the Bantu*. Student Christian Movement: London, 1928, p.193.

to urge them to correct their ways.[24] Ngubane attests to this by stating four cases where ancestors caused calamity to their families by withdrawing their protection.[25]

In the event that the diagnosis and the prognosis are unsatisfactory to the afflicted household, or if the desired results are delayed, then other experts, often from outside the village or community of the afflicted, are sought. A diagnosis and prognosis similar to that of the first expert may be divined and taken as confirmation, or a different one might arise. Usually, until the restoration of health or "normality" is achieved, the household will not cease to seek help.

Having established the cause or source of affliction and the plan for its cure—either through bone divination, trance-channelling, or through dreams—the healer and the afflicted await for recovery. Most times, as in the case of 'man-made' illnesses, the affliction will be undone by *setlhare* or *umuthi,* or less often, redirected back to the sorcerer. In the case where ancestors have been offended by omission of good action or commission of bad acts, a ritual to appease them and to correct the malady will be prescribed and performed. Since the role of protection is attributed to ancestors and the absence of such is the ancestors' withdrawal of that protection, ancestors should be the first from whom healing is sought in cases of illness. Mission and other hospital personnel had to deal with cases where admitted patients were discharged at the request of their relatives in order to perform ancestor-related rituals for health restoration. Although taken from a non-Lutheran hospital, the next example is helpful in understanding the situation of the Lutherans. Jon Larsen wrote about a young girl with paralysed legs and a crooked back called Mashobi, who, in the early 1970s was brought by her father, Molife, to the mission hospital in Nquthu. Anthony Barker, the doctor, wanted to know why the father wished his daughter to be discharged before complete recovery of health was achieved:[26]

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[24] Karen Flint, 2008, pp. 57-58. *Healing Traditions: African Medicine, Cultural Exchange, and Competition in South Africa, 1820-1948*. University of KwaZulu-Natal Press: Pietermaritzburg, 2008, pp.57-58.
[25] Harriet Ngubane. *Body and Mind in Zulu medicine*. Academic Press: London, 1977, pp. 48-50.
[26] Jon Larsen, "*KwaBaka": Excellence in Caring: the story of a mission hospital community in Zululand 1930- 2006.* Cluster Publications: Pietermaritzburg, 2010, p.47.

> Maggie and Anthony had learnt that that was often a polite way of asking if medical treatment could be discontinued. He did not consider the time was yet right for that, and so he set out to discover what was their real intention. It turned out that Molife was a sangoma – a diviner – and he and his sangoma sister desired to kill a goat and to consult the ancestors about the child's illness. He was only able to establish all of this by the goat and the child's aunt in the hospital truck and by bringing it for Mashobi to see. The little girl was delighted. But then came the repeated request that they be allowed to take her home for the ceremony. It seemed now that she would return. Anthony got their permission to accompany them and see what they did.[27]

Rituals in which ancestors are appeased by means of the sacrifices of beasts are performed for a specific ancestor who has been perceived by the divining bones to be the source of affliction. Willoughby quotes the late Zulu king Cetshwayo, to explain what the Zulus did and said to a spirit when someone was ill:

> We offer unto you, spirits of our departed relations, this beast, in order that you, who are chief relations of this patient, may invite all your other spiritual relations to partake of this beast offered unto you, even as you did on earth while alive, in behalf of the patient; satisfy yourselves and show kindness unto this patient your relation, by giving him good health.[28]

Should the prescriptions of the healer delay or not yield the desired results, in our case the restoration of health, the patient would be taken away to another healer.

We have attempted to show how the Zulus perceived the manner in which illnesses are acquired through the spiritual forces of ancestors and through the machinations of sorcery and witchcraft. This of course excludes the diseases that "just happened." Illnesses caused by night sorcery, and those acquired as a result of the withdrawal of ancestors' protection can be regarded as requiring supernatural interventions.

Healing of a person who has suffered under a day sorcerer who put poison in his or her food, can also be helped in a natural manner by an herbalist "cleaning" the bowel system with water, either through the mouth or the rectum. In isiZulu, this method is

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[27] Jon Larsen, "*KwaBaka": Excellence in Caring: the story of a mission hospital community in Zululand 1930-2006*. Cluster Publications: Pietermaritzburg, 2010, pp. 47-48.
[28] William Willoughby, *The Soul of the Bantu*. Student Christian Movement: London, 1928, p. 190.

called *ukuphalaza* (*go kapa* in Setswana) and *ukuchatha* (*go peita* in Setswana)—respectively for the mouth and the rectum.

As already mentioned, Sothos or specifically the Tswanas, were not much different from the Zulus in conceptualizing illness. The Tswanas regarded any sort of misfortune as *bolwetse*, illness. The interest of this thesis is physical and mental illnesses; there are however, illnesses of cultivated fields and livestock,[29] for which the Tswanas have approaches of healing. Let us now look at their understandings of acquisition of physical and mental illnesses.

Sorcerers, divided into "sorcerers by day" and "sorcerers by night," by Schapera in his book *The Tswana* are among the most common source of illness.[30] The Tswanas counted God among the supernatural powers that controlled the spiritual realm for diseases causation. The diviner bones could detect God as responsible for illness. "In the old days when a person had died, fallen ill, or been afflicted with some or other misfortune, a doctor was always called to divine the cause. The bones occasionally attributed the event directly to the action of *Modimo* (God), in which case nothing could be done." Schapera continued, "Alternatively, and far more commonly, the misfortune might be ascribed to the ancestral spirits, who had then to be appeased by prayer and sacrifice."[31] Although it had undergone transformation and was no longer as prevalent among the Tswanas as it used to be before the introduction of Christianity, Tswanas of the pre-Christian era believed that their soul and life were controlled by ancestors. That interconnectedness of the Tswanas with the spiritual realm of the ancestors will be discussed later, in order to see how it was used by missionaries to effect conversion.

As with the Zulus, the Tswana would also treat illnesses that 'just happened' with the help of the herbalist who would be familiar with that particular illness, to restore health to a patient. In *Ngwao ya Setswana,* a book about the pre-Christian ways of healing in southern Africa, Kgomotso Mogapi listed among the illnesses and

[29] For more information on livestock diseases especially rinderpest, see Benedict Carton, *Blood from Your Children: The Colonial Origins of Generational Conflict in South Africa.* University of Natal Press: Pietermaritzburg, 2000, pp. 66-67.
[30] Isaac Schapera, *The Tswana*. International African Institute: London, 1953, p. 65.
[31] Isaac Schapera, *The Tswana*. International African Institute: London, 1953, p. 65.

misfortunes treated and the protections administered by Batswana traditional healers: snake bites, insanity, strengthening of marriage, home, cattle, raiding parties, crop fields.

Similarly, as it was observed among the Ngunis, there were rituals among the Tswana which needed to be observed in order that illnesses and general misfortunes might not befall families. One had to follow the right order in performing a ritual, for example: initiation, courtship and marriage, burial and mourning.[32] The observance of the ritual to the letter was bound to bring desired results, i.e., life without mishaps. Although this pre-Christian trust in rituals cannot be confirmed, there are traditional healers who still promise "life without mishaps."[33]

To a large degree, the preceding passages described the traditional healing system in place among the Ngunis and the Sothos, when the missionaries and colonists came into contact with them in the 1800s. Affliction was believed to be caused by sorcery or the anger of ancestors. As we have attempted to show, the black people had ways and means of dealing with the illnesses with which they were confronted. They also relocated and found new areas to inhabit, should the one in which they lived have diseases they could not overcome. They were in no way paralysed into passivity in the face of illness. They were active agents in finding solutions to their problems; they tried various ways of dealing with illnesses; and they manifested innovative capabilities in their field.

The Zulu and the Tswana ways of dealing with health and healing are based on power relationships between those who seek and those who provide health care. Without claim of powerfulness and legitimacy, traditional healers would lose their profession as the clientele is attracted by displays of power and proof of successful health restoration.

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[32] Kgomotso Mogapi, *Ngwao ya Setswana*, L.Z.Sikwane Publishers: Mabopane, 1991, Chapters 12-15.
[33] Busy streets in cities like Johannesburg, Pretoria, Pietermaritzburg and Durban are filled with people handing out pamphlets from traditional healers promising lives without mishaps.

In his discussion of oral tradition and oral history in South Africa, Denis made the point that, generally those who make their claim to power and who wish to control others sometimes invoke tradition in order to legitimise their positions:

> What makes oral history attractive in contemporary South Africa, among groups as diverse as officials in government departments, local activists and community leaders, is its perceived ability to retrieve, affirm and disseminate long-repressed African traditions. The holders of these traditions, traditional leaders, members of royal families, healers and diviners, claim to have first-hand knowledge of the community's *amasiko* (traditions), as if they were fixed objects, mechanically transmitted from generation to generation.[34]

Though specifically referring to South Africa, Flint's argument regarding the claims of power and legitimacy by traditional health practitioners is relevant for southern Africa as a whole:

> Today South African healers use ideas of tradition to emphasize their authority and legitimacy in multicultural environment where their patients may choose from a variety of different practitioners and therapeutics. Healers thus refer to themselves in English as "traditional healers" and argue that their practice has not changed over time but reflect the practices of their forebears. This reference to ancestors alludes not only to the knowledge passed down through the generations but to the active role that ancestors play in the therapeutic process and passage of knowledge through dreams, trances, and visions. The term "traditional healer" also avoids the negative connotations and inaccuracy of "witch doctor" and is less exclusive than the colonial derived terms "medicine men and herbalists.[35]

Karen Flint suggested in the introduction to her book, that although traditional health practitioners still find it relevant to refer to their profession as traditional, it can be argued, as in the case of a certain Mafavuke Ngcobo in 1934, whose claim as a "traditional" was refuted in a court of law, that their practice was not purely traditional. The profession has experienced a major metamorphosis through the years as it came into contact with other health systems, the scientific one in particular.

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[34] Philippe Denis, "Introduction" in Philippe Denis and Radikobo Ntsimane (eds.) *Oral History in a wounded country: Interactive interviewing in South Africa.* University of KwaZulu-Natal Press: Pietermaritzburg, 2008, p.4.

[35] Karen Flint, *Healing Traditions*: *African Medicine, Cultural Exchange, and Competition in South Africa, 1820-1948*. University of KwaZulu-Natal Press: Pietermaritzburg, 2008, p.12.

2.1.2. The Mainline Churches' Approach to Illness

Protestants and Catholics use prayer and non-material interventions in their attempt to effect healing. This shows that the mainline churches also use spiritual approaches to health restoration.[36] We should note though that, unlike in the Zionist and Pentecostal-type Churches, the mainline Churches' manifestations of the presence of the Spirit is different. They are Spirit churches who use prayer and the laying-on of hands for healing purposes, unlike those who speak in tongues during healing services as we shall discuss later. Healing is part of religion. The mission societies at the close of the eighteenth century promoted scientific biomedicine and denigrated African traditional health systems which were of a spiritual nature. However, Christians today still promote prayer for God's intervention to effect miraculous healing. John and Jean Comaroff pointed out that biomedicine, as a scientific approach to health restoration, was used to promote the supremacy of God, who was a spiritual and supernatural Being:

> What began the period as an explicit discourse on moral economy ended it, at least in hegemonic form, as biomedicine; what was formerly couched in terms of Christian well-being came to be spoken of in assertive language of science. This transformation was implicated in significant, epochal shifts in the nature of knowledge, authority, and sovereignty. It was to make medicine into an archetypal profession, and enable it, with the backing of the state, to replace the church as the guardian of "health," public and private. For a good part of the nineteenth century, though, there was no simple distinction to be drawn between the pioneers of scientific healing and those purveyors of the Spirit who also treated afflicted bodies.[37]

Biomedicine as a scientific approach to health was used to promote what was spiritual and supernatural, i.e., God. This was an indication of health syncretism, which is the simultaneous belief in the efficacy of both the scientific approach and the spiritual approach to health restoration. The mainline Churches, most of whom had a close

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[36] Those like Paul Makhubu who exclude mainline churches from *dikereke tsa moya,* the spirit churches, categorization are incorrect See Paul Makhubu, *Who are the Independent Churches?* Skotaville Publishers: Braamfontein, 1988, p.20. Inus Daneel who has written extensively on the AICs in Zimbabwe also attempts a categorization of churches that involves the spirit in healing machinations, the Spirit-type churches but excludes the mainline churches. *Quest for Belonging: Introduction to a study of African Independent Churches.* Mambo Press: Gweru, 1991, pp.39-41.

[37] John and Jean Comaroff, *Of Revelation and Revolution: The Dialectics of Modernity on a South African Frontier*. Volume Two. The University of Chicago Press: Chicago, 1997, p. 325.

relationship with the mission hospitals established in southern Africa by their former mission partners, used to combine scientific medicine and prayer even in hospital wards. In the following chapters, we shall describe chaplaincy in mission hospitals in order to show how much the mission agencies valued the presence of such an intervention within the scientific health system. The inclusion of chaplains in the mission hospital staff until the mid-1970s was a clear indication of the health syncretism practised by the mainline Churches. The mainline Churches taught that diseases could be caused by God as a form of punishment for sin.[38]

God is Spirit and the trust that the mainline Churches placed upon God to effect healing in a miraculous and inexplicable manner, indicated the fact that the mainline Churches operated on the spiritual level for the restoration of health. Like the AICs, the mainline Churches can be said to be spirit Churches as they depend on the Spirit to direct their worship and healing rituals.

2.1.3. The African Independent Churches' Approach to Illness

Three authors attempted to categorize the African Independent, or Indigenous, or Instituted Churches (AIC): Bengt Sundkler,[39] Paul Makhubu,[40] and Allan Anderson.[41]

As we shall see, there is literature on the healing character of the African Independent or Indigenous Churches (AICs).[42] Among other reasons, the AICs seceded from the mainline Churches after having been accused of syncretism by their Church leaders. Paul Makhubu gave a long list of reasons cited by the Tomlinson Commission of

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[38] The thought was probably deduced from the question asked by Jesus' disciples on whether it was the sick man Jesus healed or his parents who sinned. (John 9:1-2).
[39] Bengt Sundkler, *Bantu Prophets in South Africa* James Clarke & Co.: Cambridge, 1961.
[40] Paul Makhubu, *Who are the Independent Churches*? Skotaville Publishers: Braamfontein, 1988.
[41] Allan Anderson, *Zion and Pentecost: The Spirituality and Experience of Pentecostal and Zionist/Apostolic Churches in South Africa*. University of South Africa Press: Pretoria, 2000.
[42] M.L. Daneel, *Zionism and Faith-Healing in Rhodesia: Aspects of African Independent Churches*. Afrika-Studiecentrum: The Hague, 1970. Paul Makhubu, *Who are the Independent Churches?* Skotaville Publishers: Braamfontein, 1988. N. H Ngada and K. E. Mofokeng, *African Christian Witness: African Indigenous Churches*, Cluster Publications: Pietermaritzburg, 2002.

1955 as responsible for the separation from the mainline Churches.[43] It is important for the thesis that we understand the distinct character of the AICs, especially the Zionist-type as having the Spirit at the centre of their existence.

The categories of AICs are shifting and the fact that many overlaps, is observable in the categorizations noted by Pretorius and Jafta:

> The AICs are highly diverse, and have been categorized according to a variety of typologies. Some major ones have been summarized as 'bridges to African culture', or as 'revolts against colonialist oppression', or as 'searches for supernatural power', above all physical healing. Typologies range from Sundkler's Ethiopian-Zionist-Messianic distinction to Makhubu's more recent evaluation. Such typologies should be regarded as archetypal categories, for they can scarcely deal fairly with changing historical factors in a complex context. Ethiopian and Zionist churches, for example, each have distinctive social origins and goals and arise from dissimilar historical backgrounds.[44]

The description of some AICs as Spirit Churches is problematic, as it advances the idea that such Churches are more spirit-oriented than others. This category is too inclusive and thereby of no help in understanding AICs. If Spirit Churches are those that emphasize the presence of the Holy Spirit in their form of worship, then these churches are found in the mission Churches as well as in the AICs. If spirit Churches are those that are identified by the speaking-in-tongues during worship, then Zionist and Pentecostals are included in the category. In his famous book on the AICs, Bengt Sundkler showed that the category of Spirit Churches is broad:

> Pentecostal Churches, whether they are led by Europeans or Africans, are definite on the gift of speaking with tongues: "The baptism of believers in the Holy Host is indicated by the initial physical sign of speaking with other tongues, as the Spirit of God gives them utterance." At a Zionist meeting which I attended recently the congregation had just commenced a hymn, when one of the women

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[43] Paul Makhubu, *Who are the Independent Churches?* Skotaville Publishers: Braamfontein, 1988, pp.20-38. N.H Ngada and K.E. Mofokeng, *African Christian Witness: African Indigenous Churches*, Cluster Publications: Pietermaritzburg, 2002, pp.1– 9, also give brief history of how black people separated themselves from the mainline churches to form their own churches.

[44] Pretorius, H. and Jafta, L. '"A Branch Springs Out": African Initiated Churches', in R. Elphick and R. Davenport (eds.) *Christianity in South Africa.* David Philip: Cape Town, 1997, p.212.

> suddenly started convulsive movements of the body and gesticulated with her arms in an up-and-down movement.[45]

In healing the sick, the central practice of the AICs is to use prayer and the laying-on of hands on the afflicted. As we shall see below, there are many other things used by the AICs during the ritual of healing.

2.1.3.1. The Ethiopian-Type AICs Approach to Illness

Historically, the Ethiopian-type AICs were the first to break away from the mission Churches.[46] They have delinked themselves from the mission Churches mainly for nationalistic reasons.[47] Otherwise the characteristics of the mission churches from which these AICs have seceded are still present in the leadership structures and liturgy. For the Ethiopians there are no special manifestations of the spirit as the prayers for the sick will not receive a central position in the liturgy as they do in the Zionist-type Churches as we shall see later. Makhubu observed that some of the Ethiopian-type AICs practice faith-healing and use the elements used by Zionists and Apostolics in effecting healing.[48] Among these Churches is the Bapedi Lutheran Church led by Johannes Dinkwanyane which seceded from the Berlin Mission Society (BMS) during the time of its missionary Hans Merensky in Sekhukhuneland in the Transvaal.

2.1.3.2. The Zionist-Type AICs Approach to Illness

While Anderson did not clearly distinguish between the Zionists and the Apostolics, Makhubu noted that these two types of Churches have different types of uniforms,

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[45] Bengt Sundkler, *Bantu Prophets in South Africa*. James Clarke & Co.: Cambridge, 1948, pp.247-248.
[46] Erhard Kamphausen, "Unknown Heroes: The Founding Fathers of the Ethiopian Movement in South Africa" in Philippe Denis' (ed.) *The Making of Indigenous Clergy in Southern Africa*. Cluster Publications: Pietermaritzburg, 1995, pp.84-91.
[47] Paul Makhubu, *Who are the Independent Churches?* Skotaville Publishers: Braamfontein, 1988, p.5.
[48] Makhubu, *Who are the Independent Churches?* Skotaville Publishers: Braamfontein, 1988, p.6.

ways of worship, and service.[49] Having combined their African Traditional Religions and Christianity, what do Zionists believe is the cause of illness? According to James Kiernan who extensively studied the Zulu Zionists in the Durban area:

> Zulu Zionists believe that illness, misfortune and premature death are due to the intervention of mystical agencies, commonly called spirits or angels; (umoya yesifo) spirit of disease and (umoya yokufa) spirits of death. The term used for angel (isithunywa) is ambiguous, since it literally means "messenger." The ambiguity arises in that "messenger" is capable of either a Christian interpretation (i.e. angel) or more traditional one (that of "ancestor" or deceased parent). Although belief in ancestors has been greatly attenuated, their influence still lingers on.[50]

"They are like children and we must treat them as such and bring them up with great patience."[51] Those were the words of Missionary Pfitzinger who regarded the converted Batswana Lutherans as children and "crazy"[52] because some of them were joining the Zionist churches in the area. He regarded the Zionist activities as heathen (*Heidnischen* in German) and inclined to promoting polygamy (*Vielweiberei*). He also wrote that they were using salt to heal mainly those who were hysterical. One of his successors, von Scharrel, in his 1961 Annual Report also regarded Zionism as in opposition to the work of the HMS in the area.[53]

Just as Western medicine developed within a particular cultural milieu and proved to take time to be accepted by black people in southern Africa, spiritual healing became a force to reckon with as it competed with mission Churches for converts and growth. Let us consider how Zionists conceived health problems and how they tried to find solutions within their worldviews and changing circumstances. Hennie Pretorius and

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[49] Makhubu, *Who are the Independent Churches?* Skotaville Publishers: Braamfontein, 1988, pp.12-13.
[50] James Kiernan, *The Production and Management of Therapeutic Power in Zionist Churches within a Zulu City*. The Edwin Mellen Press: Lewiston, 1990, p.94.
[51] 1945 Annual Report from by Missionary Heinrich Pfitzinger to the HMS office in Germany, dated January 1946. That document written in German is found in HMS archives in Hermannsburg, Germany in Folder A: SA 42 – 339, 1935 - 1969. *"So wie sie jetzt sind, sind sie Kinder, und wir muessen sie auch also solche behandeln und mit grosser Geduld erziehen."*
[52] … *nicht vichtig sind im Kopf* = they are not good in their minds.
[53] Annual Report to HMS office in Hermannsburg, Germany, dated 13/01/1962. That document written in German is found in HMS archives in Hermannsburg, Germany in Folder A: SA 42 – 339, 1935 - 1969.

Lizo Jafta provided a description of the Zionist worldview from which healing is conceived and practiced:

> The healing ministry is conducted within the traditional African view of the world as permeated by both good and bad spirits. The *iminyama* (bad spirits) are believed to attack innocent individuals constantly. Faith healers counter-attack these bad spirits through prayer and *iziwasho* (potions mixed with ashes).[54] To further clarify this point Pretorius and Jafta state that it is believed the source of *iminyama* is pollution of the air by evil spirits.[55]

Although not exactly in the same manner as a *sangoma* and a *sedupe*, a faith healer also determines the causes of affliction by "smelling-out" or as faith healers themselves say, by 'propheting'. We discuss Spiritual and faith healing concepts under this subheading because the patients in mission hospitals are taken home for visits only to be taken to another type of health provider. Faith healers would visit mission hospitals in order to provide to their patients some potions generically called *iziwasho,* which they knew the mission hospitals could not prescribe.

Spiritual healing should be understood as a kind of healing whose *modus operandi* involves faith on the side of both health provider and of the health seeker. There are cases when the afflicted health seekers are too ill to express their faith in the healing process. What it means therefore is that Spiritual healing therefore is faith healing in which someone's belief plays an important role in health restoration. Spiritual healing in the AICs was a convenient development, which can be seen as a way of having a clear separation from the domination of missionaries and mission Churches which denied African ways of health restoration.

There have been many categorizations of the independent Churches in southern Africa. In recognition of the difficulty of a clear-cut categorization of the AICs, Anderson wrote, "Much discussion over terminology seems to show that almost any term used will cause some controversy."[56] The recognition of distinctions also calls

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[54] Hennie Pretorius, and Lizo Jafta, '"A Branch Springs Out": African Initiated Churches', in R. Elphick and R. Davenport (eds.) *Christianity in South Africa.* David Philip: Cape Town, 1997, p.223.
[55] Ibid. p.224.
[56] Allan Anderson, *Zion and Pentecost; The Spirituality and Experience of Pentecostal and Zionist/Apostolic Churches in South Africa*. University of South Africa Press: Pretoria, 2000, p.24.

for the acknowledgement of commonalities. A common feature of the AICs is a concern for the health of their general membership. This concern was observed as early as 1944 by the Lutheran missionary, Pfitzinger, in Botswana when he reported that a "sect" called *BaSione* (those of Zion) had sprung up in Gabane[57] with a "green piece of cloth on the lapel" (*gruenes Laepchen im Knopfloch*) which could only be the ZCC with its unmistakable character.

In southern Africa, the practitioners of spiritual healing, i.e., the Zionist churches, were preceded by mainline Churches. Writing from a Setswana perspective Staugård noted the overlap between traditional and faith healing:

> The independent churches are to some extent alienated from Tswana culture and represent an intermediary stage between the indigenous culture and European (colonial) concepts. The methods for treatment of disease applied by the Faith Healer are different from the methods used by Dingaka. Faith Healers are not primarily health workers, although healing dominates their activity. Rather they might be considered religious workers, who utilize their presumed healing potential in promulgating their faith.[58]

The relationship between the African and Zionist approaches to health and illness were also noted by Hennie Pretorius and Lizo Jafta:

> There seemed to be an intrinsic affinity between traditional African conceptions and Pentecostal religiosity, particularly in the Zionist emphasis on healing through the power of faith and the indwelling spirit, which resonated with the traditional belief that witches, sorcerers, and the spirits of the ancestors caused illness. Yet Sundkler concluded that the beginnings of black Zion were not as exclusively "African as one might presume or would like to believe.[59]

Unlike the Zulus and Batswana of the Nguni-Sotho grouping, the Zionists do not have any tribal distinction. They are a plethora of tiny independent Churches with a few large ones like the Zion Christian Church of Moria near Pietersburg (now

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[57] Gabane was one of the outstations of the Ramotswa mission station of the HMS. 1944 two page report dated January 1945 found in HMS archives in Hermannsburg, Germany in Folder A: SA 42-339, 1935-1969.
[58] Frants Staugård. *Traditional Healers*. Ipelegeng Publishers: Gaborone, 1985, p.60.
[59] Hennie Pretorius and Lizo Jafta's "A Branch springs out": African Initiated Churches; in R. Elphick, and R. Davenport, (eds.), *Christianity in South Africa.* 1997, p.217.

Polokwane), and the St. John's Apostolic Faith Mission Church of Katlehong near Johannesburg. All these Churches collectively form part of the African Initiated Churches (AICs). They have a strong leaning towards African Traditional Religions (ATRs), as we shall see later in this sub-section.

Before looking at the conceptions of illness and healing of the Zionists during the period under review, we shall take a brief view of the origins of Zionist movement and at the place of healing in that early history.

John Alexander Dowie founded the Christian Church in Zion, with its headquarters near Chicago, USA in 1874.[60] Dowie's representative came from the US and baptized converts in Wakkerstroom, South Africa in 1904. Zionists commonly taught:

> Threefold baptism by immersion; the belief in divine healing and rejection of medicine and doctors; taboos against alcohol, pork and tobacco; the wearing of white robes and green and blue coloured cloaks, cords and turbans; holy sticks; Sabbath observance; holy dances; purification rites and various degrees of accommodation with traditional African customs.[61]

Let us now look at the early Zionists' conception of illness and how they administer "divine healing", apart from the influence of Western doctors and medicine. As the sub-title above suggests, the healing referred to as spiritual, is meant to exclude the use of physical medicine. This section will help us to understand why, later, the Zionists objected to the presence of mission hospitals. A number of good scholars emerged with excellent studies on the Zionists: among them Bengt Sundkler, Martin West, and recently Stuart Bate, top the list. I want to look at what Bate wrote because he approached the whole subject of healing from an angle rarely dealt with in connection with AICs and healing. Bate called the churches that emphasize a healing ministry, "coping-healing Churches."[62] Their healing services are defined as "a community exercise which attempts to move a group of people through a series of transformations which is then experienced as 'healing'."[63]

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[60] Kevin Roy's "Zion in Africa" in *Today Magazine*. May 2000, p.28.
[61] *Today Magazine*. May 2000, p.30.
[62] Stuart Bate, *Inculturation and Healing.* Cluster Publications: Pietermaritzburg, 1995, p.28.
[63] Ibid. p.42.

Another interesting aspect of coping-healing Churches is the presence in some of them of *isigodlo,* a hospital-like set up at the home of a prophet-healer.[64] Patients come with a variety of illnesses like, "epilepsy, mental confusion, anaemia, a bruised or sprained leg, alcoholism."[65] The healing process with hospitalized patients is characterized by induced vomiting in the morning, drinking blessed water, washing at the river and prayer by laying-on of hands. Other forms in coping-healing Churches are counselling and prayer.[66]

Bengt Sundkler[67] has devoted space in his famous book *Bantu Prophets in South Africa* to illness and healing among Zionists. Sin is regarded as a source of illness by Zionists. Sundkler further states that (like the Nguni-Sotho traditionalists) the ancestors and *ubuthakathi* (witchcraft) are often regarded as sources of disease. Martin West made the same observation in his book *Bishops and Prophets in a Black City.*[68] He mentioned a prophet-healer who identified the following sources of illness: sin, the devil directing demons, witches and sorcerers. Sorcerers are said to employ the power of the Devil to cause harm. The Zulus and the Tswanas do not regard harm as coming from the Devil. This source of harm is one of the few beliefs that Zionists did not import from traditional religion into Zionism. It is a Biblical teaching that Satan caused Job to suffer a variety of diseases and mishaps.

In a section on the making of a faith healer or prophet (*moprofiti* in Setswana), Staugård described in this way the Botswana situation which is not dissimilar to that in South Africa:

> Moprofiti—the Faith Healer—is distinctly different from the other traditional healers. For various reasons discussed later on in this chapter, he is, however, still considered a true, traditional healer. The Faith Healer is a leader of one of the independent churches in Botswana. In order to rise to leadership in an independent church a candidate must above all be able to heal. In most cases the Faith

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[64] Martin West uses this term because he argues that according to his observations prophets and healers are not different.
[65] Bate, *Inculturation and Healing.* Cluster Publications: Pietermaritzburg, 1995, p.46.
[66] Ibid. p.48.
[67] Sundkler like others was more a Christian missionary rather than an anthropologist. This does not mean that their contribution in anthropology in general and healing in particular is less significant.
[68] Martin West, *Bishops and Prophets in a Black City.* David Philip: Cape Town, 1975, p.100.

> Healer will claim that through a revelation in a dream he has been chosen by God to perform healing. A substantial number of Faith Healers have a close relationship to another Faith Healer. As a Faith Healer is chosen by God and given his power to diagnose and treat diseases, he considers questions on formal training irrelevant.[69]

Prophets and faith healers do not use traditional medicine or Western medicine but water, ashes, sashes and items of western origin like petroleum jelly and Epsom salts which are common prescriptions over and above prayer to God. Prophets and the faith-healers are in agreement with the African traditional healers as to the causes and sources of disease. With regard to power and control by healers, we shall look at the Zionist traditional concepts in the Zion Christian Church (ZCC), the St John's Apostolic Faith Mission church and the Nazareth Baptist Church. Zionist traditional health systems regard impurity and demons as the cause and source of illnesses. In the ZCC there is a strong belief in the danger of pollution and impurity (*go tshilafala* in Sotho). Every worship service or gathering in the ZCC commences with the purification of the faithful and even non-members.[70] This concern for pollution and ritual cleanliness goes beyond the ZCC's circles into other AICs of a Zionist-type, as Ashforth noted with regard to prophet-healers:

> Most of the healing procedures that are today spoken of as 'traditional' whether self-administered or directed by a professional healer such as an *inyanga*, involve, among other things, one or another of these, purification methods in order to remove harmful pollutants and invisible agents from the body.[71]

In Zionist churches, water is used to cleanse people of pollution as well as tools and dwelling places that have been contaminated with evil or impurity. Blessed water has many uses for ritual cleanliness, protecting against sorcery and witchcraft, and obtaining good fortune like employment, and abundant harvests.[72] Similarly, ZCC and St. John's Apostolic Faith Mission Church members live in constant fear of ritual impurity, contamination from bad spirits and sorcery. Linda Thomas found in her

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[69] Frants Staugård . *Traditional Healers*. Ipelegeng Publishers: Gaborone, 1985, p.54.
[70] Adam Ashforth, *Madumu: A Man Bewitched*. David Philip Publishers: Cape Town, 2000, p.145.
[71] Adam Ashforth, *Witchcraft, Violence and Democracy in South Africa*. University of South Africa: Pretoria, 2005, p.158.
[72] Allan Anderson, *Bazalwane: African Pentecostals in South Africa*. University of South Africa: Pretoria, 1992, p.104.

research on the St. John's Apostolic Faith Mission church in Guguletu near Cape Town that water was prescribed for cleansing in the healing processes. She described the healing process of the country-wide Church thus:

> The healing process at the St. John's embodied a tapestry of converging signs, symbols, speech, and actions that called on the sick to build upon the faith, belief, and life-changing experiences of members who believed themselves to have been restored, in order that the ailing might be healed. The mysterious power of community charisma flowed through the priest-healer, whose culture and history secured a lively past, including a cult of the ancestors who influenced the present. The power of the priest-healer, the gathered community, and the ancestors together manifested a holy alliance of African and Christian symbology. The signs and symbols and faith and action of St. John's adherents brought into existence a liberating pattern of healing and transformation.[73]

When dealing with healing among the Zionists, Sundkler observed during a service of the Shembe Nazarite Church[74] in Ekuphakameni, KwaZulu-Natal headquarters, that an invitation that was made to adherents to reject the use of Western medicine. "Do not waste your money on medicines. Come here and you will be healed for nothing."[75] Indicating that no connection exists between Zionists and medicine, Sundkler further wrote, "The aversion of the Zionist prophet for anything connected with *umuthi* is reflected in his reaction to *ukuphothula* (completion of training) rites, which he regards as demonic." Sundkler concluded his observations on the Zionists' aversion to biomedicine with the idea that since a traditional herbalist has power to induce hysterical possession by manipulating medicines, "Zionists draw the conclusion that medicine is not a cure of disease, but the cause of demoniacal possession."[76]

For healing to take place, sin, especially of a sexual nature, has to be confessed.[77] Apart from the confession of sin as a prerequisite for healing, items of Western origin like soap, Epsom salts, petroleum jelly, castor oil, and cords made of wool, are used

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[73] Linda Thomas, *Under the Canopy: Rituals Process and Spiritual Resilience in South Africa*. University of South Carolina: Columbia, 1999, p.59.
[74]Both Sundkler and Roy regard this church as of Zionist nature. pp.49 and p.32 respectively.
[75] Bengt Sundkler, *"Bantu Prophets in South Africa."* James Clarke & Co.: Cambridge, 1961. p.187.
[76] Ibid. p.226.
[77] Ibid. p.211.

by Zionists as purgatives for the patient. In a consultation between patient and prophet-healer the treatment is similar to the one given by West: "She prays for them, administers holy water, prescribes protective cords of colours to be tied round parts of the body and uses a variety of other substances."[78] Substances used are those mentioned above which are of Western origin and do not posses inherent healing qualities in them. It may then be enquired how Zionists provide healing. Stuart Bate addresses this question in his book *Inculturation and Healing.*

Bate concludes by saying that the healers involved in the coping-healing ministry insist that what they do is healing. Among his respondents, some were healed but others deteriorated. The latter left disillusioned because of the expectation created by the healers.

2.1.4. The Pentecostal Approach to Illness

The Pentecostal churches derived their name from the Biblical Pentecost, where the spirit-filled disciples of Jesus spoke in tongues and later healed the sick. Although the Pentecostal churches fall under the AICs, they are different from the Zionists in that they do not relate their restoration of health to the intervention of the ancestors. The Pentecostals mostly avoid the use of physical items in their attempts at the restoration of health and emphasize prayer and the laying-on of hands. Anderson described their rituals thus:

> In Pentecostal churches, healing by the use of symbolic objects is not usually found. Healing entailing laying on of hands with prayer for the sick, however, usually takes place every Sunday. All African Pentecostals at their beginning used to be opposed to the use of medical doctors and their medicine. This position has significantly changed today, so that people are free to consult medical practitioners when necessary. Especially when obvious physical disorders were encountered. One Pentecostal member felt that 'everyday complaints'

[78] Martin West, *Bishops and Prophets in a Black City.* David Philip: Cape Town, 1975, p.100. Stuart Bate gave more descriptions of observed and recorded healing services in his 1995 book, *Inculturation and Healing*.

> like coughs, headaches and stomach aches, the remedy was to pray for oneself or request the church leaders to pray by laying on hands.[79]

The Pentecostals have adopted the "prayer and laying-on of hands" as the best way to approach healing. They believe that diseases are caused by demons as in the time of Jesus. In preparation for the healing of a sick person or the exorcising of a demon, Pentecostals spend time in prayer and fasting. This category of Pentecostal churches includes the Assemblies of God, with its origins in the USA, the International Assemblies of God which was established by Nicolas Bhengu in South Africa, the Full Gospel Church of God, and the Apostolic Faith Mission, also with its origins in America.

Anderson describes a new breed of Pentecostal churches which has emerged in urban centres with a strong affinity to Western Pentecostalism:

> Today, there are a number of independent churches in Africa which have no 'mission church' connection, but which may be regarded as Pentecostal or Spirit-type churches in the true sense of the word. These churches generally tend to be closer to Western Pentecostal churches than to the 'Zionist-type' churches; nevertheless, the term Spirit-type is appropriate to them.[80]

Healing depends largely on the faith of the ill person. The positive result is often expected to happen instantaneously and miraculously. If the expected and often-promised results of recovery do not manifest themselves, the patient's faith is questioned as the Spirit does not respond to the prayers positively.

2.2. Western Approaches to Illness

Western medicine claims to be scientific, but as we shall see here, this affirmation needs to be qualified. Western medicine has developed through the ages to reach a

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[79] Allan Anderson, *Zion and Pentecost: The Spirituality and Experience of Pentecostal and Zionist/Apostolic Churches in South Africa*. University of South Africa Press: Pretoria, 2000, pp.291-292.

[80] Allan Anderson, *Moya: The Holy Spirit in an African Context.* University of South Africa: Pretoria, 1991, p.3.

stage where it came into contact with African indigenous health seekers. In his chapter *The Rise of Medicine*, Vivian Nutton has traced the history of the development of Western medicine from the pre-Christian era, through to the Dark Ages, to what he called the Development of University Medicine to the twentieth century. He concluded that at that time of its development:

> [Medieval medicine] was, in fact, capable of responding effectively to the challenge of disease within its own terms, and by invoking communal and religious responses, by involving caring and curing, it may have done as much as was possible until the therapeutic revolution of the nineteenth and twentieth centuries to maintain health.[81]

Biomedicine as we know it today and as it was practiced in the mission hospitals in southern Africa in the 1930s had evolved through centuries. Discussing the evolution of Western medicine from Antiquity to our time, Jansen concluded:

> Western medicine is the fruit of a centuries-long process of acculturation. Several civilizations around the Mediterranean Sea – Hellenistic, Arabic, Jewish, Christian, Syrian – influenced each other in the realm of medicine. The Renaissance in the European history became the dawn of modern science and medicine was integral to the scientific revolution. The breakaway of the medical tradition in the Middle Ages, when Galenic medicine was still the dominant doctrine , caused a new development, which meant that Western medicine drifted further from other healing systems that held moral theories, as in Mexico, the Arab world and South East Asia. Finally, in this century, Western medicine has grown into a cosmopolitan medicine, integrated into the prevailing world system.[82]

Many civilizations contributed to the shaping of what is known as Western medicine. In a subsection titled, "The roots of the Western medical tradition" Jansen describes how the Greeks, the Christian tradition, Arab-Islamic medicine, the Renaissance, the European Enlightenment and Postmodernism contributed to giving in Western medicine a scientific rather than a spiritual approach.[83] This health system is called scientific because its doctrine, which it followed from the Hippocratic School of the

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[81] Vivian Nutton, "The Rise of Medicine" in Roy Porter (ed.) *The Cambridge History of Medicine* (ed.), Cambridge University Press: Cambridge, 2006, p.70.

[82] Gerard Jansen, "Western Medicine-Secularized and Secularizing: A Medical Missiological Problem." In *Missionalia.* Volume 25, Number 3. November 1997, pp. 344-359.

[83] Gerard Jansen, "Western Medicine-Secularized and Secularizing: A Medical Missiological Problem." In *Missionalia.* Volume 25, Number 3. November 1997, pp. 344-359.

Greeks, presumes that bodily processes, health, and disease can be explained in the same way as other natural phenomena, and are independent of any arbitrary, supernatural interference.[84]

In southern Africa, biomedicine in its early stage of development was introduced by the traders and colonists of the Dutch East India Company, who frequented and later settled at the Cape of Good Hope. In their book *South Africa: Its Medical History 1652-1898*, Percy Laidler and Michael Gelfand traced the history of biomedicine from the formal arrival of the colonists to the Cape. The governor of the Cape, Jan van Riebeeck, himself a junior medical practitioner, was responsible for the health needs of his community from 1652.[85]

Biomedicine gradually developed through discoveries and experimentation. In southern Africa it was first developed to provide restoration of health to European settlers but later it was used to heal indigenous people as well.

London Missionary Society personnel like John Philip and David Livingstone were among those early Europeans who introduced biomedicine in southern Africa. Dr. John Philip was confined to the Cape Colony while Dr. David Livingstone went from the Northern Cape to the then-Bechuanaland in the late 1880s. Livingstone practised his medical profession more than John Philip. In 1856, George Grey invited Dr. Patrick Fitzgerald from New Zealand to begin a hospital in King Williams Town.[86] In Natal, Grey established a hospital that was completed in 1862 and named after him.[87] He began a project that was aimed at providing biomedicine to the black people of the colony, as far as Natal in 1862. Since his agenda was the conquest and subjugation of the indigenous people, he used biomedicine as a tool to maintain hegemony. For his project of conquest, George Grey took advantage of the mission societies that provided health care to the black people and he subsidised their efforts.

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[84] Gerard Jansen, "Western Medicine-Secularized and Secularizing: A Medical Missiological Problem." In *Missionalia.* Volume 25, Number 3. November 1997, pp. 344-359.
[85] Percy Laidler and Michael Gelfand, *South Africa: Its Medical History 1652-1898*. C.Struik (PTY) LTD: Cape Town, 1977, p.4-9.
[86] Percy Laidler and Michael Gelfand, *South Africa: Its Medical History 1652-1898*. C.Struik (PTY) LTD: Cape Town, 1977, p.296.
[87] Shula Marks, *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession*. Witwatersrand University Press: Johannesburg, 1994, p.17.

During the time of Sir George Grey's governance of the Cape Colony, the missionaries saw fit to use medicine to alleviate the afflictions of the nations that they regarded as still living in darkness.[88] Having provided medical help where opportunities arose, the untrained missionaries became reluctant to continue doing so when biomedicine was professionalized in Europe at the end of the 1800s.[89]

Health and healing concepts are constructed within a cultural milieu. Let us therefore consider the cultural connections between biomedical concepts and Western culture. Culture is practiced within the framework of one or several worldviews. The Europe of the nineteenth century saw an advance in science which was used to improve the lives of people through biomedicine.

It is important to see the state of biomedicine when it was introduced to southern Africa by missionaries through their dispensaries. Although he displayed some form of racism in his relationship to Black priests in the 1890s,[90] Alfred Thomas Bryant, a Catholic missionary and Zulu ethnographer, had respect for indigenous Zulu medicine. Bryant argued in his book *Zulu Medicine and Medicine-Men* (posthumously published in1960): "It is by no means an exaggeration to affirm that comparatively the average Zulu can boast of a larger share of pure scientific knowledge than an average European."[91] John and Jean Comaroff concur with Bryant that European biomedicine was not superior to Tswana medicine at the time of the encounter of the two cultural health concepts:

> In the early nineteenth century, British medicine was rudimentary, unsystematic, often unsure of itself; perhaps no more developed, and maybe less coherent than the Tswana counterpart. Hence the respect with which David Livingstone—and Henry Callaway, medical missionary among the Nguni […]—listened to local specialists, the attention he paid to their techniques, his hope to learn cures that had eluded British physicians.[92]

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[88] John and Jean Comaroff, *Of Revelation and Revolution: The dialectics of modernity on a South African frontier.* Volume Two. The University of Chicago Press: Chicago, 1997, p.324.
[89] Ibid. pp.325-326.
[90] George Mukuka, *The other side of the story*. Cluster Publications: Pietermaritzburg, 2008, pp.50-55.
[91] A.T. Bryant. *Zulu Medicine and Medicine-Men.* C.Struik: Cape Town, 1966.p.7.
[92] John and Jean Comaroff. *Of Revelation and Revolution*. *The Dialectics of Modernity on a South African Frontier*. Volume Two. The University of Chicago Press: Chicago, 1997, p.328.

In her book, *Curing their Ills*, Megan Vaughan notes that medical science in the West was influenced by the behaviour of the society to whom it was introduced. Without the observations and the co-operation of the said society, medical science would undoubtedly have developed in a different direction altogether. What Vaughan shows is that biomedicine was not a finalized product with working components like a watch that continues to work long after it has left the watchmaker's factory. For biomedicine to work, it needs to be reshaped to be relevant to its new social contexts. Vaughan observed:

> Biomedicine drew for its authority both on science and on social science. Biomedical knowledge on Africa was thus both itself socially constructed (in the sense that its concerns and its ways of viewing its object of study were born of particular historical circumstances and particular social forces) and at the same time 'social constructionist,' in that it often sought social explanations for 'natural' phenomena.[93]

As if to correct her initial critique of Western medicine, Vaughan asserts that Western medicine is indeed scientific: "It is not its scientific method so much as the particular forms of social construction used within this method which makes biomedicine different from other healing systems."[94]

As all Africans do, the Nguni-Sotho would take physical diseases and mental diseases to one and the same healer. In his *Origins of Mental Illness,* Gordon Claridge, in an attempt to show the difference between mental and physical illnesses argues that with physical medicine "the abnormalities of function are relatively localized: the patient complains of pain in the abdomen or displays tenderness or swelling in some part of the anatomy, signs which allow the possibility of disease to be recognized and understood without reference to the whole behaviour of the individual."[95]

This research aims only to look briefly at the conception of disease and healing when Lutheran medical missions were being established in southern Africa. To a large extent the herbalists and traditional healers of Europe in earlier times were not

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[93] Megan Vaughan, *Curing their Ills: Colonial Power and African Illness*. Stanford University Press: Standford, 1991, p.6.
[94] Megan Vaughan, *Curing their Ills: Colonial Power and African Illness*. Stanford University Press: Standford, 1991, pp.6-7.
[95] Gordon Claridge, *Origins of Mental Illness.* Basil Blackwell: Oxford, 1985, p.6.

dissimilar to the southern African Nguni-Sotho, as the manual called *Anglo-Saxon Herbal* of the tenth to the eleventh century shows:

> In case of a man's hair fallout, take juice of the wort which one names nasturtium and by another name cree, put it on the nose, the hair shall grow. … Against warts (boils), take this wort and yeast; pound together, lay on it; they will soon be taken away.[96]

This study will show the differences in the conception of health between Europeans on the one hand, and the Nguni-Sothos and the Zionists, on the other hand. It will help to assess the value of introducing Western forms of healing among the potential converts. It should be borne in mind that the Lutheran missions came to southern Africa in the nineteenth century and established hospitals in the early twentieth century.

The stethoscope was invented in the 1830s because "it was discovered that listening to the sounds of a persons inner organs—especially the lungs—could help in diagnosis."[97] Around the time of the establishment of mission hospitals in southern Africa, Sir Alexander Flemming of London discovered penicillin which "is practically non-toxic to human beings (except for allergies), but capable of killing a large number of disease-producing organisms."[98] Malaria was a killer disease in southern Africa and elsewhere in the late nineteenth century when the missionary societies were sending missionaries to southern Africa. Already at that time, quinine, an effective anti-malaria drug was available in Europe. In the light of the above information, one can conclude that when the Lutheran mission societies embarked on the establishment of hospitals, the world of Western medicine had made major progress in the diagnoses and treatment of illnesses.

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[96] S. Rubin, *Medieval English Medicine.* David and Charles Ltd: Newtown, 1974, p.49.
[97] Ibid. p.74.
[98] J. A. C. Brown, *Pears Medical Encyclopedia*. Pelham Books Limited: London, 1963, p.346. James Le Fanu, the author of three books and a London newspaper columnist in the area of medicine has devoted the introductory part of his book, *The Rise and Fall of Modern Medicine* to the twelve definitive moments in the development of biomedicine. Although Le Fanu only begins with penicillin in 1941, he gives a helpful historical background to the development of biomedicine as a health system on scientific experimentations and observations. See James Le Fanu, *The Rise and Fall of Modern Medicine.* Little, Brown and Company (UK): London, 1999, pp.5-186.

It needs to be noted though that at the time of such progress in Western modern medicine, there were only a few physicians to go around. Medicine was at the testing stage and western world thought-patterns were to prove very different to those held by potential converts and users of new medicine in the southern African cultural setting. Later, it developed into a highly technological and scientific field which had subsequently closed its doors to the untrained.[99] The mission societies went ahead and introduced their western medical concepts among their potential converts and actual converts at a very early stage. They harboured the conviction that their medicine was superior to the indigenous one or it was covering the gaps left by the indigenous one. The western conceptions of health restoration, unlike the African indigenous ones, were scientific and did not require supernatural intervention in order to effect healing. When used in the medical missionary work, God's power was invoked to effect healing as we shall see later in Chapter Five, under the subheading that deals with chaplaincy.

Hegemonic power based on the resources and knowledge possessed by biomedical practitioners like medical missionaries was embedded in the approach taken to provide health to the indigenous people. As it developed, biomedicine became sophisticated and it was represented by powerful outward symbols like massive buildings and staff uniforms. During its contact with Nguni-Sothos, it portrayed itself as a superior and therefore powerful health system that restored health in ways different from the traditional ones. The hospital buildings, especially those erected in rural areas, and the instruments used in them, looked sophisticated and represented power to those unfamiliar with them. The immaculate uniforms of both doctors and nurses added to the foreignness and thereby powerful demeanour of Western biomedicine.

We have seen that the black people innovatively used African traditional health systems in combination with western scientific methods and faith. They did probably, not see why they should waste anything by discarding one approach if they could

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[99] John and Jean Comaroff, *Of Revelation and Revolution: The Dialectics of Modernity on a South African Frontier*. Volume Two. The University of Chicago Press: Chicago, 1997, p.328.

benefit from a combination of both. This makes sense where one is in need of restoration of health.

For the sake of the patients, some doctors worked, though in a limited way, with traditional health specialists like *inyangas*. A drama of subtle tension between the various health systems unfolded in the mission hospitals when White nurses and doctors struggled to wean patients from traditional and spiritual concepts of health while the Black nurses encouraged them to embrace all. Two mission doctors, Ulrich Schmidt of Ramotswa and Magdalene Schiele of Emmaus "tricked" *inyangas* into redirecting patients to the mission hospitals. Schmidt explained in an interview that he befriended a famous local *ngaka* in Ramotswa and collaborated with him. The deal was that the *ngaka* should send all TB patients to the mission hospital and he would send to the *ngaka* all patients whose affliction he could not diagnose. He trained the *ngaka* in the use of a stethoscope and gave it to him as a present. The *ngaka* was so good in the use of the device that invariably all patients he referred were TB infected.[100]

In an interview with a former matron of Emmaus mission hospital, Evelyn Sommerfeld, I learnt of an *inyanga* who had tried all he could to treat his cough:

> Dr. Schiele told me this story: the *inyanga* came to her saying "I have been using all my herbs but my cough is not getting better." So she took an X-ray photo and told him he had TB. So he was in the hospital and got cured and every time he had a patient who did not get well, he said, "Well, you better go to Dr. Schiele." And Doctor Schiele would say, 'Oh that is another patient of my colleague.[101]

The examples of co-operation between Western medicine and traditional medicine although few were based on paternalistic relationships. The dedication shown by the doctors was not for learning how traditional medicine worked but chiefly to help those patients who were going to be 'taken advantage of' by traditional healers.

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[100] Dr. Ulrich Schmidt interviewed by Radikobo Ntsimane at Faeri Glen, Pretoria, on 26 February 2002.
[101] Evelyn Sommerfeld interviewed by Radikobo Ntsimane at Walsrode, Germany, on 5 August 2002.

Although it was unusual among Western medical practitioners and missionaries in the nineteenth and twentieth centuries to see co-operation as useful, there were moves towards closer co-operation, though only on a small scale. Scholars, who probably have no obligation to church bodies for their scholarship, saw connections between the two health systems. Robin Horton, one such anthropology scholar thus explains the connection and disconnection:

> From what has been said in this section, it should be clear that one commonly accepted way of contrasting traditional religious thought with scientific thought is misleading. I am thinking here of the contrast between traditional thought as 'non-empirical' with scientific thought as 'empirical'. In the first place, the contrast is misleading because traditional religious thought is no more or less interested in the natural causes of things than is the theoretical thought of the sciences. Indeed, the intellectual function of its supernatural beings (as, too, that of atoms, waves, etc.) *is* the extension of people's vision of natural causes. In the second place, the contrast is misleading because traditional religion theory clearly does more than postulate causal connexions that bear no relation to experience. Some of the connections are, by the standards of modern medical science, almost certainly real ones. To some extent, then, it successfully grasps empirical reality.[102]

In no way can we say that this evidence is convincing, that White mission physicians acknowledged the wisdom and value in the Nguni-Sotho health-conceptions. However, there are a growing number of White people who are becoming *sangomas* today. For example, the author of a book used in this thesis, David M. Cumes, is a seasoned trained *sangoma* as well as a surgeon with Western medical training. Western medicine is regularized and under the control of governments and boards, while traditional- and faith healing systems are controlled by practitioners themselves. Although collaboration could be forged, the mission boards whose primary aim were to spread the Gospel - and to convert the users of the traditional health system - could not bless it. Traditional health care systems were highly influenced by ancestors and were derogatively regarded, as we have seen in the HMS Ramotswa Reports, as childish.

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[102] Robin Horton, *Patterns of Thought in Africa and the West*. David and Charles Ltd: Newton, 1993, p.206.

3. Chapter Summary

I have attempted to show how disease or illness is understood differently in different cultural milieus and how each of the cultures manipulates natural and supernatural realms to find healing. The lamentations of the Lutheran missionaries of the HMS show that they operated under the impression that black people could not make up their minds with regard to what mode of healing they would like to choose for themselves. Blacks in southern Africa had for centuries used African traditional health systems that operated on the belief that ancestors and sorcerers could cause diseases, and that *inyangas* and sangomas could restore health by means of prescribed rituals and herbal treatments. The White missionaries introduced to the Blacks of southern Africa, biomedicine—which is a scientific system—along with prayer for spiritual healing. African converts embraced biomedicine and use of it to varying degrees in conjunction with their traditional health systems. Other African converts who seceded from missionary churches established their own African Independent Churches (AICs). Since religion is inextricably linked to healing, the AICs (Ethiopian-type Churches, the Zionist Churches, and the Pentecostal Churches) developed their own spiritual forms of healing which did not totally exclude the used of biomedicine.

Although this chapter deals with conceptions of diseases, health restoration and power, it has left out of the discussion many health systems. The chapter has concentrated on those health systems which are directly related to the Christian Churches and the southern African region.

CHAPTER FOUR

ACCULTURATION AND CULTURAL ASSIMILATION

1. Introduction

In order to understand the power relations within the Lutheran mission hospitals and how racial discrimination came to prevail in the mission enterprise, we need to look at the encounter between colonists and missionaries on the one hand and the black people of southern Africa on the other. This chapter seeks to give a picture of the conditions that brought about the assimilation of Western cultures into indigenous African cultures. Since the next chapter will among others analyse power relations in four selected Lutheran mission hospitals, we need first to show how colonists and missionaries came to know the blacks of southern Africa.

It is clear that when the colonists and the missionaries came into contact with the Blacks they misunderstood them. They used stereotypes which had a negative influence on their interaction with Blacks. This interaction took the form of a master/slave relationship even where conversion was sought. This Chapter precedes the one on the establishment of the four mission hospitals which also intends to show that the nature of the encounter between Whites and Blacks determined how biomedicine was going to be received by Blacks. We shall attempt to show the stereotypes held by Whites about Blacks. In the late 1800s and in the early 1900s, Westerners and Africans experienced difficulties in understanding one another, as their worldviews and epistemological grounding were dissimilar. Furthermore and very importantly, we shall attempt to show how western medicine was introduced into southern Africa and how that introduction was initially faced with resistance but eventually accepted.

2. The Encounter between Western and Southern African Cultures

In seeking to understand the nature of the encounter between the Whites and the Blacks, we should bear in mind the fact that the Whites introduced biomedicine among the Blacks. Some of these were eager recipients of modern medicine and others not. The four mission hospitals were founded by White missionaries mainly for Black converts.

It is necessary to begin with the dominance of the Western culture and to explain it before attempting to explain how it encountered African cultures in southern Africa. I chose this sequence because the encounter was "initiated" by Western colonists and missionaries when they came to southern Africa. Although this chapter is concerned with the interaction of the two cultures in the early twentieth century, a brief reference to the earlier period i.e., the late nineteenth-century will help us understand the history of the establishment of the mission hospitals from the 1930s to the 1970s. It was the reports from earlier encounters of explorers, merchants and traders with black people that helped Westerners to form opinions of what black people were like and how to relate to them. Opinions about Africans were mainly negative. For example, Africans were seen to be savage, superstitious, perpetual children and inferior to white people.[1]

What the southern Tswana wanted from missionaries were skills that were not just potent and elusive but that appeared to be essential to humanity, namely: the ability to understand the rich contents of books, a facility for speaking persuasively, the competence to use firearms without inflicting self-injury, and the capacity to heal and to affect changes of heart. If these were attributes of bodies and beings, it followed that the medicines which condensed their essence had to be obtained. They had to be made part of the self.[2]

As the Comaroffs have observed, the Tswana realized that there was indeed power beyond the medicine itself. The bearer of that medicine possessed some qualities that

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[1] Jean Comaroff and John Comaroff, *Of Revelation and Revolution: Christianity, Colonialism, and Consciousness in South Africa*. Volume 1. University of Chicago Press: Chicago, 1991,pp.86-89.
[2] John & Jean Comaroff, *Of Revelation and Revolution: The Dialectics of Modernity on a South African Frontier.* Chicago University Press: Chicago, Vol.2. 1997, p. 347.

made the medicine potent enough to effect healing. I shall devote some space in the thesis to show that this was the case in the establishment and operation of the Lutheran medical missions in southern Africa.

The Lutheran missionaries gradually introduced Western medicine into southern Africa from the late nineteenth century. When the government of South Africa nationalized health institutions, the Lutheran medical missions had developed sophisticated clinics and hospitals in the mid 1970s. None of the more than twenty mission hospitals or clinics was handed over to the leadership of the national churches in the 1960s. We shall look at the contribution of the indigenous people in the development of those mission health institutions.

This thesis appreciates the contribution made by Lutheran mission societies and their medical missionaries in the form of nurses, doctors, technical and administrative staff. An impression has been created, especially by Eurocentric historians that the success of the medical missions until the 1970s was solely due to the efforts of missionaries from outside southern Africa. That thinking is influenced by the theory of Eurocentric Diffusionism,[3] in which Europeans are shown as developers and others as recipients of that development.

This thesis will show that indigenous people contributed immensely to the establishment and the successful functioning of the Lutheran medical missions until they were nationalized. That contribution is termed human agency. Indigenous people contributed as providers of land, builders, cleaners, interpreters, auxiliary nurses, nurses, chaplains, etc. These services were rendered when the medical facilities were established and later when they were up and running.

Since this thesis seeks to show the agency of indigenous people in the establishment and functioning of medical missions, a brief discussion of this agency will be in order. According to John and Jean Comaroff, "Human agency is practice invested with

[3] For an in-depth discussion of this theory see George Sombe Mukuka's The Other Side of the Story: The Silent Experiences of the Black Clergy in the Catholic Church in South Africa (1898-1976). Cluster Publications: Pietermaritzburg, 2008, pp.13-14. Mukuka uses James Blaut's theory found in the book, "*The Colonizer's Model of the World: Geographical Diffusionism and Eurocentric History.* The Gilford Press: New York, 1995.

subjectivity, meaning and to a greater or lesser extent power. It is, in short, motivated."[4] In light of the Comaroffs' definition, we shall show in the thesis that indigenous people were indispensable in the work of medical missions in southern Africa.

The quest to control and convert indigenous people drove colonizers and missionaries to exercise hegemony over indigenous people. During the encounter between Western colonizers and the missionaries on the one hand, and indigenous peoples on the other, a process of negotiation was inevitable. To a large degree missionaries in the late 1880s and early 1990s did not exactly know the culture of the people they were to convert. Besides that which they heard from explorers, other missionaries and books, most missionaries had to use their experience in the field to work with indigenous people.[5] For successful conversions and the healing of ills, missionaries had to learn how the indigenous people functioned – both psychologically and culturally.

Missionaries had to know the indigenous people well in order for meaningful conversion to take place. Even if they knew them well, conversion to Christianity depended on a plethora of things to be realized. There had to be mutual trust, understanding and mutual respect, to mention but only three.

We appreciate the fact that indigenous people were not passive recipients of the Gospel message and medicine. As the case of Hans Schroeder shows, he had to abandon his original mission to the Zulus because they were not passive recipients. The resistance against his message included the rejection of his medicine in Zululand. This shows, as the Comaroffs have written, that human agency "seems almost exclusively to involve concern with the reaction and resistance of blacks to faceless forces of colonization and control."[6] During the negotiations between the colonizers and the missionaries on the one hand, and the indigenous people on the other, compromises were inevitable. Westerners had to decide how much they could give and teach to the potential converts and how much they could leave out. Although not

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[4] Jean and John Comaroff, *Of Revelation and Revolution.* Vol.1, 1991.p.10.
[5]On arrival the Hermannsburg Mission Society's first group depended on the experiences of the Norwegian Mission Society already working in Natal.
[6] Jean and John Comaroff, *Of Revelation and Revolution: Christianity, Colonialism, and Consciousness in South Africa.* The University of Chicago Press: Chicago, Vol.1, 1991, p.9.

a Lutheran, Bishop William Colenso of the Church of England had to unlearn fundamental teachings of his Church in order for his message to be plausible to the Zulus.[7]

Indigenous people also had to undergo fundamental transformation in their conversion to Christianity. The transformation was so severely felt that some lives were lost in the process. Recorded examples are those of St. Maqhamusela Khanyile[8] of the Zulus and Manche Masemola[9] of the Pedis, who were martyred by people of their own society who resisted conversion.

In advocating for the recognition of African agency in shaping theology, Tinyiko Maluleke notes that Africans have struggled against odds in shaping this theology. In many encounters with white people in southern Africa, Blacks were not only victims of dispossession as Maluleke expressed it:

> Africans have always been agents, never "simply victims, wallowing in self-pity"; they have always exercised their agency in struggles for survival and integrity. However, their agency has not always been recognized, let alone nurtured.[10]

Some tribes abandoned their fundamental cultural practices, such as trust in ancestors and rites of passage. Like the Western missionaries, indigenous people also had to negotiate which of their cultural belief systems could be discarded and what from Christianity could be taken. Ultimately, an ongoing negotiation between missionary Christian culture and indigenous African culture is observed. In that process of negotiation there were power relations to consider. We shall see in the thesis that power went from African Christians to missionaries and vice versa. Agency and

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[7] Jeff Guy, *The Heretic: A study of the Life of John William Colenso 1814 – 1883*. University of Natal press: Pietermaritzburg, 1983, p.90.
[8] Margaret Nürnberger, "Maqhamusela Khanyile (d. 1877) Martyr in Zululand. *Studia Historia Ecclesiasticae*. Volume 27, Number 1. December 2001, pp.260-276; *Indaba Yekerike (*Church History*)*. The Lutheran Publishing House: Durban, (undated), p.127.
[9] Mandy Goedhals, " 'A pair of carved saints: Sister Henrietta of the CSA & AA of Kimberley (1847 – 1910) and Manche Masemola of Sekhukhuneland (c. 1913-928) in the Twentieth Century" in *Studia Historia Ecclesiasticae*. Volume 28, Number 1. June 2002, pp. 25-53.
[10] Maluleke Tinyiko, "The Rediscovery of Agency of Africans" in Emmanuel Katangole's (ed.) *African Theology Today*. University of Scranton Press: Scranton, 2002, p.156.

power are inseparable. As an intentional agent, someone has power to effect change and also to refuse involvement.

In his book *The White Man's Burden: Historical Origins of Racism in the United States,* Winthrop D. Jordan gives an account of how Europeans in general and the English in particular, conceived of black people in Africa before they enslaved, civilized or converted them. He dedicated the first chapter of the book to the question of how stereotypes were conceived by travellers and justified through Scripture. The stereotypes created about Africans were based on the following: their dark complexion; their supposed similarities to apes, both in behaviour[11] and in looks[12], their libidinous disposition; and their inherent evil as a result of the curse of Cush as the descendent of Noah.[13] These stereotypes were among the conditions and rationale behind slavery, colonization, and conversion to Christianity. There was a need to justify why African people could be treated in a hostile manner. Europeans needed to be convinced into seeing Africans as the "savage other". Besides being portrayed as having no religion, the pity of Europeans had to be stirred into believing that Africans were also savages. It is only after conjuring enough negative images about someone else that one feels justified to treat that person or persons badly.

Dehumanization and genocides are preceded by labelling. Jordan asked a very important question for this chapter. His question sought clarity on the reasons behind the English enslavement of both Africans and American Indians:

> The pressing need in America was labour, and Irish, Scottish, and English servants were available. Most of them would have been helpless to ward off outright enslavement if their masters had thought themselves privileged to enslave them. As a group, though, masters did not think themselves so empowered. Only with Indians and Africans did Englishmen attempt so radical a deprivation of liberty—which brings the matter abruptly to the most difficult and imponderable question of all: what was it about Indians and Negroes which set them

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[11] When Fouray Bay College, established to serve the Creole population of Sierra Leone, was affiliated to Durham University of England in 1874, the Times newspaper poked fund and claimed that their next affiliation would be with the London Zoo. See, Walter Rodney's book, *How Europe Underdeveloped Africa*.1972, p.141.

[12] Saartjie Baartman, a young KhoiSan woman from the Cape Colony, was paraded in Europe as an animal. *ZAR.co.za Saartjie Baartman Biography* website, visited on 7 December 2011.

[13] Winthrop D. Jordan, *The White Man's Burden*: *Historical Origins of Racism in the United States*. Oxford University Press: Oxford, 1974, pp.3-25.

> apart from Englishmen, which rendered them different, which made them special candidates for degradation?[14]

This question sought answers to the enslavement of both American Indians and Africans enslavement by the people of European descent in the Americas. The same reasons can be employed to explain English and German attitudes towards Africans on African soil. The mentality of enslaving the "savage other" is likely to have been prevalent among the Norwegians as well. The mission societies, we need to note, proliferated in southern Africa during the second take over of the Cape Colony by the British (1806). The treatment of the indigenous people by the British was just as hostile in southern Africa as it was in the Americas. It became an occupation of the government to control Negroes and their presence in the English colonies as well as their relationships with colonists and other behaviour. No colony remained without laws dealing specifically with governing Blacks.[15] There is no doubt that colonialism and civilization were driven by European greed and desire to control vast lands and their populations. Was the quest to Christianize Africans also driven by greed and the desire to control them?

In his comparative study of Black communities and White missionaries' relationships in America and in South Africa with regard to conversion, George Fredrickson, a professor of History in the US, observed how White missionaries occupied a superior position:

> The gospel of human solidarity preached by white missionaries and abolitionists was egalitarian in an ultimate theological sense, but in practice it normally placed whites in a position of cultural superiority and validated paternalistic attitudes toward the blacks who were allegedly being rescued from heathenism and oppression. The tendency to identify Christianity with European or Euro-American civilization made whites the teachers and blacks the pupils—a hierarchical relationship that was supposed to be temporary but that tended to become, certainly in the missionary thinking of the nineteenth century, less of a sudden liberation from sin and unbelief through the miracle of divine and more of a long-term guardianship.[16]

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[14] Winthrop D. Jordan. *The White Man's Burden: Historical Origins of Racism in the United States*. Oxford University Press: Oxford, 1974. p.50.
[15] Jordan, *The White Man's Burden.* 1974, p.59.
[16] George Fredrickson, *Black Liberation: A Comparative History of Black Ideologies in the United States and South Africa*. Oxford University Press: New York, 1995, pp.57-58.

As Fredrickson has written, Europeans felt a divine duty to Christianize Africans. It is possible that the obligation felt by European mission societies to convert Blacks in southern Africa was also felt by the Americans of European descent towards the slaves in the colonies of America. Jordan clarified this point:

> Indications of internal stress bubbled quickly to the surface because the Christian tradition demanded that the souls of men be given spiritual care while still on earth; not just some souls but all, for Christianity was on this point firmly universalist. The obligation of English Christians to convert Indians and Negroes was obvious and undeniable in the eighteenth century as it had been two hundred years earlier.[17]

Although the Christian obligation to convert Blacks in southern Africa was expressed as early as the 1880s by the Churches of the Reformed tradition,[18] the people of European origin still held negative stereotypes about Blacks in the early 1900s.[19]

Any effort that may have been made by Dutch Christians was not sustainable enough to effect large scale conversions. It is not be far-fetched to say that the stereotype that Blacks were void of a conception of God pervaded the attitudes of the Dutch. The various White people who came into contact with the indigenous people claimed that they had no religion—thereby implying that they had no God. David Chidester has written extensively on this matter with regards to the Xhosas and the Khoisan in the Cape Colony:

> As one frontier closed with the establishment of European hegemony over Khoisan people, a second frontier opened against Xhosa-speaking people in the Eastern Cape. During the "hundred years war" from 1799—1878 on that frontier, comparative religion was once again conducted on battlefield. As we should now expect, the practice of comparative religion there was also began with denial. The Xhosa had no religion. Missionaries, travellers, settlers, and agents of the colonial government consistently reported that they had no religion. As a people, they were even designated by the term *Kafir,* which meant unbeliever.[20]

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[17] Jordan, 1974, p.88.
[18] Willlem Saayman, *Being Missionary Being Human: An Overview of the Dutch Reformed Mission.* Cluster Publications: Pietermaritzburg, 2007, pp.52-55.
[19] Willem Saayman, *Being Missionary Being Human*. 2007, p.56.
[20] David Chidester, *Savage Systems: Colonialism and Comparative Religion in Southern Africa.* University Press of Virginia: London, 1996, p.73.

Writing about the Afrikaners and how they realized their Christian obligation to help Blacks out of their barbarism and poverty in the 1900s, J. J. Lubbe quotes the Nederduitse Gereformeerde Kerk's position in the Missionary Commission of the Council of Churches (*Handelinge* 1921: 11-12):

> The practice of the churches follows the doctrine of the State on the relation of the white and the black races to each other. That doctrine is, that the white race is and must remain the ruling race. On the one hand, the European race must look upon the natives as a sacred trust.[21]

Not only the church was commissioned to missionary work in the document, but the white race was entrusted with a holy obligation to raise black people from poverty and barbarism.[22]

In 1935, the Reformed Council of Churches accepted a mission policy towards Blacks. The policy was geared towards developing the black people educationally, agriculturally and medically.[23] The policy stated:

> Evangelisation must not lead to "de-nationalization": "Christianity must not rob the native of his language and culture, but must eventually saturate and purify the whole of his nationalism." Education, medical services and agriculture are put forward as aids in this direction.[24]

The claim that black people were barbarians was also proved wrong on many occasions when Europeans experienced hospitality and kindness they did not deserve.[25] The term barbarian means uncivilised and given to fighting and destruction, as was the case with Goths and Vikings in early European history. The conduct of Whites towards Blacks was hostile especially when they dispossessed Blacks of their

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[21] J. J. Lubbe, "Towards 1948," in J. W. Hofmeyr *et al*. *Perspectives on Christianity: 1948 + 50 years Theology, Apartheid and Church: Past, Present and Future.* Series 5 Volume 1. 2001.p.4.
[22] J. J. Lubbe. "Towards 1948," in JW Hofmeyr *et al*. *Perspectives on Christianity: 1948 + 50 years Theology, Apartheid and Church: Past, Present and Future Series 5 Volume 1*. 2001.p. 5; Johann Kinghorn discusses this issue deeper in his chapter titled, "Modernization and Apartheid: The Afrikaner Churches", in Richard Elphick and Rodney Davenport,(eds.), *Christianity in South Africa*. 1997,pp.135-154.
[23] The Dutch Reformed Church established mission hospitals in Botswana (Mochudi) and also in the Transkei. See Chapter Two.
[24] J. J. Lubbe, "Towards 1948," in J. W. Hofmeyr *et al. Perspectives on Christianity: 1948 + 50 years Theology, Apartheid and Church: Past, Present and Future Series 5 Volume 1* 2001, p.5.
[25] Jean Comaroff and John Comaroff, *Of Revelation and Revolution*. Vol. 1. 1991, p.92.

land and livestock. White mobile stock farmers competed with Blacks for land and wars were waged as Blacks defended what was theirs.[26] Although *ubuntu* may have played a role in the settling of Whites on the land of Xhosas and Khoisan in the Cape Colony, Blacks, especially the Tswanas, saw the presence of missionaries among them as a blessing in disguise. Whites, especially missionaries, were exploited by Blacks for their own benefit. Whites served as providers of a variety of goods of European origin like guns.[27]

Blacks also requested Whites to provide school education.[28] With regard to education, the colonists and the missionaries were willing providers as their agenda of civilization and conversion was being advanced. Almost all mission societies which operated in southern Africa in the early 1900s established schools as part of their ministry. It was logical that if people could read, they would be able to read the Bible or parts thereof and sing hymns as was happening in their churches in Europe. School education was a gateway to conversion. Obstacles to conversion included bride price, initiation into adulthood, traditional healing and polygamy.[29] Between the 1930s and the 1960s the Hermannsburg Mission Society (HMS) missionaries seemed to have been especially obsessed with matters of initiation and traditional healing. Their reports from Ramotswa in Botswana are evidence that the HMS missionaries were worried by these issues.[30] They may have hoped that school education and Western medicine could obliterate the need for initiation school (*bogwera* for boys and *bojale* for girls) and traditional healers.

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[26] Janet Hodgson, "The Battle for Sacred Power: Christian Beginnings Among the Xhosa" in R. Elphick and R. Davenport, (eds.) *Christianity in South Africa: A Political, Social and Cultural History*. David Philip: Cape Town, 1997, p.69.

[27] Janet Hodgson "The Battle for Sacred Power". in R. Elphick and R. Davenport, (eds.) *Christianity in South Africa: A Political, Social and Cultural History*. David Philip: Cape Town, 1997, p.76.

[28] Roger Beck, "Monarchs and Missionaries among the Tswana and Sotho" in R. Elphick and T. H. R. Davenport, (eds.), *Christianity in South Africa*: *A Political, Social and Cultural History*. David Philip: Cape Town, 1997, p.108.

[29] A man in Gabane village, one of HMS outstations, refused to join the Anglican Church if it also forbade polygamy. 1947 Report dated 27/01/1948 by Missionary Heinrich Pfitzinger. HMS Archives in Hermannsburg, Germany. Folder A: SA 42 – 339 (1935-1969).

[30] 1929 Report by Missionary Ernst Fistchen mentions displeasure against initiation schools, (HMS Archives in Hermannsburg, Germany. Folder, A: SA Ausland Südafrika File 11. Missionary Fitschen 1927-1931). Missionary Heinrich Pfitzinger reported in the 1944 Report dated January 1945 that one woman in Mogobane joined the "Church of God" because he, Pfitzinger, refused to readmit her after she went to an initiation school, (HMS Archives in Hermannsburg, Germany. Folder, A: SA Ausland Sudafrika File 11.Missionary H. Pfitzinger 1932-1939). Khama and Kgamana princes of the BaNgwato tribe in Botswana infuriated their father Sekgoma when they chose school education over the b*ogwera* initiation of their people, Paul S. Landau's *Realm of the Word*. 1995, p.20.

Christianity and Western civilization were entrenched through the introduction of schools and the translation of the Bible, or parts thereof into indigenous languages. [31] Names of God like *Modimo* for the Tswanas and *Thixo* for the Xhosas were appropriated into the Christian belief system to bridge the differences between Western and African indigenous worldviews. In reference to Xhosas, Hodgson makes a similar point: "On one level the missionary incursion into translation was bound to be significant, even integral, to colonizing African consciousness by co-opting Xhosa words to express European concepts of Christianity."[32] New meanings to old terms meant that Sothos and Ngunis had to express their thoughts differently. For example, they now had to begin to request from *Modimo* and *Thixo/Unkulunkulu* help and favours that they used to expect from ancestors. New identities were formed as some adopted Western religious rituals and others rejected them.

2.1. The Zulus and the Making of *Amakholwa*

This subsection will help us understand the history of the four Lutheran mission hospitals among the Zulu as it addresses the development of the assimilation of Western culture. I will argue that those who adopted Western ways were not naïve but selective in what they adopted. At the time when mission societies were growing in number and gaining converts among Zulus, Xhosas and Tswanas in the second half of the nineteenth century, a number of natural and man-made disasters took place. These disasters contributed to the influx of Blacks into mission stations. They also broke the resistance of blacks to western culture and accelerated its adoption especially in urban areas. Those Blacks who did not move into mission stations did not escape the influence of Western civilization on their lives and culture.

Shula Marks recorded the devastations caused: by drought from 1895 to 1903, by locusts in 1895, by cattle diseases like lung sickness and rinderpest between 1896 and

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[31] Kuruman of the LMS in Northern Cape, Morija of the Paris Missionary Society in Lesotho and Lovedale of the Free Church of Scotland mission in the Ciskei, worked on Bible translations.
[32] Janet Hodgson, "The Battle for Sacred Power" in R. Elphick and T. H. R. Davenport (eds.) *Christianity in South Africa: A Political, Social and Cultural History.* David Philip: Cape Town, 1997, p.77.

1897, and by the South African War[33] from 1899 to 1903.[34] Although the Whites in Natal were affected by the cattle diseases especially by the rinderpest,[35] the Zulus in Natal and in Zululand suffered major setbacks to their livestock economy. The Zulus were left in an impoverished condition.[36] Those who chose residence on settler farms in Natal had to pay rent in cash or in exchange for labour. As the landowner pleased, rent was charged one or two pounds per hut, according to the number of huts on a homestead.[37] When the South African War depleted the Natal colonial treasury, the government imposed a poll tax of £1 upon unmarried men in 1905.[38] This tax led to the 1906 rebellions which caused the death of Bambatha Zondi near Greytown and the arrest of King Dinuzulu- ka- Cetshwayo of the Zulus among other rebels.[39] The tax was a burden on the nation, which was trying to recover from drought and cattle diseases.

Earlier, a rumour similar to the Xhosa Cattle Killing[40] was spread in the Natal Colony, supposedly by King Cetshwayo, that Zulus must destroy their white pigs and fowls, and utensils of European origin if they did not wish calamity to befall them. Shula Marks quotes the rumour, which according to Benedict Carton came to be known as *umhlola*:[41]

> All pigs must be destroyed as [well as] all white fowls. Every utensil hitherto used for holding food or eating out of must be discarded and thrown away. Anyone failing to comply will have his kraal struck by thunderbolt when, at some date in the near future, he sends a storm more terrible than the last, which was brought on by Basuto king in his wrath against the white for having carried a railway to the immediate vicinity of his ancestral stronghold.[42]

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[33] Also called the Anglo-Boer War.
[34] Shula Marks, *A History of the Zulu Rebellion, 1906*. 1993, pp.92-94.
[35] The Tswanas' stocks were also affected by rinderpest. See Paul S. Landau's *Realm of the Word*. 1995,p.67.
[36]Shula Marks, 1993.p.94.
[37] Ibid. p.95.
[38] Ibid. p.100.
[39] Shula Marks, *Reluctant Rebellion: The 1906 – 8 Disturbances in Natal.* Clarendon Press: Oxford, 1970, pp.280-285.
[40] J. B. Peires, "Suicide or genocide? Xhosa Perceptions of the Nongqawuse Catastrophe," in *Radical History Review.* 46/7. pp.47-57.
[41] Benedict Carton, *Blood from our Children: The Colonial Origins of Generational Conflict in South Africa.*. University of KwaZulu-Natal Press: Pietermaritzburg, 2000, pp.121-122.
[42] Shula Marks, 1993, p.103.

Although it is not known how severe the *umhlola* destruction was among the Zulu, the surviving Xhosas suffered so much that they went onto White-owned farms and into mission stations in search of livelihood. The Nguni worldview which explains things in superstitions can be said to be responsible for indirectly breaking the resistance against White culture. The destruction of livestock and crops was supposed to usher in a life of prosperity and the removal of White domination over the Ngunis. The natural disasters severely crippled the Zulus' economic independence. In their time of need the vulnerable Zulu people received help of many forms from the colonists and the missionaries. One of the assistance rendered by the missionaries was biomedicine.

Desperation, as with oppression and cultural domination leads people to engage in desperate measures. A similar incident, although on a smaller scale, took place in New Zealand when the imposition of Christianity and Western civilization became unbearable for the Maori people. A *Tohunga* (traditional healer) prophesied that a great flood was going to sweep all the *pakeha* (White people) out of existence. Like the Nongqawuse prophecy of the cattle killings and the *umhlola* rumour, that prophecy proved untrue. Children died and crops were left to rot when villages were deserted and schools depopulated.[43] In southern Africa those who lived on and around the mission stations adopted the Christian religion and Western lifestyle,[44] largely out of desperation. Among the Xhosa the converts were called *amagqoboka*[45] and among the Zulu, *amakholwa*.[46]

The *amakholwa* were not necessarily the converted as the name suggests and as understood by missionaries at the time. These were men and women who lived in and around the mission stations for the benefits the stations could offer. Those were often

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[43] R. T. Lange, "The Tohunga and the Government in the Twentieth Century," in *University of Auckland Historical Society Annual*. 1968, pp.12-38.
[44] Derek Japha, Vivienne Japha, Lucien Le Grange and Fabio Todeschini, *Mission Settlements in South Africa: A Report on their Historical Background and Prospects for Conservation*. The Department of Environmental Affairs. March 1993, p.26.
[45] The term meant "people with a hole" indicating that the 'school' people had opened a hole in the nation through which white enemy forces had entered. For their part, the 'school' people were committed to the discipline and self-improvement represented by education, wage labour, and participation in the colonial cash economy, David Chidester, *Religions of South Africa*. 1992, p.53.
[46] Plural of *ikholwa* which is a Zulu noun referring to a Zulu person, especially a Christian, who has adopted ways of living similar to those of white people.

the people not on good terms with the traditional leaders of their villages.[47] The *amakholwa* community grew even during the time of Cetshwayo. Initially all mission settlements and not only those of the Norwegians were populated by strange and undesirable characters.[48]

People of the Zulus went to live in mission stations under the guise of adopting Christianity although they in fact wanted land and other benefits that the stations could offer. As they were able to receive school education on the stations and to adopt a Western life-style, they were called *amakholwa*, as opposed to *amaqaba*[49]—who remained in their villages and did not go to school.[50] Some missionaries knew that the populations on their stations were not all genuinely converted. One of the missionaries made a deal with a Zulu *inkosi* (chief) to buy the land which the *inkosi* was renting for seven shillings and to lower the rent to five shillings. The condition was that each child under the *inkosi* was to attend school.[51] With the adoption of a Western life-style, the *kholwa* also adopted biomedicine without abandoning their traditional health system. Dean Mthethwa argued in an interview that they did not intend to abandon their traditional medicine and ancestor-related religion.

CM No, they were not allowed to go into the mission station. Dr. Astrup was hard. He did not want any healer here.
RN Were the residents of the mission not going out to visit the healers?
CM Oh, you cannot even ask that. They went privately (Laughter). They hid themselves and went when it was dark.
RN Did they really go at dusk?
CM That is obvious. For a Zulu person, there was no other way but to do it (Laughter).
RN Was there any slaughtering for ancestors on the mission station?

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[47] Norman Etherington. *The Rise of the kholwa in Southeast Africa: African Christian Communities in Natal, Pondoland, and Zululand, 1835-1880.* Microfilms International: London.1971, p.123. The Norwegian missionaries soon discovered that Mpande, while glad enough to use missionaries as carpenters, doctors, and advisors, had not intention of allowing the Christianization of his people. The king's refusal to allow black Christians to *khonza* stopped Norwegians as decisively as it stopped Robertson. Instead of gathering whole clans and homesteads as they hoped, the Norwegians ended by populating their tiny isolated stations with hired servants, orphans, and imports from Natal.

[48] Derek Japha, Vivienne Japha, *et al. Mission Settlement in South Africa*. 1993, p.27. See also Dean C. N. Mthethwa interviewed by Radikobo Ntsimane in his home at KwaMbonambi, KwaZulu on 19 November 2002.

[49] A plural of the Zulu noun, *iqaba*, which refers to a person who is strongly traditional and not educated in formal Western-type schools. *Iqaba* sometimes refers to someone who has not converted into Christianity.

[50] Derek Japha, Vivienne Japha, *et al*. *Mission Settlement in South Africa*. 1993, p.26.

[51] Norman Etherington, *The Rise of the Kholwa in Southeast Africa*. 1971, p.208.

CM That does not even need asking about, but truly it was not done openly. It may have been possible that it was not even done privately on the mission station because other *kholwa* knew about the ancestors. One cannot deny though that they did it in secret, because it was known that the mission station was meant for the *kholwa*.[52]

It is therefore incorrect to assume that biomedicine was readily accepted everywhere in southern Africa. One can see that the Western lifestyle and Christian faith were not simply imposed and accepted by the Zulus. Life situations created conditions for them to move into mission stations. As we have seen, the Zulus negotiated to find an agreeable place to settle between the two worldviews. The process of adopting biomedicine was gradual. It should also be noted that biomedicine itself was not an immodifiable product or system that could not be adapted. Wherever it was introduced, biomedicine had to be made relevant to the new society. Megan Vaughan explained this well when she wrote that where biomedicine did not adapt to new conditions, it failed:

> I have little disagreement with the central idea that biomedicine neglects to address the fundamental social, economic and political causes of ill-health, and that there can be no 'natural history' of disease. What I am less certain about, however, are the assumptions made about the nature of biomedical knowledge here. It is certainly true that many biomedical theories and interventions have failed in Africa because no account was taken of the social and political context, and there are many examples of such instances in this book.[53]

Biomedicine is not homogenous. It has developed, as I attempted to show in the previous chapter, from the basics of rudimentary science to the sophisticated technology of machinery, from social context to social context, and from historical period to historical period.

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[52] This point is further developed below under the subsection called Medical-Syncretism.
[53] Megan Vaughan, *Curing their Ills: Colonial Power and African Illness*. Stanford University Press: Standford, 1991, pp.5-6.

2.2. The Tswana and the Making of *Batho ba Thuto*

Like the previous section which dealt with the Zulus, this section attempts to show that the adoption of biomedicine among the Tswana came about after a period of mistrust and negotiation.

Among the Tswanas, the Western culture and its civilizing power was generically called *thuto,* and the willingness of their traditional leaders (*dikgosi)*[54] to adopt some of its tenets, was responsible for the tribal cultural transformations. The LMS and the HMS missionaries worked among the Tlhaping, the Bakwena and the BaNgwato, while the Wesleyans worked among the Barolong. The various Tswana tribes welcomed the missionaries among themselves with the intention of reaping the benefits that came with their presence. Schools and technology were among the benefits that the Tswanas wished to acquire from the Europeans settlers. It has already been mentioned that when the mission societies started to proliferate in southern Africa in the mid-nineteenth century, the Tswana, like the Zulu, experienced drought as well as the *Mfecane*[55] which did not allow peace and stability among the southern African tribes. The other challenge that faced the Tswana was the perennial droughts in their mostly desert north-western parts of the country.[56]

The Tswana had to find ways and means to survive in those arid areas.[57] They designed ways to eke out a living, despite unfavourable climatic conditions. Their health professionals like the *dingaka,* devised ways to manipulate nature to yield food both for humans and for livestock. They learnt how to "doctor" livestock and crops for fertility and for large harvests. The Tswanas had *barokapula,* whose specialization was to generate rain through the use of traditional medicine—*ditlhare*. On two different occasions when rain failed in Ramotswa, where one of the four mission hospitals under review in this research is located, the tribe demanded of the HMS

[54] A plural form of a Tswana noun *kgosi*, which refers to a king, a chief or a tribal leader.
[55] A stampede referring to the movement of wars in the time of King Shaka of the Zulus when tribes were displacing one another and finding new locations.
[56] Kalahari/Kgalagadi Desert in the present Northern Cape Province and Botswana.
[57] Paul S. Landau, *Realm of the Word*. 1995, p.14.

missionary that he pray for it.[58] The Tswana worldview assumed that if the missionary had a relationship with a supernatural Being, they could tap that Being for the provision of rain.

It is evident from such demands and from other "miracles" seen performed by missionaries that the Tswana people hoped that the Whites people coming to their lands would be a useful resource. It did not matter whose ritual of machinations would bring about the much-needed rain. The Tswanas obviously did not understand why the missionaries expected them to substitute their belief system when they could supplement it for added benefits. As we have seen in the third chapter with regards to Zionists and concepts of health, when one health system proves inadequate for one affliction, it is acceptable to try another system without discarding the original one. A Tswana proverb teaches that it is not advisable to discard the old-but-known item with the acquisition of a new one.[59] A Zulu proverb, similarly teaches that it is not advisable to get rid of the blanket should your baby die.[60] This system of supplementing rather than substituting was also seen in Chapter Three, when the procedure followed by a household when seeking to restore a member's health was discussed.

Let us look at the various events that broke the resistance of the Tswanas against western culture and medicine. Western medicine was adopted and worked into the broad health system of the Tswana. That assimilation should be understood against the background of the difficulties of the late 1800s and early 1900s, created as they were by adverse natural conditions, superstitions, and man-made disasters. Among these disasters we can count the South African War of 1889-1901 (Anglo-Boer War), the 1905 Poll-Tax Act, the droughts, locusts and cattle diseases. Blacks, who had resisted the introduction of the dominant Western culture under the guise of

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[58] Missionary Ernst Fitschen reports that Christians conducted prayer for rain during a funeral service and the rain poured before the scheduled tribal ritual for rain could take place. See the 1929 Report. See HMS Archives in Hermannsberg, Germany. Folder A: SA Ausland Südafrika File II, Missionary E. Fitschen 1927 – 1931.
When Missionary Heinrich Pfitzinger refused to join the tribe in the ritual of praying for rain he was accused of dividing the tribe and denounced as a *morokapula* (*Der Moruti ist kein "moroka" der regen macht* = The pastor is not a *moroka*, the rain maker*.)*. See the 1945 Report dated January 1946. See HMS Archives in Hermannsberg, Germany. Folder A: SA 42 – 339, 1935 - 1969.
[59] *Letlhaku le leswa le agelwa mo go le le gologolo.*
[60] *Akulahlwa mbeleko ngakufelwa*.

Christianity and formal education, were left vulnerable by these adverse conditions. They became dependent on the generosity of the Whites in the mission stations.[61]

Initially, one of the multiple tribes[62] within the Tswana nation, the Barolong of Ratshidi, resisted Western encroachment into their culture. However, their vulnerability in the face of the adverse life conditions of landlessness and displacements by colonialism, Boer expansions and natural disasters, made them relent. When the attempts of the Barolong of Seleka, one of the Tswana tribes, failed to generate rain, the Wesleyan missionaries sank wells and found water and subsequently gained popularity and some acceptance.[63]

Although Heinrich Schulenburg of the HMS tended the sick among the Bangwato in the then-Bechuanaland along with teaching Scripture and delivering sermons—it was the spectacular and hitherto unknown cures of missionaries such as John Mackenzie of the LMS which popularized Western medicine among tribe. Mackenzie and his colleague inoculated the Ngwato royalty, tended wounds, extracted teeth and even did eyewashes.[64] The activities of the LMS missionaries were manifesting to the Tswana the knowledge and resources at their disposal from which they could benefit. As happened later after the establishment of mission hospitals, especially in Ramotswa among the Balete tribe of Bechuanaland, the traditional healers did not take kindly to the medical missionaries encroaching upon their sphere of work. Sir George Grey and some missionaries had earlier advocated for the removal of the "witchdoctors", and their replacement with Western-trained health practitioners as a way of civilizing and converting the indigenous people.[65] In the 1880s, even the unconverted *kgosi* (chief), Sekgoma of the Ngwato, used to send patients to Mackenzie and not to healers in his court.[66] Unintentionally, Sekgoma elevated Western medicine above that of his own culture. His son and heir, Khama, realized that in comparison to

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[61] The mission societies that worked among the Tswanas did not establish mission stations to accommodate the converts. Their strategy was to convert whole villages, beginning with the *kgosi*, the tribal leader. See the HMS in Chapter Two.
[62] See P-L. Breutz, *History of the Batswana.*(self-published). Ramsgate, 1989. This is a study of the various Tswana tribes and their origins, Chapters Five to Twelve.
[63] Jean Comaroff and John Comaroff. *Of Revelation and Revolution*. Vol.1.1991, pp.208-209.
[64] Paul S. Landau, *The Realm of the Word*. 1995, p.13.
[65] PW Laidler and M Gelfand, *South Africa: Its Medical History 1652-1898*. Struik: Cape Town, 1971, p.295.
[66] Landau, *The Realm of the Word.* 1995, p. 13.

bongaka, Western culture—called *thuto*—was more powerful. Khama embraced *thuto* and gathered a strong following behind him in opposition to his father Sekgoma. The major turning point in Khama's life, according to Landau, came during the period of smallpox and hunger, as occurred in Natal and the Cape Colony. He wrote, "This was a revolutionary statement during the period of disease and hunger, when Sekgoma and his *dingaka* had failed to relieve the land of the 1862-1863 drought or the small pox epidemic that afflicted most households in the town."[67]

Despite the divisive agenda of the missionaries, Sekgoma did not drive them off his territory. Unlike with the Zulu, the missionaries working among the Tswana in Bechuanaland and in South Africa did not have the tendency of populating their stations with converts. As in the case of the HMS and later the MELFC, they aimed at converting the entire tribe along with the *kgosi*. Sekgoma was not afraid of the contest with missionaries for the sacred power over his tribe.[68] Like many tribal leaders, Sekgoma tolerated the presence of the missionaries in his tribe because he was aware of the benefits that the European culture could bring about. He knew that the presence of missionaries in his territory brought about the material and technological benefits that he sought after. What he failed to realize was that as the loyalty of his people was being divided between his leadership and that of LMS missionaries, he was losing power and influence over them.

Although not many Bangwato were converted by Schulenburg, their adoption of *thuto* through the Word of God meant to them immense power and benefits, as was the case with the *kholwa* among the Zulu. Converts to Christianity were seen to be privy to the inherent power in literacy and Christianity. Landau's explanation of the perceptions of the underfed Bangwato is relevant to all Tswana tribes of the time. The converts or *batho-ba-thuto*, as they were called:

> (They) were then "of the Word" and might derive benefits in health, status, and power from it. The cult and the Word defining it were tied to the presumed power of missionaries (in their identity as whites and an odd sort of dingaka) through shared significance in manners,

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[67] Landau, *The Realm of the Word.* 1995, p. 15.
[68] The term used by Janet Hodgson in her chapter in Richard Elphick and Rodney Davenport, (eds.*), Christianity in South Africa*. David Philip: Cape Town, 1997, pp. 68-88.

> expression, and clothing. *Lefoko la Modimo* thus implied esoteric, male authority, action upon the world, the half-seen power of the Bible and other texts, and the realm of white people. Khama and other early Ngwato Christians of the cult, for their part, shared this sense of power of *Lefoko* and found new applications of *mafoko* to their world.[69]

Although this discussion concerns the Ngwato, it represents the experience of other Tswanas in their encounters with missionaries. The same Schulenburg who introduced Christianity and Western healing among the Ngwato, later worked among the Balete of Ramotswa among whom the HMS established a hospital. It is clear that power was a sought after attribute everywhere not only among the Tswanas. This obsession with the acquisition of power was prevalent among southern Africans long before the introduction of Christianity and Western medicine.

The one who has power has *isithunzi/seriti* and can manipulate people and forces, while avoiding manipulation by other people and forces. As seen in Chapter Three, individuals, households, cattle byres and crop fields—among other things—were fortified against malice. The fear was that supernatural enemy power could weaken or destroy them for good. With conversion to Christianity and the adoption of Western medicine which proved superior in times of need, *batho-ba-thuto* had power from God and could therefore face the challenges of everyday life. Having seen how a new middle class of black people was created among Zulus and Tswanas, let us look at how biomedicine was integrated into the Southern African indigenous health systems.

2.3. Accommodation and Assimilation of Biomedicine

It took fairly long for biomedicine to be fully accepted among the indigenous people of southern Africa. In the beginning, most people did not trust biomedicine mainly because it was in the hands of the white people whose sincerity was questionable. White people, we should remember, were not necessarily seen as diverse with categories such as traders, mobile stock farmers and missionaries, each with a specific

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[69] Landau, *The Realm of the Word*. 1995,p.19.

purpose. Since in the 1800s the missionaries sometimes behaved like the colonial masters, they were sometimes seen as having the same intentions of conquest. James Cochrane arrived at the same conclusion when he wrote about Natal, "The implication is that Africans in general, converted or not, saw the missionaries as part of the forces of conquest."[70]

They were all White and could be harbouring a malicious agenda, yet undisclosed to the traditional rulers and their people. In 1856, the governor of the Cape Colony, Sir George Grey,[71] had intentionally wanted to substitute traditional health systems with that of the West one in order to entrench White domination over the Blacks.[72] Shula Marks observed a fierce contest for control, as she writes, "Apart from the Old and New Somerset Hospitals in Cape Town, frontier warfare had resulted in the expansion of hospitals – especially under Sir George Gray, the Governor who saw western medicine as an important weapon in breaking down the resistance and winning them over to the beneficence of western civilization."[73] Attacks on traditional medicine also came from missionaries, who saw it as a stumbling block to the conversion of the Blacks.[74]

A number of events and processes in the nineteenth and early twentieth centuries opened the door for Western medicine to be made part of the culture of southern Africa. Such events included: industrialization and urbanization, the increase of Black nurses in hospitals, and epidemic diseases like tuberculosis. One could say that Sir George Grey's wish was coming true.

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[70] James Cochrane, *Servants of Power: The role of English-speaking Churches 1903 – 1930*. Ravan Press: Johannesburg, 1987, p.21.
[71] George Grey came from New Zealand to serve as Governor of the Cape Colony. His legacy in New Zealand was followed by efforts to remove tohungaism from the Maori health system by education and increased subsidies on medical work. For further discussion on this see the R.T. Lange article in the Journal article, "The Tohunga and the government in the twentieth century," in *University of Auckland Historical Society Annual*. 1968, pp.12-38. 1968. "An account centering mainly on the Tohunga Suppression Act of 1908 and developments since that date."
[72] P.W. Laidler and M Gelfand, *South Africa: Its medical history 1652 – 1898*. Struik: Cape Town, 1971, p.295.
[73] Shula Marks, *Divided Sisterhood*. 1994, p.17.
[74] Shula Marks, *Divided Sisterhood*. 1994, p.79.

2.3.1. Industrialization and Urbanization

We have seen that wars, natural disasters like droughts and cattle diseases and superstitions like *umhlola* among the Zulu and the cattle killing among the Xhosa had left many people dead and others very impoverished. Men had to go into industrialized centres in order to find employment and to help lift their families out of the abject poverty that covered the sub-continent. Western industries also beckoned to men who needed money to pay taxes like hut tax and the poll tax to allow the colonial power to recover from the South African War (1899-1901). In order to pay the 1905 poll tax imposed upon males people in Natal and Zululand, young men had to seek work especially after the poll-tax rebellion was crushed. Benedict Carton wrote:

> The central historical event in 1908 and 1909 was not Dinuzulu's trial; rather, it was the surge of fugitive rebels and other African young men from the Thukela basin into labour migrancy. The forces of the industrial centres had already pulled more and more workers from Natal, and during Dinuzulu's treason trial, Transvaal labour recruiters conducted an unprecedented number of 'tours throughout Zululand' with an eye to 'supplying labour to the Mines.'[75]

G. C. R. Bosman wrote that in 1938, "The migration of non-Europeans in a certain sense also due to the "lure" of city life, but the exceptional de-ruralization of the native population, however, is mainly a result of the prosperity on the mines and the demand for cheap native labour."[76]

The cities of Kimberley, Cape Town, Durban and the Witwatersrand all became industrialized and saw an influx of men who were eager to participate in a monetized economy of the two English colonies and the Boer Republics.[77] Shula Marks connects industrialization with the new patterns of diseases that called for a new way of treatment. "The discovery of minerals in the last third of the nineteenth century – diamonds in Kimberly in 1868, gold in the Transvaal, first at de Kaap and Barberton,

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[75] Benedict Carton, *Blood from Your Children: The colonial origins of generational conflict in South Africa.* University of Natal Press: Pietermaritzburg. 2000, p.171.
[76] G. C. R. Bosman, *Industrialization of South Africa*. Frima G. W. DenBoer: Rotterdam, 1938, p.129.
[77] Helen Sweet, "Wanted 16 nurses of the better education type: provision of nurses to South Africa in the late nineteenth and early twentieth centuries," in *Nursing Enquiry* 2004 Volume 11, November 3, pp.176 – 184.

then in vast seams at very deep levels underground on the Witwatersrand in 1886 – transformed South Africa's disease patterns and its health care."[78]

Due to overcrowding and the squalor in industries ,[79] especially the mining industry, employers had to make sure that they had a healthy work force. Since a sick work force could only reduce levels of productivity and profits, industries had to recruit and retain healthy labourers. When recruited, the men had to be thoroughly examined to determine whether they had any diseases. That was so that prospective employers could avoid costly medical expenses while workers unproductively convalesced. KwaMuhle Museum in Durban has permanent displays showing how men used to be examined before being allowed into the monetized economy in the urban area.[80] When in the industrialized economy—for example in the mines—sick traditional employees had no choice but to make use of the Western medicine provided by the employers. We can observe how authority was exercised over Black bodies under the umbrella of Western medicine. This kind of control was based on the racial discrimination that Blacks were suffering in apartheid-era industries.

Among the Tswanas the system was similar but not identical. Some *kgosi* would select a regiment of the same age-group who were initiated together—called *mophatho*- to go to the industrialized centres for employment. A recruitment agency called the Employment Bureau of Africa (TEBA) would come into Batswana villages in South Africa and Bechuanaland and recruit for various industries. These men were also to undergo examination to determine their fitness before entering into a five-year contract. The money raised from the contracts was used by the tribal *kgosi* for development of the tribal area, to build schools and make roads. Indentured Indians working in sugar plantations around Durban had to use the Bayside and Addington Hospitals. These were originally meant for Blacks as their employers knew no other health system to help them when sick.[81]

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[78] Shula Marks, *Divided Sisterhood* . 1994, p.16.
[79] For the description of the squalor in Kimberley see Shula Marks, *Divided Sisterhood.* 1994, pp.23-24.
[80] The explanation at the museum says that men who generally came from the rural areas were stripped naked and sprayed with water to reduce lice from their bodies before they were inspected. The exercise was dehumanizing as older men had to expose their nakedness before men too young to be their sons, and be treated like cattle in a dip.
[81] Shula Marks, *Divided Sisterhood*. 1994, p.18.

In urban areas, where the government regulated the lives of Black people, it could enforce health inspection and general immunization. This was total control, not only of the Black peoples' lives but also of their bodies. Through Western medicine, the government could mark one's body, like branding for identity. The diminished will to resist Western medicine was the cost of settling in an industrialized and urban area. On the other hand, urbanization and industrialization can be credited for arresting the decline of the Nguni-Sotho traditional health system. When men, and later women, moved into urban areas in search of employment in the mines and industries, they left behind their Churches. If the Churches offered any protection to the members and sympathizers, that protection was confined to the mission stations in the rural areas. The missionary societies in the rural areas did not follow their members to the urban areas immediately after the discovery of minerals. Faced with the challenges of the new and hostile conditions of the urban centres, the converts had to find ways and means to survive. It was an opportune time to either revert to the Traditional health system or to join the Zionist-type Churches that were not opposed to such health systems.

Dedicated men from the *kholwas* established branch congregations of their denominations or founded their own churches in the urban areas due to the absence of their missionary leadership and guidance. In the late nineteenth century, men like Pambani Mzimba of the Presbyterian Church and Mangena Mokone of the Methodist Church are two examples of such initiatives.[82] John W. de Gruchy has attested to the fact that the independent churches in the urban centres created space for Black people to be innovative in managing their Christian faith and traditional religion:

> The independent churches served another significant purpose. The rapid growth of black urbanization, stimulated by migratory labour and post-war industrialization, had radically altered the socio-cultural existence of the black community since early twentieth century. As a result, much of the former tribal cohesion was fragmented and many personal and social problems arose without traditional resources

[82] G.J. Pillay and J.W. Hofmeyr, (eds.) *Perspectives on Church History: An introduction for South African Readers*. Haum Tertiary: Pretoria, 1991, p.261.

> available to handle them. The independent churches enabled blacks to cope with this alien world of townships.[83]

The Zionist Churches that did not prohibit their members from using traditional medicine, quickly increased in towns where there was no competition from mainline Churches. Their unsophisticated Church structure and tolerance of traditional health systems made them attractive to black people in the urban areas. In the absence of church-friendly white people in these areas, especially in single men's hostels, the Nguni-Sotho health system showed resilience and reversed the decline caused by the challenges of missionaries and missionary-trained Blacks.

In the absence of missionaries and due to poor preparation for an unknown urban life, the temptation to seek sustenance from the familiar became irresistible. Some mission societies like the HMS and the MELFC[84] were of rural origin and not adequately prepared to help their *kholwa* deal with urban temptations. People from the rural settings had fears of a supernatural nature that needed to be allayed through traditional health systems. Ashforth was puzzled by the fear of the occult that gripped people in post-apartheid Soweto. He tried to make sense of it, as he wrote:

> To understand why people can "still" believe in witchcraft despite no longer living in a world that remotely resembles anything "traditional," it is first necessary to understand how claims about their forms of agency embodied in material substances, objects, and images can be made to seem plausible. And if it is true that the people of whom I write in Soweto are living in a world with witches while also, and at the same time, living in the same world as people like me and the people who are reading this book, then the conditions of this plausibility should be describable without having to be translated from one culture to another or one putative scheme of rationality to another.[85]

What is happening today, where not only urbanized people but even Christians are continuing to fear witchcraft in the cities is, according to Ashforth, pretty "normal".

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[83] John W. de Gruchy with Steve de Gruchy, *Church Struggle in South Africa* (25th Anniversary Edition). SCM Press: London. 2004, p.45.
[84] Mission Superintendent Christoph 'Mbokojwane' Johannes used to visit Lutherans in Sophiatown and Roodepoort from Salem mission station near Piet Retief. He would conduct a service which included confession of sins and Holy Communion.
[85] Adam Ashforth, *Witchcraft, Violence, and Democracy*. University of Chicago Press: Chicago, 2005, pp.120-121.

Due to the segregation in towns, employed men initially had to live in single male hostels, but later families were allowed to live in townships. With regard to hostels, it is not a coincidence that the researcher Adam Ashforth and his bewitched friend Madumo[86] had to find the traditional healer Mr. Zondi, in the Merafe hostel in Soweto. Traditional healing found a willing clientele in and around the hostels of South Africa, as Ashforth observed on many of his visits as a researcher:

> Our interview was over. Clients were gathering in the waiting room. At this time of the afternoon, commuters start arriving by train from Johannesburg, and Mr. Zondi has many clients who stop by for consultation on their way home.[87]

2.3.2. The Multiplication of Black Nurses in Hospitals

When the Berlin Missionary Society missionary Heinrich Schumann employed a nurse to help the local AmaNgwane women with their maternity needs in Emmaus, the men in the area were not in favour. They did not see the value of the nurse as their women had for years delivered babies without the help of an outsider (Xhosa) nurse, Millicent Nukuna.[88] This was long before the Schieles established a proper hospital after the Second World War. In Botshabelo, the women of the village refused to use the ante-natal clinic introduced by the MELFC missionary, Friedrich Dierks.[89] Like Heinrich Schumann in Emmaus, Dierks asked the women of the congregation, especially Priscilla Mokone, wife of Nun Mokone, to encourage women to use the hospital.[90] These examples confirm that the acceptance of Western medicine among the black people involved a long struggle. Shula Marks gave credit to the African nurses in mission hospitals whose presence there served to persuade Africans to use biomedicine:

> Undoubtedly in South Africa, too, it was initially the mission hospitals and the mission-educated nurses who persuaded Africans of the efficacy of western medicine. By the 1930s and 1940s the numbers of

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[86] Adam Ashforth, *Madumo: A Man Bewitched*. David Philip: Cape Town, 2000.
[87] Adam Ashforth, *Madumo.* 2000, p.95.
[88] Lawrence Zikode, "A History of the Emmaus Mission." (Unpublished and undated). pp.15-16.
[89] Friedrich Dierks interviewed by Radikobo Ntsimane at Bleckmar, Germany on 18 July 2002.
[90] Ibid.

> black South Africans seeking western medical treatment had greatly increased, a reflection of increased urbanization and the high levels of morbidity in the black population; and it was widely believed that the fear Africans used to have of hospitals had 'diminished rapidly' largely because of 'the increase of non-European nurses …. The presence of a nurse of his own race by his sickbed must add considerably to a patient's confidence in his treatment and his ultimate cure.'[91]

The presence of a Black nurse at the sickbed of a Black patient must not be understood in a simplistic way. Black nurses had the unwritten responsibility to negotiate their culture into the hospital setting. Black patients would surely expect them to understand and to defend the traditional health-enhancing practices that they were conducting or bringing into the hospital to accelerate their own recovery or to supplement Western medicine. The nurses served as a bridge to bring Western culture into their culture for the sake of the mission establishment. Simultaneously, they served to bring their culture into the hospitals for the sake of their people. They tamed the hospital and claimed space for indigenous cultures. As we shall see in the next chapter, nurses were vital to the smooth running of the hospital as they not only helped with interpretation but they also communicated the complex worldviews of patients to the White leadership of the hospitals. They served as a two-way conduit in the hospital – a contested terrain of two cultures having to meet and accommodate each other.

Black nurses knew of the prohibitions regulating hospital territory. They also knew of taboos in their culture meant to protect patients from misfortune. Simply put, the Black nurses understood how Black patients made sense of their illnesses because they shared a common worldview. For example among the Zulus, an *isiphandla,*[92] an object meant to indicate a recent ancestral ceremony, may not be allowed into an operation theatre. Other things may be taboo and the hospital may not recognize them, for example impurities connected to menstruating, pregnant or breastfeeding women. Hospital regulations may have expected patients to do or to eat certain things for the restoration of health which their culture deemed unacceptable. Mbiti gave the following example regarding dietary regulations in his book *African Religions and Philosophy*:

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[91] Shula Marks, *Divided Sisterhood*. 1994, p.11.
[92] It is a skin strap cut from a fresh ritually slaughtered goat and worn around the wrist.

> Another regulation concerns food: expectant mothers are forbidden to eat certain foods, for fear that these foods would interfere with the health and safety of the mother or child, or would cause misfortune to either of them after birth. For example among the Akamba the expectant mother is forbidden to eat fat, beans and meat of animals killed with poisoned arrows, during the last three months of pregnancy.[93]

Mbiti's example comes from east Africa, but it resonates with the cultures of southern Africa. Only the presence of Black nurses who understood the cultures of the patients would be able to make the White nurses and doctors appreciate that the patients' fears and charms were located within a certain worldview. For these reasons, Black patients would feel less intimidated by the foreign surroundings of the hospital. Thanks to Black nurses, they would not run the risk of dying of a disease like tuberculosis that Western medicine could cure. The presence of Black nurses in mission and other hospitals in southern Africa helped to demystify biomedicine.

2.3.3. Tuberculosis and other Epidemics

Tuberculosis (TB) proved to be a very stubborn disease for traditional Tswana and Zulu medicine to cure successfully. Tuberculosis has been in South Africa and neighbouring countries since 1919 and reached epidemic levels in 1961.[94] When people suffered from this contagious disease, they were wise if they went to seek help from a practitioner of Western medicine. Despite available medication, tuberculosis continues to this day to be a problem facing many health centres. Rapid urbanization, with not much public education on sanitation and ventilation, made both black and white people vulnerable to TB. When urban people infected with TB visited their relatives in rural areas they spread it to the healthy. Evelyn Sommerfeld listed a few illnesses which brought patients to Emmaus Mission Hospital:

> The most prevalent one was TB because of people living in such close huts or even stone houses. They did not have enough air in their rooms

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[93] John S. Mbiti, *African Religions and Philosophy*, (2nd.Edition.) Heineman: London, 1969, p.108.
[94] Leabiloe Rampa-Molapo, "A cost-Effectiveness analysis of the Clinical Curative measure as an alternative to Tuberculosis's Management in the Pietermaritzburg-Msunduzi Council area." An Unpublished Master of Social Science Degree. University of Natal. 1999,p.7.

> and they live twenty or more in these houses. So diseases could spread easily. My impression was that TB was very prevalent and in children kwashiorkor and measles. Measles was a disease that white people brought into South Africa and therefore children did not have resistance and they had very, very bad complications. So we started then a programme of immunization. And the trouble was, they were always not on time. Measles, rubella….[95]

We have seen the examples of two traditional healers in Emmaus and Ramotswa who sent their TB-infected patients to the hospital, as they could not cure the disease with their medicine.[96] While the action was commendable, what we are learning is that Black patients were now being sent by their trusted healers to use Western medicine.

2.3.4. Medical Syncretism

One would assume that when Western medicine had been accepted, especially in the urban areas where there would be fewer traditional healers, Black people would make use of it exclusively in their quest for health and wholeness. That, however, was not the case because Black people in the urban areas were faced with fears and challenges that needed to be addressed and understood within the context of African worldviews. Advocating for the recognition of the value of other health-care systems, Robin Horton wrote from his experiences in West Africa. Like Africans who used both Western medicine and their traditional medicine, Horton does not believe that Western medicine is the only effective health-care system. He argued:

> The point I am trying to make here is that if life in modern industrial society contains sources of mental illness adequate or exacerbating a wide range of sickness, so too does life in traditional village communities. Hence the need to approach traditional religious theories of social causation of sickness with respect. Such respect and readiness to learn is, I suggest, particularly appropriate to what is commonly known as mental disease. I say this because the grand theories of Western psychiatry have a notoriously insecure empirical base and are probably culture-bound to a high degree.[97]

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[95]Evelyn Sommerfeld interviewed by Radikobo Ntsimane at Walsrode, Germany on 5 August 2002.
[96]Evelyn Sommerfeld interviewed by Radikobo Ntsimane at Walsrode, Germany on 5 August 2002. Dr. Ulrich Schmidt interviewed by Radikobo Ntsimane at Faeri Glen, Pretoria on 26 February 2002.
[97] Robin Horton, *Patterns of Thought in Africa and the West*. Cambridge University Press: New York, 1993, p.204.

What Western medical practitioners term mental disease, is generically termed by Africans to be man-made disease (*izifo zabantu* in Zulu and *mafu a batho* in Sotho) as Ashforth explained above. Human-made diseases logically require a health provider familiar with the worldview of the cultural milieu of the health seeker. In New Zealand the Maoris have also found it difficult to abandon their health care system and to replace it with Western medical care systems for the same reason. Maori diseases are treated by Maori *tohungas*, and other diseases are treated by *pakeha* (White or non-Maori) doctors as T. R. Lange explained:

> It is true that European medical techniques are now generally accepted —only this explains the great decline in mortality rates. The official claim—that "it may well be that as confidence in hospitals for maternity cases now approaches the European level of 99%, Maori confidence is hospital treatment of illnesses or injuries in general" will approach European level—is probably justifiable. But Maori medical traditions persist, partly as insurance. Differentiation is made between "pakeha" and "Maori" sicknesses; these are treated by doctors and tohungas respectively.[98]

Mine workers had to fortify themselves with *ditlhare*/*muthi* in order not to be afraid to work underground where a snake was supposed to dwell. Industrial workers had to have *muthi*[99] in which to bath themselves to generate *seriti/isithunzi,* in order to find favour with prospective employers, to be loved by co-workers and to be protected from malicious harm from enemies.

The main malice that black people may have to deal with is jealousy. Adam Ashforth writing about Soweto argued that sorcery is informed by jealousy. Competition and rivalry is rife in Soweto and one needs to have power in order to be able to survive sorcery. In a discussion with church-going neighbours about the fear of sorcery, Ashforth discovered that indeed sorcery is a highly feared malice from invisible sources. Irrespective of their social standing, educational level or Christian beliefs, most people harbour this fear for sorcery. They will not readily admit to being in the practice of reinforcing themselves against sorcerers' machinations because they know

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[98] R.T. Lange, "The Tohunga and the Government in the twentieth century" in *University of Auckland Historical Society Annual*. 1968, pp.12-38.

[99] *Umuthi* can also be used: to induce vomiting, (*ukuphalaza* in Zulu and *go kapa* in Tswana); to spread on some body parts; to carry on ones' person; to make incision especially on the body joints (*ukugcaba* in Zulu and *go phatsa* in Tswana); all for the purpose of generating good luck

syncretism is frowned upon in some circles, especially in the Churches. When Adam Ashforth asked a Soweto Christian woman whether or not she believed in the existence of sorcery, her first response was in the negative. Later, she related her experiences of sorcery.[100]

In an interview with Matron Evelyn Sommerfeld, I learnt how fear of jealousy from colleagues could retard progress and human development. Sommerfeld responded in an interview:

> What I wish to have changed that our Zulu, Xhosa, *S*otho nurses will be more able to take over more of the work that one did, take more responsibility. And that, as I said, I only got a little bit done with Sister Ndaba who I got to be my vice matron. It's very hard. She was not happy in this position because of other sisters who did not accept it that she was in this position. Because they told that she would tell me everything they said. That I could not make them understand how important it was for them to take over this post. It was for their own good and their own people. That was very important and I have a feeling I could not make them understand that. But I hope that as I saw later on it came to that taking over the responsibility and later generations … sort of…[101]

We observe two conflicting cultural dimensions emerging from the contact made between the two health systems. Black health seekers adopted a syncretistic approach while the Western health providers adopted a monolithic approach to health. As we have seen earlier, Dean Mthethwa insisted during the interview that the *amakholwa* did not hesitate to visit traditional healers under the cover of the night. It happened much against the instructions of the missionaries. Traditional health practitioners were just as open to learning and adapting methods and techniques from biomedical counterparts as their black patients were, as Digby wrote:

> Healers were more open-minded: some seeing the advantages of using pharmaceutical drugs, as well as a few individuals selectively assimilating the technological symbols of biomedical power in their use of stethoscope, thermometer, or syringe. African patients were

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[100] Adam Ashforth, *Witchcraft, Violence, and Democracy in South Africa.* Chicago: The University of Chicago Press, 2005, p.35.
[101] Evelyn Sommerfeld interviewed by Radikobo Ntsimane in her house at Walsrode, Germany on 05 August 2002.

> more eclectic in their choice of health care and patronised different kinds of practitioners according to their availability or perceived utility. Responding to new patterns of diseases, and a growing ability to recognise them, African patients took 'European' diseases to western doctors and 'African' diseases or conditions to healers.[102]

Doctors refused to acknowledge the fact that the indigenous people derived any help from traditional healers. To them, Western biomedicine was the ultimate help in times of sickness. This is an example of negative *ubuntu,* where individual initiative and ingenuity is not welcome in a group. This is in congruence with Robin Horton's observations of inconsistencies in West Africa: as in the case of nurses who take the opportunity to develop themselves through schooling and training but fear to go beyond their peers when chances come their way. Horton wrote:

> I am thinking here of fundamental inconsistencies in the values taught to members of traditional communities. Thus aggressive, thrusting ambition may be inculcated on one hand, and cautious reluctance to rise above one's neighbour on the other. Ruthless individuals may be inculcated on one hand, and acceptance of one's ascribed place in a lineage system on the other. Such inconsistencies are often sharp as those so well known in modern industrial societies.[103]

This is the shade of *ubuntu* which retards progress and development.[104] Oliver Ransford, not specifically writing for southern Africa, gave an analysis of this with no reference to *ubuntu per se:*

> The conformance to tradition arose from pervading fear of the spirits who were believed to frown on innovation: their unceasing influence bred mental discipline, fortitude, and self-denial, as well as lack of initiative or ambition. On the credit side it resulted in the Africans developing a strong sense of community. Of necessity so much of their time was spent in acquiring food or propitiating the ancestral spirits that little was left for intellectual pursuit. Few questions were asked, few doubts raised, and curiosity was discouraged by the tribal elders lest it challenged their authority. And so, because the inhabitants

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[102] Anne Digby, *Diversity and Division in Medicine: Health care in South Africa from 1800s*. Volume 5. Peter Lang: Oxford, 2006, p.33.
[103] Robin Horton, *Patterns of Thought in Africa and the West*. Cambridge University Press: New York, 1993, pp.204-205.
[104] For deeper discussion of various shades of *ubuntu* see Claudia Nolte-Schamm, **"**A Comparison between Christian and African Traditional Paradigms of Reconciliation and how they could Dialogue for the Benefit of South African Society**,"** Unpublished PhD Thesis, University of KwaZulu-Natal, 2006.

> of Old Africa sustained a culture of acceptance and encountered the minimum of novel experiences, the already conservative pressures of society tended to be perpetuated and made them highly resistant to change.[105]

Of course the other reason for the continuity of traditional medicine under medical syncretism is the one prevalent in many cultures where several health systems are tried in order to restore health. Syncretism in New Zealand among the Maori was also prevalent for the same reasons that it was practiced by Nguni-Sothos in southern Africa. Similar to the procedure followed by traditional Zulus when a family member is sick, R. T. Lange explained, in a sceptical tone, the Maori practice thus, "Even if a doctor was consulted early, the medicines were cast aside and the *tohunga* contacted if there was no immediate recovery, and in the few cases where the patient recovered, the *tohunga* got credited."[106] It is obvious that the Maori like the Nguni-Sothos, did not make sense of the thinking of the colonial government and of the Western missionary mentality, which expected them to discard what had power to heal. In their need for health restoration and power, they sought what was available and affordable. As mature people, they had to take charge of their own lives and choose any health system they deemed appropriate.

3. Chapter Summary

In the twentieth century, Whites who came from Europe to colonize and convert the people of southern Africa, had to abandon their stereotyped preconceptions of what black people were like. The colonists and missionaries acknowledged that the Black people were shrewd and were seeking to embrace Western education in order to enhance their knowledge but not at the expense of relinquishing their worldviews and epistemologies after conversion. The missionaries in the early 1900s began to acknowledge that the ancestor-related rituals mistaken as witchcraft were, in fact, not as undesirable as initially thought. As Wallace Mills observed, they realized that to

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[105] Oliver Ransford, *Bid the Sickness Cease: Disease in the History of Black Africa*. John Murray: London, 1983, pp.19-20.
[106] R. T. Lange, "The Tohunga and the Government in the Twentieth Century*" in University of Auckland Historical Annual*. 1968, pp.12-38.

antagonize *ilobolo* was to sow the seeds of divorce, as women were no longer going to be valued for lifelong relationships.[107] Among the Xhosa they desisted from speaking against *ukweluka* when they realized that young men would undergo the ritual no matter what. Due to the focus of the young men to even go against their parents who were ministers in the mission churches, Wallace wrote, "In any case, with regard to circumcision, missionaries were confronted by a stone wall."[108]

New approaches towards converting Blacks became imperative during the encounter of the two cultures. Without a change of approach, the missionaries' attempts would have been as futile as those of other missionaries who turned to trading after dismal failures to effect conversions. Black people resisted total conversion and took advantage of other benefits brought along by the White people from Europe. We have seen that the small numbers of converted people grew after the natural disasters ravaged crops and livestock of the indigenous people. The converted and educated Blacks, *amakholwa* and *batho-ba-thuto* became convinced of the benefits of a relationship with the mission and what it preached and taught. As a result they accepted Western medicine with ease.

Those who were not convinced of the benefits of Western medicine were forced to accept it when they sought employment in the mines and industrialized centres of southern Africa. The increased and visible presence of Black nurses in hospitals also made it easy for those who previously distrusted hospitals to use them. Diseases like tuberculosis and syphilis which traditional *sangomas* and *inyangas/dingaka* could not heal, led blacks to seek health-care in hospitals. Despite having adopted biomedicine, it has been seen that Blacks continued to seek the intervention of traditional medicine with which they were familiar, in treating man-made diseases.

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[107] Wallace Mills, "Missionaries, Xhosa Clergy and the Suppression of Traditional Customs", in H. Bredenkamp and R. Ross (eds.), *Missions and Christianity in South African History*. Witwatersrand University Press: Johannesburg, 1995, pp.156 -157.
[108] Ibid. p.165.

CHAPTER FIVE

THE FOUR MISSION HOSPITALS

1. Introduction

It has been mentioned repeatedly in this thesis that the introduction of biomedicine in southern Africa through dispensaries, clinics and hospitals was not without traces of domination over the indigenous people. The Western health providers were, at least in the beginning, composed of missionaries and colonists and the health seekers were mainly from the indigenous communities. Undoubtedly, missionaries wanted to facilitate a way for the indigenous people, especially the converts, to have an alternative health care system in their time of giving birth[1] and for other illnesses.

This chapter will show that the dispensaries and clinics developed into sophisticated institutions, initially from the efforts of lay medical missionaries, then from the efforts of nurses, and later from those of doctors. The chapter will also acknowledge the contributions of Black people in the development of the mission hospitals. In tracing the development of mission hospitals, I will show elements of racial discrimination at play, where Black people took a subservient position to missionaries in the hospital setting. Such racial differences were among the Lutheran missions' mirror of how White people and Black people related to each other in South African apartheid society.

Apart from this good intention, this chapter seeks to show that there were other intentions which were not as explicit. These intentions, as with those of the colonial powers of southern Africa during the early 1900s, aimed to discredit Africans' traditional health practices and to speed up Africans' conversion to Christianity and

[1] We shall see later that the four Lutheran mission hospitals in this chapter and other mission hospitals in southern Africa were established initially to mainly provide maternity services. See chapter two on this matter.

the adoption of Western ways of life. The intentions were a disguised manoeuvre for the missionaries to convert the Africans and for the colonists to subjugate them.[2] Those intentions were already prevalent in earlier centuries.

This chapter intends to trace motives of the missionaries towards the indigenous people by using biomedicine. The four hospitals will be investigated according to the following sub-headings: the events leading to the establishment of the mission hospitals; the challenges to the existence of the hospitals; and the government's intervention and take over of the mission hospitals.

2. Events Leading to the Establishment of the Hospitals

Mission hospitals were established in a very haphazard manner by zealous missionaries who received little or in some instances, no support at all from their sending mission societies. In his seminal book, Christoffer Grundmann devoted a large section to the reasons why mission hospitals were established. Although no direct reference to southern Africa, or to the period covered by this thesis is made, Grundmann made the following points. He mentioned the fact that medical mission was used as a mission strategy and method. In that case, science was used to propagate faith. He also pointed out that the establishment of mission hospitals was an act of charity. It was informed by Christian compassion for the needy. The need of the missionaries in the field for medical care was another reason advanced by Grundmann for the founding of mission hospitals. People of European origin did not readily adapt to the climatic conditions of Africa and elsewhere and needed professional health care if they were going to survive and propagate the gospel. Medical mission work was also founded on the doctrine of imitating Christ who went about healing the sick.[3]

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[2] Laidler and Gelfand, *South Africa: Its Medical History 1652-1898: A Medical and Social Study*. Struik: Cape Town, 1971, p. 295.
[3] Christoffer Grundmann, *Gesandt zu Heilen! Aufkommen und Entwicklung der Ärtzlichen Mission im neunzenten Jahrhundert*. Vol.26, Missionswissenschaftlichen Forschungen. Gütersloh: Gütersloher Verlagshaus Gerd Mohn, 1992, pp. 290-304.

Grundmann's work is very helpful in order for one to have a broad understanding of the background to the founding of medical missions and the establishment of hospitals. Other authors involved in medical missions have observed the shortcomings involved with the establishment of this form of health-care provision.

It is interesting to note the words of Friedrich Hopf, the most influential mission director of the Bleckmar Mission after the Second World War, confessing his society's lack of good organization of hospital work at its inception:

> The work in the hospital of our mission began without any specific programme and also without any orientation of what kind of knowledge had been gained elsewhere about the foundation and arrangement of this kind of work that was highly pressured by multiple bodily needs of black Christians and pagans that called us to help and heal.[4]

Hopf's confession is relevant not only to the Bleckmar Mission Society, but also to other Lutheran societies. The establishment of hospitals in the 1930s and later was not co-ordinated and in some cases, was rejected by the various societies. Though the hospitals were later adopted and supported by the mission societies with personnel and finances, their initiation was an uphill struggle on the side of the individual medical missionaries in the mission field.

2.1. Bamalete Lutheran Hospital

In the light of the above I want to argue that the mission societies had no formal and recorded intention to make healing a part of their mission to convert or to help Africans. At least that was the case before the Second World War. We do not however suggest that the Lutheran mission societies were not aware of the prevalence

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[4] Friedrick W. Hopf, "Zur Begründung unserer Hospitalarbeit", in *Lutherische Kirche Treibt Lutherische Mission: Festschrift zum 75 jährigen Jubiläum der Bleckmarer Mission 1892 – 14 Juni 1967*. Mission Evangelisch – Lutherischer Freikirchen: Bleckmar über Soltau. 1967, p.143. *Die Hospitalarbeit unserer Mission began ohne besonderes Programm und auch ohne Orientierung über die anderswo gewonnenen Erkenntnisse über Begründung und Gestaltung dieser Arbeit unter dem harten Druck der vielfachen Leibsnöte schwarzer Christen und Heiden, die zum Helfen und Heilen zwangen.*

of diseases like malaria, small pox and bilharzia which traditional indigenous healing could not cure. The Lutheran mission societies were also quite aware that some of their missionaries in the field had some sort of medical training and were dabbling in healing: for example Hans Schreuder of the Norwegian Mission Society (NMS), Christoph Schulenburg of the HMS—both of whom came to southern Africa in the nineteenth century. Besides, the Lutheran mission societies were aware of the medical activities of the London Missionary Society (LMS) among the Batswana, especially those of Dr. David Livingstone.[5]

Since the Lutheran mission societies did not directly support the medical institutions of their isolated missionaries until after World War One, it is necessary to investigate what influenced the individual missionaries to found health centres like dispensaries, clinics and hospitals. Although Christoph Schulenburg of the HMS dabbled in biomedicine both in northern Bechuanaland among the Bangwato, and in the south among the Balete, there is no evidence that he established a health centre. It is important to note though that the fact that Schulenburg practiced biomedicine among the Balete laid a strong foundation for the acceptance of Western medicine by the tribe, and later in 1932, for the establishment of a hospital in Harmshope (later referred to as Ramotswa in HMS reports).

In her book, *Heil und Heilung*, Schulte refers to these early LHM medical missionaries as *Laienmediziner*[6]—lay physicians. These lay-physicians undoubtedly sowed the seeds for the acceptance of Western medicine among the indigenous people with whom they came into contact with. It is logical to assume that if one patient has been cured of a certain illness by means of biomedicine, that their relatives in similar conditions would readily accept such medicine. It should be borne in mind though that these forerunners of biomedicine were not as competent in the profession as the medical missionaries who were trained after World War I. Reasons for that were that biomedicine was not as developed as it was in the post-World War I era and its practitioners were mainly preachers and not full-time doctors. I am not suggesting that

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[5] Helmut Lehmann, *150 Jahre Berliner Mission.* Evengelisch – Lutherischer Mission: Erlangen, 1974, pp.23&56.

[6] Fiona Schulte*, Heil und Heilung: Entwicklung und Beteutung der medizinischen Arbeit in der Hermannsburger Mission von 1849 bis 1945*. Hermannsburg: Verlag der Missionshandlung, University of Marburg published doctoral Dissertation. 1998, p.46.

there were no incompetent medical missionaries after World War One, but rather that the missionaries credited with the establishment of medical institutions had prior connection to medicine. That is why they ventured into the project. Unguided philanthropic drive alone would not have sustained the projects.

The HMS missionary Heinrich Pfitzinger, whose knowledge of medicine is not recorded in the available literature probably because it was non-existent, nevertheless had a sibling—Emma—whom he recruited from a house of the Neuenberg Lutheran congregation of the deaconesses in Ingwiller[7], Alsace, to begin a formal medical centre in Ramotswa village. Two reasons have been cited by different people as being responsible for the establishment of a proper hospital in Ramotswa:

i. A hospital in Ramotswa would elevate the importance and status of a small tribe of Balete among the Batswana tribes in Bechuanaland;[8]

ii. A hospital would frustrate the attempts Roman Catholic Church to gain a stronghold in Ramotswa.[9]

As was the case with some tribes that invited missionaries into their areas in order to benefit in both a religious and non-religious manner, the Balete *kgosi* invited the HMS to Pata Lecopa. For a tribe to widen its horizons, a missionary was invited to help in that area.[10] To have a hospital was a bonus for any tribe. While the Balete were a minor tribe in the Bechuanaland Protectorate, any missionary would need a stronger reason to establish a hospital than merely elevating a tribal status. Another reason for the establishment of the hospital was that the old school building of the tribe had been made available to the mission. The reason that the hospital was founded—as a result

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[7] In 1899 the Neuenberg Deaconesses, a congregation of the Lutheran Church of Alsace to which Emma Pfitzinger belonged, opened a house in Ingwiller in northern Alsace. The number of deaconesses went from forty-five in the first decade of the twentieth century to eighty in the mid-1950s. In 1933 Emma Pfitzinger left Ingwiller to found what is today the biggest hospital in Botswana. <http://www.ingwiller.com/PBCPPlayer.asp?ID=151528/> [Accessed 15 August 2012].

[8] Retired HMS Missionary Heinrich Voges's response to Radikobo Ntsimane in an impromptu interview held in Arcadia, Pretoria on February 2002.

[9] Missionary Fitschen's 1931 Report on the Harmshope Mission Station (Ramotswa) to the HMS headquarters in Germany, Folder A: SA Ausland Südafrika File II, Missionary E.Fitschen 1927-1931.

[10] The leader of the Transvaal Republic, Andries Pretorius, was approached by *Kgosi* Sechele of the Bakwena in Bechuanaland to invite a missionary when the London Missionary Society left Molepolole, the Kwena capital.

of the available space in the old tribal school—does not hold water because the school was only made available in the early 1960s when Dr. Ulrich Schmidt had already been recruited.

At that time Sister Emma Pfitzinger, the first nurse, had already left. No mention of a special illness in the village or of need for a doctor was made in the annual reports of the Harmshope's mission station from 1902 to 1922.[11] Missionary E. Fitschen (1927-1931) who took over the station after World War One also made no mention of any special disease or a need for a Western-trained nurse, in the first year of service. He nevertheless mentioned an outbreak of malaria in subsequent years, which led to many conversions. No specific numbers are provided. On Pentecost Sunday during a visitation of the Mission Director, Fitschen reported that many heathens and their children (*viele Heiden und Heidenkinder)* had been baptized.[12]

It is the 1931 report that first mentioned the need for a nurse. The reason given was to gain an upper hand over the Roman Catholic mission's endeavours in Ramotswa. The fear was that the Roman Catholics might lure away the already-converted Lutherans. Though the hospital that was established grew to be of great assistance to the Balete tribe and to the rest of Botswana, one of the reasons for its founding was to counter the Roman Catholic presence in Ramotswa. In the 1931 report of the mission station, Fitschen wrote, "More serious is the run of Catholicism. Rome is on its way forward … we could hear that through all preceding reports."[13]

Fitschen thought that the HMS could arrest the Catholic *Marsch* by procuring a nurse and establishing an industrial school.[14] He had discovered that the Roman Catholics wanted to frustrate any progress made by the Lutherans in Ramotswa by finding a

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[11] See reports in HMS Archives in Hermannsburg, Germany, especially those of Missionary H. Richert 1902-1913 and of Pastors Jakob Lebele and Israel Manope 1921/1922 in Folder A: SA Ausland Südafrika. File II.

[12] See HMS Archives in Hermannsburg, Germany. Folder A: SA Ausland Südafrika File II. Missionary E.Fitschen 1927 – 1931.

[13] Missionary Fitschen's 1931 report, *"Ernster ist derAmstrum des Katholizismus. Rom auf dem Marsch, d.i. bereits durch alle früheren Berichte hindurchgeklungen*". See HMS Archives in Hermannsburg, Germany. Folder A: SA Ausland Südafrika File II, Missionary E. Fitschen 1927-1931.

[14] *"Notwendigkeit einer Krankenschwester und eine Industrieschule*."1931 Report in the HMS Archives in Hermannsburg, Germany Folder A: SA Ausland Südafrika File II, Missionary E. Fitschen 1927-1931.

doctor for their mission station in the same village. He wrote in the same report, "Now the last attempt is to get settled through medical mission. Therefore, [the Roman Catholics] asked the government for permission to employ a doctor at their mission station."[15]

Fitschen's successor in Harmshope Mission Station was Heinrich Pfitzinger. In his 1932 report, Pfitzinger makes no mention of a need to counter the Roman Catholics in Ramotswa. Instead he mentions the village's need of medical help. The nearest doctor was thirty-four kilometres away and the nearest hospital fifty kilometres away. According to Pfitzinger, the problem was not only the distance but that the community did not have the means to pay for medical care. His solution to the problem was "a well educated nurse who would find a broad variety of work in this town."[16]

Pfitzinger adopted the same anti-Roman Catholic intentions as those of his predecessor. The tone of his language in the reports was unmistakably clear. He had established from a corrupt government official that Roman Catholics had "conspired" with the village *kgosi* to acquire a piece of land in order to build a *Medizinhaus* and a church. Since the annual report for a particular year was written at the beginning of the next year, the 1933 report by Pfitzinger mentions that a nurse (the name of Emma was not given at that stage) had arrived in Harmshope. The nurse's presence according to the Lutherans could help thwart all plans of the Roman Catholics to advance.[17]

These un-ecumenical reports should be understood in the context of the mindset prevailing among missionaries of the time as they did from a country where Lutherans and Catholics harboured animosity toward each other as a result of the Reformation.

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[15] Missionary Fitschen's 1931 report, *"Der letzte Versuch nun ist der, durch ärztliche Mission Fuss zu fassen. So baten sie die Regierung auf ihrer Missionstation einen Arzt anstellen zu dürfen"*. HMS Archives in Hermannsburg, Germany Folder A: SA Ausland Südafrika File II, Missionary E. Fitschen 1927 – 1931.

[16] Missionar Pfitzinger's 1932 Report stated, "*eine gut geschulte Krankenschwester, die allein in dieser Stadt ein grosse Arbeitfeld finden würde"*. See HMS Archives in Hermannsburg, Germany. Folder A: SA Ausland Südafrika File II, Missionary H. Pfitzinger 1932 – 1939.

[17] Missionar Pfitzinger's 1933 report stated," *konnten wir vielleicht den Katholiken das Wasser abgraben*." See HMS Archives in Hermannsburg, Germany. Folder A: SA Ausland Südafrika File II, Missionary H. Pfitzinger 1932 – 1939.

Pfitzinger came from Alsace, a fact that could have also been responsible for his anti-Roman Catholic tendencies. Protestants in Alsace had a dislike for Roman Catholics because during the time when Alsace was annexed by France, the king, Louis XIV, decreed that each Protestant church building should have a choir section that could be used for Roman Catholic Church services. Protestant and Roman Catholic unity was imposed in Alsace. The above was recorded by the famous Alsace medical missionary Albert Schweitzer:

> When Alsace became French under King Louis XIV, the French government intended to undermine the Protestants and decreed that in Protestant towns where there were at least seven Catholic families, a choir space should be provided for them. Every Sunday a church building should be made available to them at a specific time. It happened that a number of churches in Alsace became Protestant and Catholic at the same time.[18]

In consideration of the above I argue that the hospital in Ramotswa came about as a result of the anti-Catholic drive—at least on the side of the missionaries—rather than from philanthropic sentiments *per se*.

2.2. Untunjambili Mission Hospital

I interviewed three men connected to the Untunjambili mission station.[19] With regard to the founder they all responded that Untunjambili Mission Hospital was established by Lillian MaYangwe, the wife of the American Lutheran Mission missionary Karl Otte. The daughter of these two missionaries, Solveig Otte, begins the story of Untunjambili far earlier than when her mother began the dispensary in her attic.[20] Miss Solveig Otte explained that her great-grandfather Nils Astrup, who succeeded

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[18]Translated from an Afrikaans version of Albert Schweitzer's book, *Uit My Jong Dae*. Balkema: Cape Town, 1957, p.36: *Elsas onder Lodewyk XIV Frans word, het hy, om die Protestante to verneder, bepaal dat in die Protestante dorpe waar daar minstens sewe Katoliek gesinne woon, 'n koorgedeelte vir hulle ingeruim moes word. Elke Sondag moes die kerk op bepaalde tye vir hulle godsdiensoefening beskikbaar wees. So het did gebeur dat ,n antaal kerke in Elsas terselfdertyd Protestants en Katoliek is.*

[19] Mr. Eli Makhoba (19 July 2000), Mr. Sibusiso Xulu (22 July 2002) and Dean CN Mthethwa (19 November 2002).

[20] Solveig Otte interviewed by Radikobo Ntsimane in her home in Mayors Walk, Pietermaritzburg on 8 May 2007.

Hans Paladin Schreuder as the bishop of the Mankankanana Synod, came from Norway in 1883, sent by the Norwegian Mission Society. Whilst Nils Astrup worked in Untunjambili, he taught to his daughter homeopathy whilst he was practising it. Hannah was married to a former HMS missionary called Hienrich Otte and in 1897 they settled in KwaHlabisa in Zululand where they began a dispensary.[21] As was the case with Missionary Wilhelm Weber, who is credited as the forerunner of Itshelejuba Mission Hospital, Bishop Nils Astrup also introduced homeopathy, which probably led to the acceptance of biomedicine by the Zulu.

It is probable that homeopathy was in its elementary stages at that time but already spreading from Europe to other countries including South Africa, India and South America:

> During the nineteenth century Hahnemann's ideas spread quickly from Germany across Europe and then to the Americas, and also eastwards to Asia. Today homeopathy is well respected in some countries, notably in Britain, France, Germany, Netherlands, Greece, India (where it is recognized and supported by the state), South Africa and South America, but mistrusted in others.[22]

Homeopathy was introduced to South Africa in 1857 by Mr. Hugh Eaton, who trained in England.[23]This form of medicine grew and spread throughout the country, probably to areas where there was no biomedicine:

> In British Kaffraria it was in growing favour during the mid-eighteen sixties and at King Williams Town, Messrs. Bute and Co. obtained a regular supply of homeopathic medicines and medicine chests. By 1875, a homeopathic dispensary was established at No. 5 Church Street, Cape Town, under a committee which included the Rev. C. W. Stegman and Dr. C. W. Kitching.[24]

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[21] We shall see later when we discuss the work of the Lutheran Medical Foundation that KwaHlabisa was one of the mission hospitals taken over by the government.
[22] Andrew Lockie, *The Family Guide to Homeopathy: The Safe Form of Medicine for the Future*. Hamish Hamilton: London, 1989, p.12.
[23] Percy Laidler and Michael Gelfand, *South Africa: Its Medical History 1652-1898: A Medical and Social Study*. Struik: Cape Town, 1971, p.338.
[24] Ibid. pp.338 - 339.

As mentioned, the two missionaries, Wilhelm Weber and Nils Astrup, practiced homeopathy before biomedicine was widespread in South Africa. Although it is today used as an alternative form of medicine, one can see that in the beginning homeopathy was used as the sole health care system by missionaries and other enthusiasts, both for their own health and for that of others:

> The current use of homeopathy in many non-Western countries has occurred for many of the same reasons. With the low availability of physicians and the inability to pay for expensive drugs and technology, self-care with homeopathy has become a necessary and a valuable commodity for many families in developing countries.[25]

One can indeed argue that homeopathy served as a precursor to biomedicine and paved the way for the establishment of mission hospitals in southern Africa in the 1930s.

When Lillian Mary Young, a nurse from the American Lutheran Mission, married missionary Karl Otte of KwaHlabisa in 1930, she had to leave her nursing work at Entumeni. Karl, the son of Heinrich Otte, had just finished theological training in America and was sent to train evangelists at Untunjambili.[26] Since Lillian was trained and had opportunity to use her skills as a nurse, she saw the need and started a small clinic. Solveig Otte remembers how the hospital began:

> They started … my mother just started from a cellar. When she first came she was at Entumeni … Hlabisa and Entumeni before they married. And when she was married she just administered medicine from her home. At Untunjambili we had a big cellar down in a house that my great grandparents Astrup had built. They had built a cellar just like they have overseas. People came to the back door. And then my father was busy training the evangelists and then he moved…he built another evangelist school and this evangelist became the first part of the hospital. So she used to have medicine at the back door and then she would also go back and forth to the hospital.[27]

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[25] Wayne Jonas and Jeniffer Jacobs, *Healing with Homeopathy: The Complete Guide*. Warner Books: New York, 1996, p.36.
[26] Solveig Otte interviewed by Radikobo Ntsimane at her home in Mayors Walk, Pietermaritzburg on 8 May 2007.
[27] Solveig Otte interviewed by Radikobo Ntsimane at her home in Mayors Walk, Pietermaritzburg on 8 May 2007.

When asked why the American Lutheran Mission society established the Untunjambili hospital, Dean CN Mthethwa responded:

CM The medical work started in Untunjambili with a limited number of medicines which were brought by missionaries to cure ailments of school children who used to live in the mission [station]. When someone suffered from stomach pains, she would give you castor oil or soda to drink. That is how it went.
RN Bicarbonate of soda?
CM No, Epson Salt![28]

The nearest hospital to Untunjambili was in Pietermaritzburg and nearly one hundred kilometres away. When difficult cases were brought to MaYangwe, she would refer them to two medical practitioners who had different private practices in Kranskop, namely Dr. Grevel (the Welshman with copper teeth) and Dr. Thomas.[29]

Before the hospital became recognized and registered for financial support by the government, it experienced major financial challenges as we shall see later in the section on finances. What we can see from the above discussion is that Untunajmbili Mission Hospital came about mainly for three reasons: firstly the dedicated nurse Lillian Otte whose marriage to a missionary forbade her to earn a salary; secondly, the need for provision of medicines which grew steadily as the medicines became available; and thirdly the great distance from the nearest health.

2.3. Emmaus Mission Hospital

Missionaries Bernhard and Magdalene Schiele of the Berlin Mission Society (BMS) are credited with the establishment of the Emmaus Mission Hospital in 1947. However, the initiatives of Missionary Christian Schumann, who was the first to introduce biomedicine at Emmaus, should be noted. According to Lawrence Zikode in the booklet *A History of the Emmaus Mission,* Schumann introduced Western

[28] Dean CN Mthethwa interviewed by Radikobo Ntsimane in his home at KwaMbonambi near Empangeni on 19 November 2002.
[29] Solveig Otte interviewed by Radikobo Ntsimane at her home in Mayors Walk, Pietermaritzburg on 8 May 2007.

medicine through maternity cases. His attempts were initially torpedoed by men of the Amangwane tribe, who protested that the missionary was wasting money to pay a midwife since their wives knew what to do during labour. Through the help of the Women's League members, Schumann managed to convince the women of the community to use the services of Nurse Millicent Nukuna, who was employed by Schumann.[30]

It is not clear how much medical training if any, Schumann underwent. There is evidence though that Schumann was a very sick person, suffering from a hernia among other ailments. In a letter that the mission official Kark Axenfeld wrote to the German government, he arranged for Schumann to return to Germany from Lupembe in the then-Tanganyika for recuperation.[31] While in South Africa, Schumann also underwent a series of tests and had to face surgical operations. In his letter to the Mission Director he wrote that more tests were to be done on his stomach to establish the need for more operations.[32]

His wife was also suffering from serious nerve disease (*Nervenkrankheit*)[33] for a long time. In the letter of identification (Ausweis) that Mission Director Axelfeld of them BMS wrote to facilitate Schumann's trip, there was no mention of Schumann's medical training.[34]

It is interesting to note though, that before Schumann left Germany for South Africa, efforts were made to give him a supply of medicines and medical instruments.[35]

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[30] Lawrence Zikode, *A History of Emmaus Mission*. (Undated), p.15f.
[31] Axenfeld's letter to German Government dated 5 January 1914. Kept in the BMS Archives in Kreuzberg, Berlin in Germany. (ELAB BMW/1-8345).
[32] *Der Arzt meinte auch, ich würde enschieden in Durban noch einmal geröntgent werden müssen, damit die Ärzte sehen, wie mein Magen funktionere. Ich bin immer noch nicht ganz fertig mit der Operation*. BMS Archives in Kreuzberg, Berlin in Germany. (ELAB BMW/1-11226).
[33] Schumann's letter to Mission Inspector dated 17 February 1921. Kept in the BMS Archives in Kreuzberg, Berlin in Germany. (ELAB MBW/1-11226).
[34] Axelfeld's letter to German Government dated 2 August 1916. Kept in the BMS Archives in Kreuzberg, Berlin in Germany. (ELAB MBW/1-11226).
[35] In his letter to Schumann dated 8 October 1921 an acting treasurer (Stellvertr. Schatzmeister) writes, *"Wir werden Ihnen jedenfalls noch 7 Kisten nach Emmaus mitgeben, welche Instrumente für die dortige Ärztliche Mission enthalten."*. Kept in the BMS Archives in Kreuzberg, Berlin in Germany. (ELAB MBW/1-11226).

There is no mention of such instruments in Zikode's booklet.[36] One area of medical practice where Schumann was actively involved, besides getting the maternity service accepted in Emangwaneni village was tooth extraction. He wrote a letter of gratitude to the Mission Inspector for the tooth-extractor (*Zahnzang*) he received.[37] One cannot be sure if Schumann refers to his dentistry activities as service to the sick or if he had other medical work that might have been overlooked in the many reports from Emmaus. About his medical involvement he writes to the Mission Inspector on the year of his arrival: "Emmaus has a lot of work, for Christians and pagans; a huge amount of work is still waiting for me. I have been serving the sick for a long time and it is also a service that is slowly winning hearts.[38]

When Schumann writes that he had served the sick already for a long time, does he mean that he did so while in Tanganyika or after arriving in Emmaus? One cannot be sure since the words *schon lange*, already for a long time, do not specify a length of time. The quotation above suggests that Schumann believed that biomedicine could be of help in winning souls (*der langsam die Herzen gewinnt).* He was also convinced that biomedicine could be employed in countering witchcraft in the area and eradicating it from among Christians. Schumann expressed those convictions vividly during his last years, when he was advocating for the establishment of a hospital in Emmaus. He wrote to the Committee of the BMS:

> A hospital is operating in Emmaus that will grow better for the well-being of the natives, too, if an interested force entrusts it with reputation; even if the hospital is not directly connected to mission work. But indirectly, a hospital is the reservoir that could also be understood in a missionary way.[39]

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[36] In a letter to Schumann dated 10 March 1926, where an author is not stated, a second consignment of "*ärztliche Instrumente*" and tooth extractors for Schumann, is mentioned. Kept in the BMS Archives in Kreuzberg, Berlin in Germany. (ELAB MBW/1-11226).

[37] Schumann's letter to Inspector dated 14 December 1930. "*Br. Brügemann brachte mir als Gruss von Ihnen wunderschöne Zahnzang mit, die ich früher mal von Ihnen gewünscht hatte. Jezt habe ich meinen 2000ten Zahn hier auf Emmaus gezogen, jezt sind es 2002*." Kept in the BMS Archives in Kreuzberg, Berlin in Germany.

[38] Schumann's letter to Inspector dated 22 September 1922. *"Emmaus hat eine grosse Arbeit, an Christen und Heiden, es wartel meiner noch eine Reisenarbeit. Den Kranken diene ich schon lange und auch das ist ein Dienst, der langsam die Herzen gewinnt.* Kept in the BMS Archives in Kreuzberg, Berlin in Germany. (ELAB MBW/1-11226).

[39] Schumann's letter to BMS Committee dated 2 February 1936. *Ein Hospital ist auf Emmaus im Gange, das auch besser gedeihen wird zum Wohle der Eingeborenen, wenn eine dafür interessierte Kraft im ein ansehen gibt, wennauch das Hospital nicht direkt Missionarbeit tut. Indirekt aber ist ein*

The desire for a mission hospital in Emmaus came in response to the challenge posed by the newly-built township called Zakheni, in Ladysmith, where many sects, as Schumann called them, were practising their religion.

Schumann was neither the first nor the only missionary to be driven by long and life threatening sicknesses into the love of medicine. Albert Schweitzer[40] and the Schieles, who succeeded Schumann in Emmaus, also suffered sickness at some stage before becoming missionaries.[41] Missionary Bernhard and his wife Dr. Magdalene Schiele underwent medical training in Germany, and for Magdalene an additional training was undertaken in England, in preparation for the work in southern Africa. It is not exactly clear what exactly drove Dr. Schiele (born Tscheuschner) to study medicine. She had already started her medical studies before meeting Bernhard, although she had a brother who would later going to come to South Africa as a missionary.

The BMS encouraged Bernhard to take tropical diseases courses at the Deutsches Institut für ärztliche Mission (DIFÄM), in Tübingen. Like Schumann, he was not in good health, as noted by his father in a letter to Dr. Landgraff: "He says that my son's stomach is not totally okay, because of under nourishment during the war and post-war period, and also his nerves are not sound."[42]

After examining Bernhard, a Dr. Fritz Hirschberg of Berlin-Wilmersdorf wrote about his condition, "The stomach is chemically and physically okay, which means there are no reservations against South Africa because of the stomach."[43]

Hospital der Sammelpunkt, in dem man kann auch in missionarischer Hinsicht. Kept in the BMS Archives in Kreuzberg, Berlin in Germany. (ELAB MBW/1-11226).

[40] Albert Schweitzer. *Uit My Jong Dae.* Balkema: Cape Town, 1957, p.5.

[41] Those called to become *sangomas* invariably become very ill or face life-threatening circumstances before taking up the all. See Susan Schuster Campbell, *Called to Heal: Traditional Healing meets Modern Medicine in Southern Africa Today*. Zebra Press: Halfway House. 1998, pp. 120-25. Also see Mogomme Alpheus Masoga "Becoming *Ngaka*: Coming to terms with oral narrative discourses' in Jonathan Draper (ed.) *Orality, Literacy and Colonialism in Southern Africa*. Cluster Publications: Pietermaritzburg, 2003, pp.219-20.

[42] Letter to Dr. Landgraff dated 25 November 1926, author unknown. *Er meint, dass sein Sohn infolge Unternährung in der Kriegs-und Nachkriegszeit mit seinem Magen nicht ganz in Ordnung sei und dass auch seine Nerven nicht ganz taktfest sein.* Kept in the BMS Archives in Kreuzberg, Berlin in Germany. (ELAB MBW/1-11226).

[43] Dr. Fritz Hirschberg's medical certificate on B. Schiele dated 4 November 1926. *Chemisch sowie motorisch ist der Magen völlig in Ordnung, so dass von seiten des Magens keine Bedenken gegen Süd-Afrika bestehen.* Kept in the BMS Archives in Kreuzberg, Berlin in Germany. (ELAB BMW/1-9254)

Before her medical work intensified, while she was still in Rosenstein near Bergville, Dr. Schiele suffered a sickness that required her to take a holiday at the seaside.[44] To say that Dr. Schiele's suffering from this illness at an early age drove her to become a medical doctor, will be purely speculation at this stage.

Their training might have been partly responsible for their desire to do medical work at the Swaziland mission station, later known affectionately as KaShile in Mbabane. Since the focus is on Emmaus Mission Hospital, I shall not delve too much on KaShile Hospital that was established in 1930. I want to mention that the establishment of the KaShile Hospital was far from being driven by philanthropic sentiments alone. In his twelve pages letter to Mission Director D. Knak, Bernhard wrote (among other matters concerning his work in Swaziland) about his wife's medical mission. He mentioned the presence of a hospital in Mbabane charging £1-5-0, where Black patients were also welcome.[45]

The question is, why the Schieles insisted on starting medical work which their sending mission BMS could not support financially and in an area where a government hospital[46] was serving the population's medical needs? Leonora Schiele quotes Rev. J. Mndiniso, the first Lutheran minister in Swaziland, as having asked Bernhard Schiele for the hospital: "We need a hospital in Mbabane but it should be different from KaHaynd. Our people should be able to feel at home."[47] While Mndiniso's request might have touched the Schieles, the financial demands of a hospital, or even of an out-patients (*poliklinik*) project, as Bernhard suggested, militated against it. I am not sure why the Schieles thought that they could provide biomedicine in a manner that Dr. Haynd could not. Considering the unavailability of funds from the BMS to support the medical initiative and acknowledging the fact that the KaShile Hospital was going to be a duplication of resources, I am concluding that another factor for establishing KaShile Hospital was that Dr. Schiele did not wish to

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[44] Dr. A.L.Wilson's medical certificate on M. Schiele dated 22 September 1929. Kept in the BMS Archives in Kreuzberg, Berlin in Germany. (ELAB MBW/1-9255)
[45] *Ihre Arbeit würde dann in ihren freien Stunden Poliklinik sein.* Kept in the BMS Archives in Kreuzberg, Berlin in Germany. (ELAB BMW/1-9261).
[46] A four-page History of the KASHILE Hospital compiled and kept by Leonora Schiele states that, "The only existing hospital in the whole of Swaziland was in Manzini (then 'Bremersdorp'), was KaHaynd, the hospital of the Church of the Nazarene under Dr. Haynd.", p.1.
[47] Ibid.

remain idle while qualified to serve. Unlike in other cases, no mention is made of countering witchcraft or of civilizing indigenous people is made with regard to the Swaziland initiative. Was the purpose of the initiative for the provider to feel good, or was it meant to address the needs of health seekers?

Returning to the Emmaus Mission Hospital, we can deduce another thing that drove the Schieles to work tirelessly to do medical work in the mission station. The Schieles, who were Germans, were removed from Swaziland, a British Protectorate, and were subsequently resettled by the British; first in Rhodesia and then in Tanganyika.[48] The seven years that they spent in the internment camp in the then Rhodesia because of World War Two under very difficult conditions might have reinforced their motivation to do medical mission work. They might have felt that God had spared them for a special purpose. After their release in 1947, the Schieles devoted their time to parish work, the building of the hospital and constant communication with the home office of the BMS.[49]

2.4. Itshelejuba Mission Hospital

With regard to the establishment of the Itshelejuba Hospital, matters were different. Missionary Wilhelm Weber of the Bleckmar Mission grew up on a farm in the Piet Retief district. According to his son, Dr. Wilhelm Weber,[50] missionary Weber's first career choice was to become a medical doctor. That career was discouraged in the farming community, as a form of laziness. Finally Weber made up his mind and was accepted in a seminary into Bleckmar, after he had already passed the required age of entry.[51] In the already mentioned interview, Dr. Weber mentioned that his father continued to read medical books in order to keep his passion for medicine from dying

[48] Information regarding this period is contained in letters found in folder identified as B. Schiele, kept in the BMS Archives in Kreuzberg, Berlin in Germany. (ELAB BMW1, 10797).
[49] Schiele's letter dated14/7/1947 to his supporters in Germany after his release declared, "*Der Herr hat mir für diesen Dienst neue Freudigkeit geschenkt*." Kept in the BMS Archives in Kreuzberg, Berlin in Germany. (ELAB BMW1, 10797).
[50] Dr. Wilhelm Weber interviewed by Radikobo Ntsimane at Enhlanhleni Mission near Pomeroy on 5 May 2000.
[51] Wilhelm Weber, *Missionarleben unter den Zulu*. 1960.

out. The missionary Dr. Friedrich Dierks concurred that Missionary Weber had knowledge of *boere medisyne* before becoming a missionary.[52]

When Weber came to Itshelejuba for the first time, this is what he observed about the area, "There was no house, no tree, no fence, therefore nothing to begin with."[53] Dierks sums up the conditions which may have led Weber to establish a hospital, thus, "Itshelejuba is in an area that used to be remote and without any infrastructure. The big, pagan population had almost no opportunities to reach medical help."[54] People of Itshelejuba hardly had the possibility of obtaining medical help on time due to the underdevelopment of their village and its remoteness from the nearest medical doctor, who was stationed in Piet Retief.

Although Dierks was a strong proponent of using medical care for converting "heathens", he cited different reasons for the establishment of Itshelejuba. In the *Missionsblatt* article referred to above, he mentioned the needy condition of the community and the initiative of the missionary as driving forces that culminated in the establishment of Itshelejuba.[55] Weber, in his autobiography, mentioned the need for medical care among the community, especially the children, as well as the need to counter the traditional healing (*Zauberei*) prevalent in the area. He saw an opportunity to eradicate the fear of and belief in witchcraft from the sick. In his mission station's report published in *Missionsblatt,* he wrote, "Especially with the sick people one can work mostly against belief in the most, so they will loose their fear of magic".[56]

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[52] Friedrich Dierks interviewed by Radikobo Ntsimane in the Missionshaus, Bleckmar, Germany on 18 July 2002.
[53] Wilhelm Weber, *Missionarleben unter den Zulu*. Mission Evangelisch Lutherischer Freikirschen: Bleckmar über Solltau (Hannover) ,1960, p10. *Dort war kein Haus, kein Baum, kein Zaun, also gar nichts für den Anfang*.
[54] *Missionsblatt Evangelisch Lutherische Freikirche*, *Itshelejuba liegt in einem Gebiet, das früher abgelegen und verkerhsmössig wenig erchlassen war. Die grosse heidnissche Bevölkerung hatten kaum Möglichkeiten, ärztliche Hilfe zu erreichen*. Nr.1, Jan.1978, p.9.
[55] Ibid. "*Die Notlage der Bevölkerung um Itshelejuba und die Initiative des Missionars veranlasten unsere Mission, auf der Missionstation Itshelejuba die erste organisierte Kranarbeit unserer Mission zu beginnen*.''p.10.
[56] *Missionsblatt Evangelisch Lutherische Freikirche*, Nr.4, July 1950, p.5. *Grade bei den Kranken kann am meisten gegen den Zauberglaube gearbeitet werden, damit sie die Furcht vor der Zauberei verlien.*

A desire to counter traditional healing, or witch-doctoring as it was called, was not original. Many a missionary and colonial authority regarded traditional healing as an obstacle to conversion and civilization.

Although Weber introduced biomedicine in the Itshelejuba area, he did not personally involve himself in the use of medicine in curing diseases in the area. His efforts to acquire a deserted veterinary surgeon's cottage, to transport it, and to erect the first Itshelejuba mission hospital building, in addition to convincing a doctor from Piet Retief to regularly visit Itshelejuba, are noteworthy. The proper commencement of the medical institution was when the first nurse, Ruth Bauseneick, arrived in Itshelejuba in 1953 from Germany, six years after the first hospital structure was constructed.

We shall see in the following subsection that the growth and sustenance of the mission hospital was not an easy thing to do as there were many challenges and obstacles along the way. Issues of personnel, finances, and structural relationships between mission societies and hospitals, as well as among the various layers of workers within the hospital setting, were experienced at the various times at the various mission hospitals under the scope of this research.

3. Challenges to the Existence of the Hospitals

The stage of development at which one refers to a medical institution as a hospital, is unclear. For the sake of this thesis, a working definition shall therefore be devised. *The New Oxford Dictionary* defines a hospital as an institution "providing medical and surgical treatment and nursing care for the sick or injured people."[57] In the light of this definition can one then refer to two small huts with a qualified physician and a nurse, as was the case with KaShile, as a hospital? Is it over-rating a medical institution, to name it such, where there is only a bench and a table in a big building, and where a doctor visits once a week, as was the case in Itshelejuba in its early stages of development? Or does such an institution become a hospital after acquiring the services of a resident nurse? Previously, institutions that were only run by nurses

[57] *The New Oxford Dictionary of English*. 1998.

were called clinics. They could refer serious cases to a hospital, which had resident doctors and sophisticated instruments and facilities to admit patients. Today this distinction is not used because private hospitals, like Lesedi in Soweto are referred to as clinics, despite the fact that they admit patients and have sophisticated medical instruments.

Dr. F. Dierks refers to Itshelejuba before the arrival of Nurse Bauseneick as a 'medical centre'.[58] Zikode chose the term clinic for the work started by Schumann at Emmaus in 1930 where a Dr. Freested visited fortnightly from Weenen, and where staff-nurse Nukuna was serving as a midwife.[59] If a medical institution does not receive its grading from the qualification of its personnel, could it possibly receive it from the availability of its medical facilities, e.g. X-Ray and surgical services?

This small digression shows the difficulty of using the same term for institutions of different size or quality of service. Before the nationalization of most of the mission hospitals by the government, a registration and grading process was introduced.[60]

In this thesis, a hospital is defined as follows: an institution run by at least one trained nurse; having a resident or a visiting doctor, and having a number of beds to admit patients for observation and recuperation. This definition is in accord with the etymology of the word 'hospital' that is related to words like hospitality, hospice and hotel. The idea is that one is accepted and cared for in a home.

Let us look at how far these places of medical care provided the necessary service. At their inception these institutions faced many challenges as they were trying to heal diseases of the indigenous people. The challenges they faced included: the staffing of the hospitals, the financing of the hospitals; the resistance against hospitals; the resistance against by the local people; and the professional and legal hindrances to the establishment of hospitals.

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[58] "Itshelejuba, Place of help for Bantu People" in *Reports and Papers on Mission Hospital Work in South Africa*. 1972, p.1.
[59] Lawrence Zikode, *A History of the Emmaus Mission*. (Undated), p.15.
[60] The process will be elaborated upon when dealing with the section on the government's take over of mission hospitals.

3.1. Staffing the Hospitals

Working staff play an important role in the life of any given hospital. Without staff there would be no hospital. Bearing in mind that biomedicine as it is known today was still at an elementary stage of development even in Europe, trained nurses were scarce. Any medically trained person availing him or her to the mission would have either been highly motivated, or someone seeking adventure within the framework of mission work. Africa, especially southern Africa, was a romanticized world for Europeans. Although the name South Africa had been in use for three decades, most missionaries still referred to their mission field as Africa whenever they made reports during their furloughs and wrote articles in the newsletters. They still made slide shows that showed southern Africa as a land of wild animals, witchcraft and almost naked adults in animal skins. Missionaries were recruited mainly, or at least their calling affirmed, by listening to and reading reports of those who had already been in the field.[61]

Despite the fact that the First World War had taxed the European community emotionally and financially, especially Germany, the period after the war witnessed an unprecedented proliferation of missionaries to southern Africa. While the number of regular missionaries increased, their number cannot be compared to that of medical missionaries. Even before the First World War, Missionary Wilhelm Weber had requested the services of a nurse from Bleckmar Mission. The first nurse, Ruth Bauseneick, only came to Itshelejuba in 1953.[62]

The question is, what kind of people became medical missionaries, and why was an insufficient number of them coming to southern Africa. Undoubtedly conditions in southern Africa played a role in convincing prospective missionaries to devote their lives to the mission field. Dr. Dierks for example became a missionary because, for as long as he could remember, his clan had always been involved with missions. As

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[61] Dr. David Livinstone, the great adventurer heard Robert Moffat speak about his experiences in southern Africa. Also see Helmut Lehman's *150 Jahre Berlin Mission*. Evangelische – Lutherische Mission: Erlangen, 1974, p.82.

[62] Mission Director A.Blanke's' Berich über das Missionswerk der (ehemalige) Hannoverischen Ev. Luth. Freikirche Gegen am 14 Juni 1949 in Scharnebeck bei Lüneburg', *Bleckmarer Missionsblatt 1950-1933.*

the interview shows,[63] Dierks left his medical training to continue only with theological training following the request made by Mission Director Blanke that there was a shortage of missionaries in southern Africa.

Dr. Kurt Bergter, the first physician of Itshelejuba, had previously been a doctor for a private company workforce in India, before returning home to Germany to start a private practice. He became disillusioned with private practice because the people who sought his help were not really ill but over indulging. He took the first opportunity of going out into missions to help ill people.[64]

Nurse Emma Pfitzinger of the Alsatian Hospital in Ramotswa, was recruited by her missionary brother to join him in Bechuanaland. She belonged to a diaconical organization in Alsace. Dr. Ulrich Schmidt, who succeeded Pfitzinger as head of the hospital, came to the mission field through the influence of Missionary Dehnke of the HMS, who worked in Hebron near Pretoria. Dehnke was a lay medical missionary who used to invite medical students from the University of Pretoria to help in his out-patients practice.[65]

We have already seen how Dr. Magdalene Schiele and her husband became involved in medical mission. Their co-worker, both at KaShile Hospital and at Emmaus Mission Hospital, nurse Hilda Prozesky, was a daughter of HMS Missionary August Prozesky who received three months basic medical training in Germany,[66] before working as a missionary in Königsburg Mission station. Being raised in a mission station might have been of great influence to Hilda, as is often the case with the children of missionaries and pastors.

Though the reasons given above do not cover the whole spectrum of events leading medical missionaries into the mission field, they still show that not all candidates had

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[63] Friedrich Dierks interviewed by Radikobo Ntsimane in Missionshaus in Bleckmar, Germany on 18 July 2002.
[64] Dr. Kurt Bergter interviewed by Radikobo Ntsimane at Bad Öynhausen, Germany on 28 August 2002.
[65] Dr. Ulrich Schmidt (and his wife) interviewed by Radikobo Ntsimane at Faeri Glen in Pretoria on 26 February 2002.
[66] Oskar Prozesky, 'Biography of August Prozesky', an Unpublished PhD Dissertation at University of Natal, p.89. See also Lawrence Zikode, *A History of Emmaus Mission*. (Undated). p.18.

similar motivations. To leave the familiar Europe of the 1930s for the unfamiliar southern Africa was quite a big sacrifice on the part of the medical missionaries who came out to southern Africa at that time. Generally, it is more desirable to remain in a known and safe place than to venture into an unknown[67] and potentially dangerous place. Southern Africa was still infested with malaria, especially in and around the area of Swaziland and the then-eastern Transvaal. News of Africa being a white man's grave might have reached all potential missionaries at that time. Why then such great sacrifices?

Doctors from Germany, as it was the case with Magdalene Schiele, had to learn English (to be in a British colony) and a local language for effective communication with the local people. Besides language training the medical qualification expected of nurses from Germany coming to southern Africa was higher than that was required in Germany itself.[68] Since leading positions in hospitals were reserved for German nurses, they were forced to undertake training in South Africa before they could be recognized as matrons. In some cases, nurses from Germany who had never given orders to staff but who had only taken orders from doctors, had to take control of a clinic or hospital with a staff that was not only better qualified but also more experienced.[69]

This short comparison clearly shows that medical missionaries could have worked unhindered in Europe without having to upgrade their qualifications. Since the requirements for working in southern Africa were so stringent, one can conclude that at no period was there ever an abundance of qualified medical missionaries for any given mission society, even after the First World War.

Although medical missions preferred European staff, they had to train local personnel to fill vacancies created by the expansion of the work and the departure of some medical doctors and nurses to Europe. Preference for staff from Europe should be

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[67] It took the first Schieles more than a year before it was finally decided that they will work in Swaziland.
[68] Schiele's letters are saturated with the advice on the frustrations of registering nurses and upgrading of nurses' qualifications.
[69] Interview between Nurse Meyer (formerly Tiedemann) and Radikobo Ntsimane in her house in Germany on 4 September 2002.

understood in the context of exposure. Europeans were already exposed to hospitals and their operations. One needed such a type of exposure for an effective execution of duties. Besides, a hospital is a complex institution with sophisticated machinery that needs prior training before any attempt is made to operate it.

All hospitals started training locals as nurses and general workers in order that the work should progress.[70] Initially almost all staff was recruited from among the congregation members. In the 1950s, Ruth Bauseneick worked in Itshelejuba with members of staff who came from among the Lutheran church members.[71] In the 1960s before she could begin formal but private training for nurse aides, the wife of Dr. Ulrich Schmidt in Ramotswa worked with local young women as helpers – such as Magdalene Seabo.[72] Obvious reasons for recruiting from among church members were that the members already understood the missionary work ethic and shared the same faith. Although major mission hospitals like Victoria in the then-Cape Colony, and McCord in Natal had already begun training nurses at the beginning of the 1900s,[73] the drive for more Black nurses was intensified in the 1950s in many mission hospitals albeit at lower levels.[74] Later, when qualifications rather than religious convictions and loyalty determined suitability, salaries had to be increased to attract better qualified staff. The Lutheran mission hospitals recruited non-Lutheran nurses. For example, in the 1950s when the work overwhelmed nurse Bauseneick, Nester Dlamini was recruited from Swaziland to be the first qualified black nurse to work in Itshelejuba.[75] The increment of salaries directly challenged the financial status of both the institution and the mission society.[76]

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[70] Those responsible for training nurse-aids in basic nursing were Mrs. Schmidt at Bamalete Lutheran Hospital, Nurse Ruth Bauseneick at Itshelejuba Hospital and Dr. Schiele at Emmaus Mission Hospital.
[71] Ruth Bauseneick interviewed by Radikobo Ntsimane in Missionshaus Bleckmar, in Germany on 5 August 2002.
[72] Ulrich Schmidt interviewed by Radikobo Ntsimane in his home at Faeri Glen, Pretoria on 26 February 2002.
[73] Shula Marks, *Divided Sisterhood*. Witwatersrand University Press: Johannesburg, 1994, p.83.
[74] Shula Marks, *Divided Sisterhood.* 1994, p.98.
[75] Ruth Bauseneick interviewed by Radikobo Ntsimane in Missionshaus Bleckmar, in Germany on 5 August 2002.
[76] Missionary Bernhard Schiele requested that the Berlin Mission Society increase salaries. Letter of Schiele to Mission Director Julius Oelke dated 2 April 1956. (ELAB MBW/1-12556).

3.1.1. Nurses and Nursing

Here also we see disproportionate power relations among the hospital staff. Wherever there was colonialism, the colonisers were the powerful while the colonized were generally powerless. That was the reality in South Africa in the 1800s when the British dominated the blacks, the Afrikaners, the Coloureds and the Indians. Matters of power pervaded all the spheres of life in southern Africa and the mission hospitals were not an exception. The relationships between nurses and doctors and between nurses and nurses were influenced by power dynamics of race and class.[77] The mainly White doctors and White matrons were generally in charge of mission hospitals until in the early 1970s when mission hospitals were nationalized by the government. Because of the treatment the Black nurses received from the medical missionaries, they were reluctant to take up leadership positions in mission hospitals when such hospitals were later supposed to be under the leadership of Blacks.

3.1.1.1. Origins and Early Development

Before discussing power relationships and issues of authority among nurses and their work within the mission station, we will briefly look at the development of nursing in South African society. Although the period we are now looking at is the late 1800s, we acknowledge that nursing has been a practice of care giving to the sick and infirm from time immemorial. The quotation from Minnie Goodnow, cited by Charlotte Searle in her 1965 book, *The History of the Development of Nursing in South Africa 1652-1960*.: *A Socio-Historical Survey,* summed it up well:

> Nursing is one of the oldest arts. There has always been helplessness of one sort or another and to a greater or a lesser degree; wounds have demanded attention; babies and old people have needed care; and disease in some form—due to wilful or ignorant disregard of natural

[77] Although not specifically referring to mission hospitals, Shula Marks wrote about this matter in her book titled *Divided Sisterhood*. Witwatersrand University Press: Johannesburg, 1994, pp. 31-32.

> laws—has always been present in the world. The great universal mother instinct has met these emergencies by what we call nursing.[78]

Goodnow is correct, but only as far as nursing is a voluntary service out of compassion. What he neglected to mention was that nursing developed into a sophisticated profession beyond the borders of churches and nunneries.

A historian of medical missions, Helen Sweet, has sketched the history of the beginnings of nursing and nurse training in South Africa. Mentioning the early presence of missionary wives, colonial nurses in settler and military hospitals and the sisters of the religious orders, Sweet insists that it was only in the late nineteenth century that significant numbers of trained nurses arrived from Europe.[79] That was made possible by the fact that nursing was opening up as a career thereby attracting many to the Colonial Nursing Association, in England later known as Overseas Nursing Association in England founded in 1895.[80] The mission hospitals were largely understaffed as far as medical missionary nurses were concerned and began to receive nurses of varied qualifications from various European countries. Those nurses began training young Black women in the 1960s to staff the mission hospitals. Although both the religious sisterhoods and the settler professional nurses had compassion in common, they had one major difference. This was that the nurses from the religious sisterhoods were bound by vows to obey instructions from superiors, while the secular nurses were not bound in the same way. They still had homes and could discontinue their nursing whenever they desired, especially when facing difficult South African hard conditions and when they wanted to get married.[81]

In South Africa, both the religious and secular nurses came to serve in the mission hospitals and secular hospitals. Unlike in the period under review, the religious sisters who came to the Cape Colony in the 1800s worked in secular hospitals. Among the Roman Catholic nuns the following sisterhoods came to serve in South Africa: the

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[78] Minnie Goodnow, *Nursing History*. Philadelphia: Saunders. 1953, quoted in Charlotte Searle, *The History of the Development of Nursing in South Africa 1652-1960: A Socio-Historical Survey*. Struik: Cape Town, 1965, pp.4-5.
[79] Helen Sweet, "'Wanted: 16 nurses of the better educated type:' provision of nurses to South Africa in the late nineteenth and early twentieth centuries." in *Nursing Enquiry* 2004; Vol. 11 (3) pp.176- 184.
[80] Ibid.
[81] Ibid.

Assumption sisters in Grahamstown (1849); the Dominican sisters in King Williams Town and in Rhodesia (1877); and the Sisters of the Holy Family in the Johannesburg General Hospital until 1915.[82]

The Anglican sisters of the All Saints Sisterhood sent trained nurses to the Somerset Hospital in Cape Town in 1861. In 1874, the Order of St. Thomas the Martyr sent a sister who founded the Order of St. Michael and All Angles, which worked in Bloemfontein and Kimberley. There were other religious orders besides the ones mentioned, which came to serve in the secular environment than the ones mentioned.[83]

Having set the stage with the above background information, I shall now analyse the drama in which nurses were the main characters. This drama comprised of the challenges that the secular nurses faced in their work and how such challenges were diffused into the mission hospitals.

3.1.1.2. Pioneering Lutheran Missionary Nurses and their Protégés

In a critical analysis of institutional power one can do injustice to the part played by the people who were involved in the shaping of mission hospitals, if one neglects to mention their role. In a hospital, nurses, doctors and administrators can choose the direction they believe to be correct and push it to its realization, irrespective of the obvious possibilities of failure and disputes with co-workers. This happened often with those who pioneered mission hospitals and sacrificed much for their development.

The aim of this sub-section is to look at the first nurses who participated in the establishment of the four mission hospitals, namely: Bamalete Lutheran Hospital; Itshelejuba Mission Hospital; and Untunjambili Mission Hospital; and Emmaus Mission Hospital. By looking closely at the recruitment of the nurses, their degree of

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[82] J. M. Mellish, *A Basic History of Nursing*. Butterworth: Oxford, 1984, pp.89-90.
[83] Charlotte Searle, *The History of the Development of Nursing in South Africa 1652-1960*: *a Socio – Historical Survey*. Struik: Cape Town, 1965, pp.4-5.

dedication, and their contribution to the growth of the hospitals, we shall be able to understand how these hospitals developed in the manner they did until they were nationalized in the 1970s. One of the major challenges at the time included the language of communication with the indigenous people, as all the pioneer nurses were of European origin. Support of both of a financial and of personnel nature from sending Churches and mission societies was one thing that reports and letters mentioned often as lacking.

In the 1930s, when most mission hospitals were established, nursing was still at an elementary stage and far from its current state of development. Rules and regulations were not yet in place and it was important that nursing care was provided to those most in need. Let us now look at four particular medical mission nurses to establish their contribution in building up the four mission hospitals in this study. They were Emma Pfitzinger, Hilda Prozesky, Ruth Bauseneick and Lillian Otte.

3.1.1.2.1. Emma Pfitzinger

On Tuesday 23 January 1934, Sister Emma Pfitzinger arrived at the mission station of the Hermannsburg Mission Society called Harmshope in Ramotswa. She came from Alsace, where she was living with the sisters at the Neuenberg. She was recruited to work as the nurse in Ramotswa among the Balete tribe, where her brother Heinrich Pfitzinger was a missionary.[84] Sister Emma worked hard among the tribe delivering babies, visiting various homes to ensure good hygiene and writing reports, among others duties. Due to exhaustion, she went back to Germany in 1956.

3.1.1.2.2. Lillian Otte

The young Lillian Mary Young wanted very much to be a missionary, when she heard stories about China from friends whose parents had been missionaries there. Such

[84] Peter Schildknecht, "50 years Medical Services at Ramotswa" in an unpublished booklet commemorating the fiftieth anniversary of the Bamalate Lutheran Hospital, p.3.

dedication drove Lillian to work as a teacher to raise funds to pay her way through university in North Dakota and to finally qualify as a nurse. She left her parents' wheat farm to serve at Entumeni mission station, under the Norwegian Lutheran Church in America. This mission society came to work in South Africa at the invitation of the Mankankanana Mission of Hans Schreuder, that had severed ties with the Norwegian Mission Society. After their marriage in the early 1930s, Lillian and Karl Otte moved to Untunjambili in 1941 where Karl was to serve as a teacher of evangelists.

The move to Untunjambili was a blessing in disguise for MaYangwe[85] (as she was known by the Zulus), as she could once again take up her work as a nurse once again. The rule of her mission society, of not employing the wife of their missionary, had caused Lillian to be dormant for a while.[86] In Untunjambili she began to practice her profession and to help the mission station and the surrounding local communities. When asked who founded the Untunjambili Hospital, one of the business people in the area, Mr. Bhekumusa Xulu responded:

> MaYangwe was already a nurse when she married into the Ottes family from America. She found that there was no hospital in this area but the congregation needed one. Since she was a loving person she visited people in their homes with her husband and helped people. She was not employed anywhere so she helped in the delivery of babies. She then got in touch with overseas people who gave her medicines and pills to use at home to help school children and the community in Untunjambili.[87]

MaYangwe was so dedicated to her work that she refused to acknowledge that it was dangerous to her health. Very often she was begged by her family to rest, by spending time with her children. Her daughter, Ms. Solveig Otte, remembers how her mother used to work:

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[85] When asked why Lillian Otte was called MaYangwe, Mr Elli Makhoba explained that the people loved her so much that they accepted her and treated her as one of them. They called her by her maiden surname Young.

[86] Mr. Bhekumusa Xulu interviewed by Radikobo Ntsimane on 22 July 2000 and Ms. Solveig Otte interviewed by Radikobo Ntsimane on 8 May 2007.

[87] Mr. Bhekumusa Xulu interviewed by Radikobo Ntsimane at Untunjambili on 22 July 2000.

> And I remember my mother was at one time … she had not slept properly for twelve nights and she said to me as a little girl, "You know I might die one of these days. I … I just … and I remember feeling very angry because I thought how she dared leave me behind. But she was so exhausted because she was cut out often…at some point she had to stay up with people who were dying or with urgent cases and waiting for deliveries. And she was so exhausted and my father would try to get her to come in the car with him when we went to boarding school in Hermannsburg. Just to get her to have a rest. And he tried…they tried weekends when we were home on holiday. He tried and said to my mother, "Try to be with the family and children as much as you possibly can." But she was … she was a very, very hard worker. She was there [clicking fingers] at the moment's call. And she had the love for the people.[88]

With all the pioneering nurses, we see a selfless dedication to the work of bringing health to the tribes among whom they served. Why such sacrifices to even neglect themselves to the levels of exhaustion and ill health as was the case with Emma Pfitzinger and Hilda Prozesky?

3.1.1.2.3. Hilda Prozesky

According to Rev. Leonora Schiele, a retired Lutheran minister from Mbabane, Swaziland, there was so much work in the newly-established KaShile Hospital that the missionary Doctor Magdalene Schiele could not cope without assistance. Rev. Leonora Schiele wrote in a four-page typed history of KaShile Hospital, "The arrival of Sister Hilda Prozesky at the end of March 1931 was therefore highly appreciated."[89] Sister Hilda came from a family that had long connections with the BMS in Natal, South Africa. In an informal and brief discussion with Sister Hilda's godson, Professor Martin Prozesky, it became clear that Hilda Prozesky was the daughter and a grand-daughter of a missionary who worked for many years at Konigsburg mission near Ladysmith.[90] When the Schieles were preparing to work in

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[88] Solveig Otte interviewed by Radikobo Ntsimane in her home at Mayors Walk, Pietermaritzburg on 8 May 2007.

[89] The original document is kept by the author in loose pages. It is likely that this document was prepared to be read in a celebration and not for publication. It is a narrative without criticality at all.

[90] See Oskar Prozesky, "The Life, Work and Influence of Johannes Julius August Prozesky (840-1915) Missionary of the Berlin Missionary Society in South Africa." PhD Dissertation at the University of Natal. 1995.

Mbabane, Missionary Bernhard had already identified Hilda as a nurse who could help run the coming KaShile Hospital.[91] Hilda's salary while working in Swaziland was to be paid by the Women's Mission Union (Frauenmission Bund).[92] Among the duties she was to perform in KaShile, were helping to treat the sick (*Krankenbehandlung*), visiting the sick (*Krankenbesuchen*) among women and children (*unter Frauen und Mädchen*) and direct mission work.[93]

When the Schieles were interned in British concentration camps in Southern Rhodesia and later in Tanganyika (present Tanzania), Hilda was spared. The reason was probably that she was a South African. In a letter to Director Knak, Bernhard Schiele wrote that Hilda was working in the Dundee Mission Hospital of the Swedish Mission Society.[94]

Unlike Ruth Bauseneick about whom we shall hear later, Hilda Prozesky had not any experience of running a hospital on her own. She was not a pioneer in the sense that Bauseneick and Pfitzinger were. That does no, however, diminish her importance in the establishment of the Emmaus Hospital, where she later worked with the Schieles after World War Two.[95]

Hilda Prozesky was a sickly person who often needed medical attention: in 1951 she underwent rehabilitation by taking pills for an unidentified illness[96] and took six months of furlough in 1954.[97] In 1955, Schiele wrote to the Swazikreis, which was

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[91] Letter of Bernhard Schiele to BMS Director dated 2 March 1930. Kept in the BMS Archives in Kreuzberg, Berlin in Germany. (ELAB MBW/1-9259).
[92] Letter of B. Schiele to BMS Director dated 24 January 1931. Kept in the BMS Archives in Kreuzberg, Berlin in Germany. (ELAB MBW/1-9259).
[93] Ibid.
[94] Letter of B. Schiele to Director Knak dated 13 November 1942. Kept in the BMS Archives in Kreuzburg, Berlin in Germany. The Swedish Mission Hospital in Dundee was called Bethania. (ELAB MBW/1-8996).
[95] In a letter dated 23 February 1949, an unidentified person from the BMS Directorate sent greetings to Hilda in Emmaus. B. Schiele in a report to Friends dated June 1950, wrote that Hilda works in the out-patients (Poliklinik) and in the hospital (Krankenhaus) in Emmaus. Kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-9262).
[96] Letter of B. Schiele to Gerhard Brennecke dated 2 May 1951. Kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-10797).
[97] Letter of B. Schiele to Oelke dated 25 January 1954 mentions that Maria-Paula Schiele who had just completed General Nursing Course in Pietermaritzburg and Training in Bloemfontein was to stand in for Nurse Hilda Prozesky. Kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-11306).

often referred to as Friends in correspondence, that Hilda was hospitalized in Bethanien Hospital in Germany. In 1961 she had to go to Pretoria to consult with a specialist for phlebitis.[98]

3.1.1.2.4. Ruth Bauseneick

n 1951, Missionary Superintendent Christoph Johaness of the Mission of the Evangelical Lutheran Free Churches (MELFC) wrote to his mission superiors in Germany that there was an urgent need for a nurse (*Dringend eine Schwester gesucht*) in a new hospital in South Africa.[99] That hospital was Itshelejuba, which Missionary Wilhelm Weber had built some years earlier.[100] The Mission Inspector, Adolf Blanke, sent out Sister Ruth Bauseneick soon after she finished fifteen months training in Harmburg. She was sent out on Epiphany Sunday from her home congregation of Gistenbeck. She spoke of her congregation as very mission-oriented: it had produced five pastors, four of whom were missionaries in South Africa.

Sister Ruth was born in Dannberg, Köln, on 22 July 1923. She trained as a nurse, and although she was addressed as *Schwester* (Sister in German), she was not qualified to the level of nursing sister according to South African standards. This point will be clearer later in this chapter, when Sister Ruth needed further training. She did a one-year course at Henriettenstift before the training. As with many German medical missionaries, Sister Ruth also spent some time in the German Institute for Medical Mission in Harmburg. This institute served as a support base and a preparation station for Germans who were going out into the mission field. We shall note later that this institute also provided hospital equipment and money to mission hospitals in southern Africa.

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[98] Letter of B. Schiele to Johannes Althausen dated 19 August 1961. Kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-9152).
[99] Report 8-9 May 1951 in Missionsauschluss in Bleckmar (Missionhaus), Germany. In 2002, the MELFC archive needed proper filing and cataloging.
[100]Dr. Wilhelm Weber interviewed by Radikobo Ntsimane at Enhlanhleni near Pomeroy, KwaZulu-Natal on 8 May 2000.

Like Sister Emma Pfitzinger who worked in Ramotswa, Bechuanaland, Sister Ruth started the Itshelejuba Mission Hospital from the foundation. Sister Ruth understood her call to Itshelejuba as a call for service. She walked in the surrounding areas of the hospital attending to maternity cases, accidents and others. She tended the Sick who came to the hospital from various places. She had to be available when Doctor Ferreira from Piet Retief came for regular visits. Since she also responded to night calls to attend to the sick, Sister Ruth became exhausted. Remembering one of her difficult days, when she complained to Dr. Ferreira on one of his visits, she said:

> I said, 'Dr. Ferreira, I can no longer manage. I have to work day and night time. And to go up the mountains, people call me.' And he clicked his fingers like that saying: "No one has ever died from work.[101]

This is how Titus Dlamini, a local chief, remembered the indefatigable Sister Ruth:

> She had no transport, she used to walk. Even if you go to her at night, she would take a torch and go with you to that person who is sick, no matter how far. With her bags, she would give injections and pills and everything, eh that *inyanga.* Even now we still we wish for her. That is an *inyanga*, we still cry for her. She worked very hard. She would go through all these mountains where there were houses; she would arrive up there by foot. If you come to her at night she would ask where you lived and go there. Everybody knew her because of her help. She had no time to sit down. If there was a sick person who became well, people would ask what happened and they would be told that the Sister came. People would be amazed to see the person recovered and well. That was an *inyanga*![102]

Sister Ruth's dedication went beyond the call of duty. She used part of her £5.00 monthly salary to purchase medicine for the hospital and supported ten adopted orphaned and abandoned children from around Itshelejuba.[103] When she could not come back to South Africa to take up a position of matron, for which she went to train in 1968 in Germany, Sister Ruth fostered ten German children. The "Africanization" process of staff, which Dr. Kurt Bergter[104]had to implement on arrival in Itshelejuba

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[101] Ruth Bauseneick interviewed by Radikobo Ntsimane at Bleckmar, Germany, on 5August 2002.
[102] Titus Dlamini interviewed by Radikobo Ntsimane at Itshelejuba on 6 July 2000.
[103] Ruth Bauseneick interviewed by Radikobo Ntsimane at Bleckmar, Germany on 5August 2002.
[104] Kurt Bergter interviewed by Radikobo Ntsimane at Bad Öynhausen, Germany on 28 August 2002.

excluded Sister Ruth who felt that her duty there was far from over. Except for a few visits, Sister Ruth only came back to South Africa to work for about two years in another former medical institution of MELCF, called Dirkiesdorp, situated between Piet Retief and Wakkerstroom. A very devout woman, Sister Ruth said that whenever someone came to thank her for their recovery of health, she would tell them, "Not I, the Lord!"[105]

3.1.1.3. Class and Race in the Nursing Profession

Although the problem in Europe was not as acute as it manifested itself in South Africa, there were opposing classes in the nursing profession in South Africa.

The many wars fought between the British and the indigenous people, between the Boers and the indigenous people and between the Boers and the British, resulted in a great need for the nursing of those especially among the Europeans, who became casualties.[106] As in war situations anywhere during that period, diseases like typhoid, dysentery, measles and pneumonia caused thousands of soldiers to be hospitalised.[107] Nursing and medical care was also needed for women and children in the concentration camps that came about as a result of the South African war. Due to their feeling of racial superiority and their class mentality, it was not easy for the British nurses to nurse their enemies back to health. Young Afrikaner young women had to be recruited into nursing in order to work among their own people. In the early 1900s, Blacks also had to be recruited into the profession to help their own people.
In the light of this, one can conclude that there was tension between the British nurses and the local population. A great need of health provision around them demanded a closer relationship with other races in the colony but they were reluctant to integrate. There was a tension between the call to help others without prejudice and the need to preserve one's racial identity while performing professional duties. It was a tug-of-war between religious convictions and professional compassion on the one hand and

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[105] Ruth Bauseneick interviewed by Radikobo Ntsimane in Bleckmar, Germany on 05August 2002.
[106] Helen Sweet, " 'Wanted: 16 nurses of the better educated type:' provision of nurses to South Africa in the late nineteenth and early twentieth centuries." in *Nursing Enquiry* 2004; Vol. 11 (3) pp.176- 184.
[107] J.M. Mellish, *A Basic History of Nursing*. Butterworth: Oxford, 1984, p.93.

the quest for self-preservation as a superior race on the other hand. As we shall see it was indeed difficult to decide how much other could races be allowed into the secular nursing profession which had hitherto been monopolised by the British nurses. With regard to Whites monopolising the nursing profession in the 1930s, Grace Mashaba, a professor of Nursing Science at the University of Zululand wrote:

> The qualified black nurses found it extremely difficult, if not impossible, to find employment. They faced societal rejection on the one hand and antagonism from their white colleagues on the other, especially as the latter did not like to have black nurses associate with them in hospital work. The white nurses were also not keen to be relieved of their duty of nursing black male patients, who provided good clinical experience.[108]

The recruitment of nurse probationers from other races posed major difficulties for the authorities. As far as young Afrikaner women were concerned, English as a medium of instruction in training was quite a hurdle to jump. For Blacks, a plethora of hurdles manifested themselves when recruiting was initiated. Since the four hospitals under review were exclusively for Blacks, I shall devote more time to the blacks versus English tension than to the Afrikaners-versus-English one. I have used Afrikaners to show how nursing as a profession could not be easily disentangled from racial and class mentality.[109]

3.1.1.4. The Black Nurses Join the Ranks

Charlotte Searle mentioned a number of reasons that impeded speedy ascent of young black women into the nursing profession:

> Tribal prejudices, a lack of sufficient secondary facilities, the poverty of the people, a tendency of Bantu parents to give preference to their male children in secondary school opportunities, early marriage of young women, the *lobola* system, a drive by the Cape educational authorities to absorb Bantu women with secondary education or higher primary education into teacher training schemes, and use Bantu

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[108] T.G. Mashaba, *Rising to the Challenge of Change: A History of Black Nursing in South Africa*. Juta & Co, Ltd. : Kenwyn, 1995, p.16.
[109] Shula Marks, *Divided Sisterhood*. Witwatersrand University Press: Johannesburg, 1994, pp.66-77.

> hospital beds in urban areas for the training of White nurses had all tended to retard the training of Bantu women as professional nurses.[110]

Earlier the mission hospitals trained young Christian women as assistants. They were only required to know the basics of nursing in the early 1900s. The White mission hospital nurses, especially Lutherans, were also not sufficiently trained to provide sophisticated training for professional nursing.[111] These nurses from Europe found ways to train Black young women in less regulated ways to do basic nursing work.

Since the mission hospitals did not have the capacity to train their own candidates to the desired level, they initially depended in the beginning on secular hospitals like Victoria Hospital in Lovedale, and McCord Zulu Hospital in Durban. Despite the high standard set for the nursing examination, Cecilia Makiwane managed to qualify and became the first Black woman in South Africa to be registered in 1908. She trained at Lovedale. McCord Zulu Hospital, which recruited mainly from the Inanda Seminary, only it's first received its qualified candidate in 1924. According to Mellish, the number of qualified Black candidates in South Africa only increased after the Second World War.[112]

Before the phenomenal increase of these qualified probationers, the government had already taken upon itself to subsidise the training of Black nurses. The Native Affairs Department decided to subsidize mission hospitals in training Black probationers from 1930 to 1931, increasing the number of facilities training nurses to forty-nine in Natal.[113] These were not major facilities. Although their contribution to producing the needed Black nurses cannot be regarded as insignificant, they mainly trained nurses at a lower level than that of both the McCord Zulu Hospital and the Victoria Hospital.[114] This was achieved despite a long struggle between those who were for and those who were against it. There were two reasons for refusing Blacks the same level of training

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[110] Charlotte Searle, *The History of the Development of Nursing in South Africa 1652-1960.* 1965, p.268.
[111] Emma Pfitzinger of Harmshope, Lillian Otte of Untunjambili and Hilda Prozesky of Emmaus to mention a few.
[112] J.M. Mellish, *A Basic History of Nursing*. Butterworth: Oxford, 1984, p.96.
[113] Shula Marks, *Divided Sisterhood*. Witwatersrand University Press: Johannesburg, 1994, pp.88-89.
[114]. Shula Marks discusses this at length in Chapter 4 of her 1994 already-mentioned book, *Divided Sisterhood*.

as Whites: Blacks would take the white nurses positions of authority in the hospitals, and they would have to be on the same salary scale as White nurses.[115]

In the 1940s, the hospitals followed a pyramid-like hierarchical structure, with levels of authority in a top to bottom fashion. The many Blacks doing menial jobs like scrubbing floors and washing laundry occupied the lowest bigger level. The Black nurses were just below the White nurses while the (White) doctors were on the top level.[116] There was co-existence for as long as the hierarchy remained undisturbed. It is clear that Blacks had to shape up or ship out. They had to behave like white young White ladies in order to fit into the mould.[117] White nurses gave orders, army style, and the insufficiently trained Black nurses and orderlies followed them.[118] They had to remain in the periphery while Whites controlled the centre. This structure, originally disguised as created along the lines of training and knowledge, crumbled down when blacks acquired the same level of training and knowledge. The acquisition of knowledge gave them power.

The professional nurses that qualified at the secular hospitals were employed in the State hospitals, in the mines, and in the mission hospitals. Examples of these nurses were Millicent Nukuna who worked at Emmaus Hospital and Mathilda Lekgetho, who first worked in the mines before working at a Lutheran hospital in Botshabelo near Lichtenburg.[119] Statistics of the number of nurses trained and registered are not available. What is more important is to see the contribution that the newly trained women made in the healing profession.

3.2. The Introduction of Doctors in Hospitals

I argue in this sub-section that the introduction of biomedicine through hospitals in southern Africa was not a purely philanthropic exercise. We have seen how

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[115] Shula Marks, *Divided Sisterhood*. 1994, pp. 134-137.
[116] Shula Marks, *Divided Sisterhood*. 1994, pp.59-60. White nurses objected to taking orders from a black Dr. Molema in Mafikeng.
[117] Ibid. p.103.
[118] Ibid. p.102.
[119] Dr. Friedrich Dierks interviewed by Radikobo Ntsimane at Bleckmar, Germany, on 18 July 2002.

biomedicine was introduced gradually in the 1800s through dispensaries at mission stations, and through lay doctors whose practice can hardly fit the description of a medical doctor today. From the itinerant lay doctors we moved to nurses who were responsible for the clinics and hospitals to the sophisticated professional nurses discussed in the last sub-section. All health workers possessed immense power through their knowledge and ability to use medicine in curing various diseases. The health seekers who depended on that knowledge had to subject themselves to the power of the health workers. The introduction of doctors to mission hospitals ran along the same lines of the inextricability of power from knowledge.

In order to show how the coming of doctors in mission hospitals influenced fundamental changes in health care discourse, I am going to look very briefly at: how and where they were trained; how and why they were recruited; and finally, how their presence changed the identity of the mission hospitals.

3.2.1. The Training of the Mission Doctors

The doctors who made a major impact on three out of the four hospitals under review did not begin their medical training with the intention of becoming medical missionaries. Magdalene Schiele of the Berlin Mission Station happened to fall in love and married Benhard, a seminarian designated for the mission field. Ulrich Schmid of the Hermannsburg Mission, while studying medicine at Pretoria University, had contacts with missionary Dehnke of nearby Hebron, but ended up being called from the then South West Africa. Bergter of the Mission of Evangelical Free Churches on the other hand, came to the mission field having already returned to Germany after working for years for a private company operating in India. The Norwegian Mission Society did not send a doctor to Untunjambili until the late 1970s. Since there was no special training institution for them, the mission doctors received the same training as ordinary doctors. In light of the previous paragraph, the mission doctors often chose to go into the mission field after or during their training. However, in preparation for the work in Africa some mission doctors together with

other doctors had to undergo post-graduate studies in tropical medicine at the Deutsches Institut für ärztliche Mission in Tübingen.

Earlier, in Chapter Three I have shown that the Western concepts of healing differed from the indigenous and the Zionist ones.[120] In the 1930s, which was around the time when mission hospitals were established in Southern Africa, training for doctors had advanced tremendously.

With the discovery of penicillin and other drugs in the 1930s, medical science regarded itself as a discipline which existed to solve the problems that the people brought. Often when one goes in for a consultation, one hears doctors asking, "What is the problem today?" The unmentioned intention of the doctor and the unmentioned expectation of the patient is that whatever your problem is, the doctor can solve. This sort of training and mentality, according to Ian Kennedy in *The Unmasking of Medicine*, is problematic in the sense that doctors start to look for problems efficiently, and "the more they find and the more problem-solvers we need."[121] I want to agree with Kennedy that doctors are trained to see themselves as problem-solvers. Unlike diviners, doctors do not care about looking for social and spiritual causes of problems but based on their knowledge they seek the proper medication to deal with the specific illnesses presented to them. Doctors' training made them special in the sense that people depended on them as problem-solvers, even on matters unrelated to medicine. On his return to Germany, Bergter, in an interview said that he was frustrated by the German people who indulged in food and drink and then came to him for help.[122] He was unaware that his training made him to be perceived and used by the people as a problem-solver. Obviously, doctors' methods of solving problems would need the technology they were exposed to in academic hospitals during their training.

Besides the problem-solver mentality, doctors in general and medical doctors in particular possess training that gives them power over the hospital staff and the

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[120] They tried to heal the whole being in relation to his/her social relations.
[121] Ian Kennedy, *The Unmasking of Medicin*e. Allen & Unwin: Sydney, 1981, pp. 29-31.
[122] Dr. Kurt Bergter interviewed by Radikobo Ntsimane at Bad Öynhausen, Germany on 28 August 2002.

patients. This was to be expected since the hospitals they came to work in were smaller versions of those in Germany. The first inclination was to make the mission hospitals operate in the same manner as those in Germany, or at least strive for that goal. Here one thinks of the doctor in a white coat, towering above all in the hospital and giving instructions as he walks along the corridors, in the gardens and in the wards. His exclusive knowledge made him powerful indeed.

Although undoubtedly powerful and influential regarding how the hospital was to operate, doctors had limitations in their training. The acute limitation was the inability to speak the local language. While there were missionaries and other doctors who managed to learn and master the local languages of their patients, many had inadequacies in communicating with their patients. The powerful missionary doctors and nurses became dependent upon the people whose health they wanted to restore. The lack of communication rendered the medical missionaries powerless, as Antjie Krog, a White journalist learnt during the Truth and Reconciliation Commission and when she and her co-authors tried to analyse a certain Mrs Konile's testimony:

> For the first time I, as a white South African, could access some of the deepest thoughts, traumatizing events and personal experiences of black South Africans in their own words – people could express themselves fully. Frantz Fanon said, 'Mastery of language affords remarkable power'. But listening now to this Mrs Konile, I am left with a feeling that no, I am *not* like her! Even more serious, I don't want to share a country with this kind of 'blackness'. To tell you the truth, there is a kind of callousness, a non-logic, a superstitious senseless world in her testimony that I really want to flee from.[123]

In the mission hospitals the intervention of nurses who were bilingual was largely indispensable.[124] In order to further reduce the gap of communication, booklets were prepared to help doctors to learn in the local languages the different parts of the body and their related ailments. [125] Such books were necessary as doctors cure the body parts rather than heal the whole person, as already mentioned above.

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[123] Antjie Krog, Nosisi Mpolweni and Kopano Ratele, *There was this goat: Investigating the truth Commission Testimony of Notrose Nobomvu Konile*. University of KwaZulu-Natal Press: Pietermaritzburg, 2009, p.21.
[124] Nukuna of Emmaus and Lekgetho of Botshabelo.
[125] A.M. Merriweather, *English – Setswana Medical Phrasebook and Dictionary*. Bechuanaland Book Centre: Lobatsi, 1964; G.D. Campbell and Harry Lugg, *A Handbook to aid in the Treatment of Zulu*

Apart from Schmidt who trained at the University of Pretoria, the two other doctors mentioned were trained in Europe. It is possible that the developments of medicine and science in Europe and the perception of Africans by Europeans had an impact on why these doctors became interested in using scientific discoveries in the mission field. The Europe of the 1930s-1940s had discovered penicillin.

3.2.2. The Pioneering Mission Doctors and their Service

> I do solemnly declare that I will keep silent about those things which I have seen or heard whilst dealing with the sick and that in my relations with patients and colleagues I will conduct myself according to the ethics of medical profession. I will not knowingly or intentionally do anything to any person which may harm them for any consideration and I will exercise my profession to the best of my knowledge and ability for the good of all persons whose health may be entrusted to me.[126]

Doctors have been in existence for centuries and in many parts of the world. It is therefore not surprising that there is an oath that has been sworn by doctors for many years. This oath is supposed to have been formulated by Hippocrates, a Greek physician. As is clear from the wording, physicians as professionals are knowledgeable and skilled in health restoration. They are trained to have the best knowledge and ability in medical care. As the oath states, the health of many is entrusted to them. The oath is necessary to encourage them to be ethical and respectful of their patients. Today the Hippocratic Oath is helpful in keeping watch and control over misused power by doctors over their patients as it encourages ethics.

The oath calls for accountability unlike in African traditional health systems where practitioners are largely accountable to no professional structure. In line with this

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Patients: For doctors, nurses, Medical Students, Dispensers and Administrative Staff. Natal University Press: Pietermaritzburg, (undated); Chris Ellis, *Communicating with the African Patient*. University of KwaZulu-Natal Press: Pietermaritzburg, 2004.

[126] Although not yet qualified as physicians, students admitted at Nelson Mandela Medical School of the University of KwaZulu-Natal take this oath in the presence of their parents or guardians on their first day at university. Copies of this Hippocratic Oath are handed out freely to any one interested. At the end of the oath space is reserved for student name, signature and student number.

research, let us now look at the hospitals and the profile of each of the doctors who was the first to work in them before they were nationalized in the 1970s.

The order which I will follow in introducing the very first doctors who worked in the selected mission hospitals will follow the order in which the various mission hospitals were founded. We will note that Dr. Magdalene Schiele of Emmaus arrived before the other doctors as she began work at Emmaus in 1947, while Ulrich Schmidt of Bamalete Lutheran Hospital came to Ramotswa only in 1960, initially for a period of six months. That was despite the fact that Bamalete Lutheran Hospital was the first to be established. We will note also that Untujambili never had a resident doctor until it was nationalized in 1978. However, while serving in the Board of the Lutheran Medical Foundation, Dr. Hestenes of Hlabisa Mission Hospital acted as non-resident Medical Superintendent of Untunjambili Mission Hospital in 1948.[127]

3.2.2.1. Dr. Ulrich Schmidt of Ramotswa[128]

Mrs. Schmidt	What made us stay was the fact that one knew we were needed. We knew why we were there. You often do work just for money but it was not for money. It was being able to serve people. And I think that is where we got our satisfaction.
Dr.Schmidt	And the reward was the also the knowledge that we were totally accepted in Ramutsa. It was a very, very pleasant relationship between us and the villagers and the council, the village council.[129]

Although Dr. Schmidt and his wife could find work anywhere due to their high qualifications in medical surgery and advanced nursing respectively, they chose to stay in Ramotswa and serve there. As they both explained above, job satisfaction, in service and amicable relationship with the Balete tribe of Ramotswa in Botswana were the key points that made them stay and work long in the establishment of the

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[127] Lissah J.T. Mthalane, "The contribution of the Lutheran Mission societies to the development of health services in Natal 1898 – 1978 (80 Years)." University of South Africa unpublished MA in Nursing Science. 1984, p.97.
[128] Unless stated otherwise, the information on Dr. Schmidt was gathered when Radikobo Ntsimane interviewed him and his wife in their home in Pretoria on 22 February 2002.
[129] Corrupted form of "Ramotswa".

Bamalete Lutheran Hospital. But who was this doctor who left an indelible mark among one of the smallest tribes of Botswana?

Born in South-West Africa (now Namibia) in 1927, Eugen Ulrich Schmidt studied medicine at the University of Pretoria after the Second World War. After qualifying as a medical doctor in 1952, he worked in hospitals in Pretoria and later in Barberton, before opening a private practice in Omaruru, Namibia. Dr. Schmidt married Miss Straeuli of Wartburg, South Africa, and had five children. Mrs. Schmidt trained as a nurse at the same university as her husband and they became involved in the hospital work of the Hermannsburg Mission Society (HMS) in Hebron, near Pretoria. Dr. Schmidt remembered how they were involved in this work while still studying at the university,

> My wife trained as a nurse when I was studying. And I think what must be mentioned… we were very closely involved with the mission work of Rev. Heinz Dehnke[130] who was at that time missionary in Hebron, about thirty miles from Pretoria. We travelled there as students by bicycle. We were much involved in that mission that my wife took over that clinic that was run by the wife of Missionary Dehnke while they were away on leave in Germany, for six months I think, *ja*![131]

Dr. Schmidt came from Namibia to the Bamalete Lutheran Hospital as its very first doctor. He was recruited by Mr. Richard Otto, the then-secretary of the HMS in Pretoria, in 1960. The Schmidts agreed to spend six months in Ramotswa before Dr. Schmidt started his specialist surgeon studies at the University of Pretoria. When Dr. Schmidt arrived in Ramotswa, he found the rondavel which was used by the pioneer nurse, Sister Emma Pfitzinger.[132] The three buildings which served as the school built by the tribe were made available to serve as the new hospital buildings. The Bechuanaland Protectorate Government had just completed building a new school for the tribe elsewhere in the village.

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[130] These are the same Dehnkes as those who influenced Dr. Dierks's love for medical mission and who helped with the clinic of MELFC in Botshabelo. See appended interview between Radikobo Ntsimane and Friedrich Dierks on 18 July 2002.
[131] Ulrich Schmidt interviewed by Radikobo Ntsimane at Feari Glen, Pretoria on 26 February 2002.
[132] The rondavel is still standing today and it is used for HIV and AIDS counselling.

After graduating as a surgical specialist, Dr. Schmidt was called by the tribal leader *Kgosi* (Chief) Mokgosi Mokgosi, to help build the hospital and to serve it as its first doctor. Schmidt said, "I then received a letter from the chief, Mokgosi Mokgosi, personally asking me whether I wouldn't consider coming back to Ramutsa. It had really moved me a great lot that he had personally approached me."

Dr. Schmidt and his wife worked hard in the building of the hospital. They brought better quality water to the hospital. They trained the local people as hospital workers, especially nurses. They also established out-stations to reduce distances for patients in far away villages. This dedication was acknowledged by the first president of the Republic of Botswana, Sir Seretse Khama, when he gave honours to Dr. Schmidt.
Dr. Schmidt remembers the honour bestowed upon him with a strange combination of pride and humility:

> *Ja*, when we left for … after we have been in Ramutsa till 1970 we had six months leave where we went to Germany. And one day I had a call from Gaberones,[133] from one of the officials in the offices of Sir Seretse Khama. And he said that it had been decided that I would receive an award for meritorious service. I was totally flabbergasted at that stage … he just informed me and asked when I would be back and when I would be able to receive that award. And after we had returned in '71 we received that award for meritorious service from President Sir Seretse Khama, which was a great honour to me.[134]

3.2.2.2. Dr. Magdalene Schiele of Emmaus

Dr. Magdalene Schiele, born Tcheuschner, was already married to missionary candidate Bernhard Schiele when she completed her medical studies in Harmburg. The Berlin Mission Society (BMS) supported Magdalene's career, although her father was still expected to carry some of the costs for his daughter's training.[135] That was the case especially when she was in England (London) to take her examination for service in one of the British colonies, South Africa.

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[133] Corruption of "Gaborone", the capital of Botswana.
[134] Ulrich Schmidt interviewed by Radikobo Ntsimane at Faeri Glen, Pretoria on 26 February 2002.
[135] Letter from BMS to Mr. Tcheuschner dated 27 July 1927. (ELAB MBW/1-9253).

It is not easy to capture the thoughts and voice of Dr. Schiele in the correspondence with the BMS leadership leading to her direct connection with the mission. The reason is that it was her husband who was connected directly to the mission initially, as its employee. Only later when she was employed at Emmaus Mission Hospital, did Dr. Schiele write a few letters directly to the BMS. Her husband was, from the tone of the letters and reports, a very strong person who did not hesitate to speak his mind to the mission leadership. For example, in 1929 due to a financial misunderstanding while he was serving in Mbabane Swaziland, he reminded the BMS leadership that his wife was not sent into the mission field as a medical missionary.[136] Missionary Bernhard Schiele could easily be mistaken for the missionary doctor by the level of his involvement in the hospital matters, especially at Emmaus after the Second World War from 1947.

While in Swaziland, the status of Dr. Schiele as a missionary was always a contested one. A decision was taken to close KaShile Hospital for a year in order to give the Schieles a year of furlough after ten years of service in the mission field. Superintendent Pakendorf wrote to Mission Inspector Schoen that the hospital should be closed, as Dr. Schiele was not a medical missionary.[137] In the light of this letter it was obvious that the BMS did not recognize the value that KaShile Hospital had brought to the overall work of BMS. As a matter of fact the BMS did not even support the medical mission work done by Dr. Schiele in Swaziland. An organization called Swaziland Freundekreiss, which comprised friends of the Schieles and some Lutherans congregations in Germany, supported the KaShile and later the Emmaus medical mission initiatives. In 1937, when in Germany for their furlough, Dr. Schiele was strongly challenged when she opted to spend time in a hospital in Magdeburg-Sudenburg to learn new things in her profession.[138] While the doctors and nurses were powerful within mission hospitals, the mission boards and committees above them

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[136] Letter of B. Schiele to BMS dated 28 November 1929. Kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-9254).
[137] "*Da Frau Dr. Schiele nicht Missionärtzin.*" Letter of Superintendent Pakendorf to Mission Inspector Schoen dated 25 January 1936. Kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-9262).
[138] Letter of Dr. M. Schiele to Mission Director Knak dated 12 August 1937. Kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-9261).

were more powerful. As employers, they often had the final word in matters related to the mission societies and their employees.

Mission Director Knak refused to grant permission to Dr. Schiele to promote medical work on a particular day while in Germany because, although the medical work was important it was not more important than a meeting of missionaries. While in Swaziland, Dr. Schiele's position as medical missionary of the BMS was unclear and contested. As mentioned earlier, after being interned in the British concentration camps in Salisbury in Southern Rhodesia and in Tanganyika (present Tanzania), [139] during the Second World War,[140] the Schieles took over Emmaus, both as medical mission doctor and as congregation missionary supported by the BMS.

The dedication of Dr. Schiele as a doctor was seen mainly in the camp in Tanganyika.[141] Despite being in "captivity" under stressful and vulnerable conditions she continued to perform her duties as a doctor. Although she could not work freely, she dispensed her duties where there was need and suffering. Such dedication resonates with the Hippocratic Oath of old that compelled doctors not to refuse to help wherever they could, and in the case of Dr. Schiele, even to serve while living under unconducive conditions.

In Norton, Southern Rhodesia, the Schieles learnt that they were not allowed to return to Swaziland[142] but they could work in South Africa, thanks to the Smuts government's good will.[143] Before returning to South Africa to serve at Emmaus, the Schieles served in the Mochudi Hospital of the Dutch Reformed Mission in the then-

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[139] Letter of B. Schiele to Mission Director Knak dated 13 November 1942 in folder B. Schiele File Vol. 2 (1942-1956). Kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-9259).
[140] Information regarding this period is contained in letters found in folder identified as B. Schiele File Vol. 2 (1942-1956), kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-9259).
[141] Letter of Herman Schiele to Mission Director Knak dated 22 March 1943. Kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-9259).
[142] Letter of *Dezernant* to Knak dated 1 January 1947. Kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-87).
[143] Letter of B. Schiele to Knak written from Norton and dated 20 May 1947. Kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-9261).

Bechuanaland.[144] For the first time, the BMS seriously considered the work of Dr. Magdalene Schiele as an important part of their mission when the couple was sent to Emmaus. Superintendent S. Krause wrote about the suitability of Emmaus for the Schieles. The new area they were called to made provision for medical practice.[145] Both Dr. Schiele and Rev. Schiele saw that chance to work in Emmaus as an opportunity. Superintendent S. Krause had been told about the medical needs by a Pastor Zungu, who had taken care of the congregations around Emmaus in the absence of a missionary.[146] Zungu also mentioned the weak faith of the people, their fear of witchcraft, and their trust in traditional healers. According to Krause, the re-opening of the hospital by Dr. Schiele was going to bring hope to the Emmaus community.[147]

When Dr. Schiele began work in Emmaus, there were seminary class buildings available for use.[148] One can deduce from the letter of Knak of 4 August 1947 to the Schieles that they were already working in Emmaus in that year. While involved in medical mission work, Dr. Schiele also raised two children Maria-Paula (born 26 May 1930) who became a nurse in Emmaus and Richard (born 30 May 1931) who became a missionary in the BMS and later the bishop of the Eastern Diocese of the Evangelical Lutheran Church in Southern Africa (ELCSA) in Mbabane, Swaziland until retirement.[149] The internment that the Schieles endured both in the then-Tanganyika and in the then-Rhodesia, because of the Second World War, did not in any way dampen their spirit to serve as medical missionaries. Instead they were more dedicated when they became involved in the establishment of the Emmaus Mission Hospital in 1947.

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[144] Letter of B. Schiele to Knak dated 20 May 1947. Kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-9261).

[145] "*und bietet auch die beste Gelentheit für Schw. Schiele ärtzliche Tätigkeit, der Lage und der Gebände wegen*." Letter of Superintendent S. Krause to BMS dated 13 August 1947. Kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-10824).

[146] Report by Pastor Zungu dated June 1947. File number 2814 in the BMS Archives in Berlin. Kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-9261).

[147] "*Durch die Eröffnung der medizinischen Arbeit durch Frau Schiele und die Besetzung von Emmaus durch miss. Schiele besteht die Hoffnung, dass vieles besser warden wird und dass die erleben wird, wie die Zerfallene Kirche, die von der dt. Gemeinde Bergville zum Jubiläum wieder schön hergerichtet worden ist*." (ELAB MBW/1-9261).

[148] Letter of B. Schiele to Knak dated 25 July 1947. Kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-9261).

[149] Bishop Richard Schiele interviewed by Radikobo Ntsimane in his retirement home in Pietermaritzburg on 13 May 2000.

3.2.2.3. Dr. Kurt Bergter of Itshelejuba[150]

> You know, my father, he was a minister. He had in our house … when I was still a boy…he had all these black African people coming into our house and giving a show on handicraft of black Africa, mostly East Africa and West Africa, and this was fascinating to me. And I saw those people from Africa and I thought to myself, these are real good people because what they are showing us here is something very fascinating for me. I think this was the very beginning for my love to black Africa and to mission.[151]

Historians know that things do not just happen; they are influenced by a number of social and natural events. This holds true in the case of doctors, nurses, pastors and all other missionaries who left their homelands to go into the mission fields among people of cultures very different from theirs. In the case of Dr. Kurt Bergter, it was not the spiritually-charged revival meeting but the regular presence of Africans in his home that influenced him to go into the mission of the Church.

Born on 21 April 1921 in Eisenburg, Germany, Kurt Bergter finished the German equivalent of Matric called *Abitur* in 1939. After serving as a conscript in the army that marched into Warsaw, Poland, on 29 September 1939, he was discharged to study medicine at Magdeburg University. After the first doctors' examination Bergter was called into the army to serve as an interval infantry officer. In 1941 he was near Moscow and the following year he was wounded and hospitalized. When he was cured he served the same field hospital with two hundred beds in a typhoid ward. Although vaccinated, Bergter caught typhoid and since it attacks the brain, he lost seven days of his life which he can not recall. He went back to Germany to complete his studies. He sat for his state examinations in medical studies and finished early in 1945. When the Russian and the American armies met in May 1945 Bergter was relieved, "So I was lucky to be at the Western side when the Americans took over on 2nd of May 1945. The war was over for me. It was a feeling of relief, after there was so much shooting and not being hit and finally nobody trying to kill you."[152]

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[150] Unless indicated otherwise, all the information about Dr. Bergter was gathered during the interview in his home in Germany, 28 August 2002.
[151] Dr. Kurt Bergter interviewed by Radikobo Ntsimane at Bad Öynhausen, Germany on 28 August 2002.
[152] Ibid.

Although Bergter did not mention his safe return from the Second World War as a driving force into the mission, some people have interpreted such near-fatal experiences as God's calling into active ministry.

Dr. Bergter married three times. His first wife left him when their daughter was twelve years old. His second wife, Edith, came along to South Africa when Bergter was called to Itshelejuba Mission Hospital. After they were married for twenty eight years she left him. She could not live in Itshelejuba away from European society. Bergter confessed that his wife's decision to live with another man was not easy to bear, "So she left me there in Itshelejuba. It was very difficult for me being alone there and feeling alone but I started that very moment and asking, 'Lord Jesus Christ, please be with me because I am feeling very, very alone'. And he did … he did help me to continue my work in Itshelejuba until the time [of] eight years was over with my contract to the mission."[153] On the day of this interview, Suzie, Dr. Bergter third wife, was with him. They met in Umhlanga, Durban, while he was off duty and she was on holiday.

Before coming to Itshelejuba, Bergter had been working in the Indian mission field. He worked in Wittenberg and in Harmburg in an affluent clinic for six years and then joined the mission of the Evangelical Reformed Church in India. Thereafter he worked in the large hospital of a German steel plant. On his return to Harmburg he found a different Germany altogether, as he mentioned:

> I came after ten years to my home Hamburg. I was lost in this society. Profit, increase of profit, power, because the society was building up that time in 1965. I was very lost. I started my practice in the outskirts of Hamburg, a private practice. And I was practically…this rural doctor. And they called me out for everything. But the people were not sick. They were just ailing, just stomach pain because they had eaten too much of cognac and so and so. And this I did not like, it was for me actually frustrating.[154]

[153] Dr. Kurt Bergter interviewed by Radikobo Ntsimane at Bad Öynhausen, Germany on 28 August 2002.
[154] Ibid.

After praying for a way out of that society, Bergter was appointed by the Mission Director Hopf, of the Mission of the Evangelical Lutheran Free Churches (MELFC), to serve in Itshelejuba Mission Hospital, South Africa. "So I was thankful to the Lord for getting out again. When we got there in Itshelejuba we were feeling like humans again, we had a real good task there to do something there for humanity and for real suffering people."[155] Before the South African appointment, Bergter went to study tropical medicine in Liverpool for one semester.[156]

Kurt Bergter began in Itshelejuba in February 1969. When asked about his impression of Itshelejuba on arrival he said:

> And I came there in a raw place like a farm, more or less a few houses were standing there. The old rondavels where Rev. Weber had started work were still there and now used for staff nurses. But there was only one hospital building, with about eighty nine beds. A German sister was there but she did not have the required training in Germany, as required by the South African laws. So she had to leave for Germany. Her name was Sister Ruth.[157]

The arrival of doctors made it possible for cases that were referred to far away missions or government hospitals, to be treated in the mission hospitals. It also meant that the government grading of these mission hospitals grew and could increase their capacity of personnel and machinery. Government grading was accompanied by financial support which made it possible to meet all the obligations of a hospital with a medical doctor. Let us see what changes were brought about by the need for financial resources in the various hospitals. While analysing the issues of finances in the mission hospitals, we should bear in mind that those who have resources can manipulate those who will gather around them for benefiting from them.[158]

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[155] Ibid.
[156] Dr. Bergter's business card shows his qualifications as: Internist, Tropenmedizin DTM & H (Liverpool).
[157] Kurt Bergter interviewed by Radikobo Ntsimane inhis house on 28 August 2002.
[158] Sue Russell, *Conversion, Identity, and Power: The Impact of Christianity on Power Relationships and Social Exchanges.* University Press of America: Lanham, 1999, p.2.

3.3. Motivations of the Missionaries to Establish and Serve in Hospitals

I have already alluded above to the dedication of the medical missionaries, viz. the nurses, the doctors and other staff members from the mission agencies. The nurses and the doctors wholeheartedly dedicated themselves to the work they believed they were called to do. The objective in this subsection is to show that the mixed motivations of the various medical missionaries were an indication that not all intentions were philanthropic. Such dedication of the medical missionaries was not unique to the Lutheran medical missionaries of the four mission hospitals under review. For example, Dr. Gerrit Ter Haar, who worked as a medical missionary in Rietvlei, a Dutch Reformed Mission hospital in the former Transkei, explained in an interview, "Most mission hospitals were run by quite dedicated people who came from all corners of the world who to serve was their sole motive".[159] To mark the Christian value of the work to which medical missionaries were sent, special dedication services were conducted in churches, as was the case with Sister Ruth Bauseneick of Itshelejuba Mission Hospital. Showing the photograph of her church's altar piece in Gieselberg, Germany, Sister Ruth said, "My congregation was Gieselberg. I am baptized in Gieselberg. Confirmation in Gieselberg and Pfarrer Hopf and Pastor Heicke sent me at Epiphany 1953 in Gieselberg before the altar, to South Africa, in the mission."[160]

Sister Ruth came as a medical missionary to help alleviate the suffering that the people around Itshelejuba were experiencing. Her predecessors came to southern Africa to preach the Gospel and reported back to their mission agency on the necessity of responding to the medical needs of the indigenous people. Ernst Holman, a Lutheran medical missionary who worked in Tanzania, stated in the following manner what he felt the missionary societies were called to do:

> The Lutheran mission movement has, from its earliest beginnings, developed concurrent streams of medical and educational programs along with its main emphasis, the propagation of the Gospel. There were practical reasons for these parallel movements. In almost every

[159] Dr. Gerrit Ter Haar interviewed by Radikobo Ntsimane in Pietermaritzburg on 19 November 2007.
[160] Sister Ruth Bauseneick interviewed by Radikobo Ntsimane at Bleckmar, Germany, on 5 August 2002.

> field of mission activity, the early missionaries found the people in desperate straits; physical illness resulting from lack of good or sufficient food, parasitic involvements, complete ignorance in the basics of hygiene and importance of cleanliness, a total lack of awareness of what constituted diseases, at least by western standards."[161]

In reference to the helplessness of the indigenous people, Holman wrote that the medical missionaries saw their work as a way to alleviate the suffering of the indigenous people. He explained in the *Report* how one missionary began a health centre:

> He found too that a man who was rocked in the fever of malaria was not receptive to the Word of God. There was no one else; there was no other agency to help. The missionary and his church stepped in to fill the void, thus beginning in simple ways at first, the long build-up of church-sponsored medical and education programs.[162]

Holman was not entirely correct when he stated that before the medical missionaries came to southern Africa, there were no agents to help the indigenous people in their need for health care. There were a variety of traditional and faith-healers who attended to the health of the indigenous people long before the arrival of the Lutheran medical missionaries in southern Africa. But Holman was right when he said that when "the missionary and his church" saw a need for health care, they were motivated to provide it as they could.

Almost always, the dedication of the agent is seen and appreciated by the recipients and beneficiaries. With regard to the Lutheran mission hospitals, Mr. Zikode of Emmaus wrote with admiration about the help brought to his people by the BMS, in his booklet[163] and Dean Mthethwa of KwaMbonambi mentioned in an interview[164] the great help brought by the Norwegian American Mission through the Untunjambili Mission Hospital. Referring to the Ntunjambili Mission Hospital, Mthethwa likened

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[161] Ernst Holman, *A Report on the Medical Program of the Evangelical Lutheran Church in Southern Africa - Eastern Region Natal Province Republic of South Africa.* Volume II, 1966, p.82.
[162] Ibid.
[163] Lawrence Zikode "A History of the Emmaus Mission" self-published and undated, pp.23-27.
[164] Dean C. N. Mthethwa interviewed by Radikobo Ntsimane in KwaMbonambi on 19 November 2002.

the coming of the mission hospitals to the appearance of dawn after a long period of darkness.

Let us take a brief look at what motivated the mission agencies and the missionaries they sponsored, to provide the indigenous people with health care. In his article on the issue of motivation, Gunther Pakendorf, who taught at the Department of German at the University of Cape Town, saw heartfelt emotional Christianity as the context that drove the BMS agents into mission:

> It is in this context that the wish to do mission work arose, as the desire to help others achieve salvation and forgiveness which one has experienced oneself. This spiritual impulse cannot be underestimated as a powerful driving force for missionary work; it also helps to explain how the "heathen" were viewed by most missionaries. Thus the constitution of the Berlin Missionary Society, founded in 1824, states that members of the society wish to spread the gospel because they are "filled with compassion for the wretched spiritual state and the resulting physical decay and degeneration of millions of heathen who live with us on earth and with whom, in spite of the distortion of the divine image, we feel closely related (*stammverwanndt*" (Quoted in Richter 1924:9).[165]

That which Michael Gelfand wrote about the Zimbabwean situation was relevant also to other southern African countries at the time when hospitals proliferated in the 1930s: "The outstanding feature of the medical missionary and nurse was that, through their faith, they chose to go out to help the poor and less fortunate in places where no such help existed. They went to lonely, unhealthy places, cut off from the outside world. There they served without material recompense."[166]

Was there more than faith that drove the missionaries to provide health care to indigenous people? When one goes through the reports from the Hermannsburg Mission Society missionaries living in Ramotswa, Botswana, in the early twentieth century, one finds many reports of witchcraft and sorcery. The missionaries wrote that the Tswana people were involved in witchcraft or sorcery as a way to find cures of their illnesses or to fortify themselves against illnesses and bad luck. For the HMS

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[165] Gunther Pakendorf, "For there is No Power but of God: The Berlin Mission and the Challenges of Colonial South Africa," in *Missionalia* Volume 25, No.3 November 1997, pp.255-273.
[166] Michael Gelfand, *Godly Medicine in Zimbabwe*. Mambo Press: Gweru, 1988, p.13.

missionaries the ideal situation was when the Batswana could refrain from consulting *dingaka* and using their medicine and instead trust in the Lord in accordance with the missionaries' religion. Similar mention is also found in the MELFC correspondence.[167]

In the 1930s, the fear of witchcraft and sorcery as an obstacle to the conversion of the indigenous people was prevalent. In the reports sent by the missionaries to their sending agencies, witchcraft and sorcery were presented as a stumbling block to conversion and civilisation. The antagonistic position of missionaries towards African Traditional Religious practices emanated from the fact that they did not see the difference between it and witchcraft. In order to remove the fear of witchcraft among the potential converts, the missionaries introduced biomedicine as an alternative health system. Michael Gelfand wrote that the medical missionaries understood their participation in mission hospitals as a means to an end—that end being conversion to Christianity—and as Sir George Grey, the governor of the Cape Colony said in the mid-nineteenth century, as a way of undermining the value of the so-called witchdoctors:

> The Churches, mostly Protestant at that stage, were anxious to spread the Gospel to the people of Africa, whom they regarded as heathen. They viewed the influence of the witchdoctor with alarm and regarded his practices as inhuman. They were determined to save the people from the evils of their belief in witchcraft. Missionary doctors came out because they believed in the power of Christian healing in which prayer, combined with Western medicine, was more effective than merely leaving the cure of illness to lay doctors and nurse.[168]

From the beginning of their work in southern Africa, Lutheran missionaries had concerns about the trust that indigenous people had in traditional healing. In the mission reports and interviews conducted with medical missionaries, one finds many references to traditional healing and witchcraft. That is why missionaries and medical

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[167] Letter by Nurse Erika Lawrence to Mission Director Friedrick Hopf dated 1 September 1961 mentioned the struggle they had with traditional medicine (which she called *Zaubermedizin*, witchcraft medicine) in Itshelejuba. Letter found in MELFC Archives in Bleckmar, Germany. In his book 1960 *Missionarleben unter den Zulu*, Wilhelm Weber the founder of Itshelejuba Mission Station complained about the presence of traditional healers who he referred to as witchdoctors *(Zauberdoktoren*) who charge patients exorbitantly. p10.

[168] Michael Gelfand, *Christian Doctor and Nurse*. Mariannhill Mission Press: Mariannhill, 1984, p.296.

missionaries took it upon themselves to substitute traditional health systems with biomedicine, so as to free converts and potential converts from superstition and baseless fear.[169] According to Matron Evelyn Sommerfeld, at Emmaus, Doctor Schiele did not tolerate any thing that had connections to traditional healing as it was understood to be associated with witchcraft. Here is how she responded to a question during an interview regarding the Emmaus Mission Hospital where she used to work:

RN What was the relationship between the hospital and the traditional healers because you are nearly doing the same job of healing?

ES Ya we are, I must say we hardly had any connection with them except for the herbalist who sent us his people when his herbs had not effect so he sent them to us. But real witchdoctors, *sangomas*, we never had any contact with them.

Nurse Ruth Bauseneick mentioned in an interview, that at Itshelejuba Hospital she did not work directly with traditional healers, although she knew them and that her patients used them. She and her colleagues suspected traditional healers to be related to witchcraft.

RN Did the *sangomas* and other traditional healers disturb your work?

RB Sometimes.

RN How?

RB People call me to come near Pongola to see a patient. And then I come to the kraal where they were staying. I call "sawubona." I am waiting for them to call me in. The witchdoctor came out. Then I say, "You call him or you call me!" Then I didn't work here, then he did his work. Then I was going back and told them when something is going wrong and is not feeling better then come to Itshelejuba. I didn't work together with him.

This concern about the prevalence of what the missionaries mistakenly assumed to be witchcraft, as a disturbance to the spreading of the Gospel and civilization was not only the concern of Lutherans. The Methodists and the Anglicans were just as cautious about the continued prevalence of ancestral ritual practices, especially the *ilobolo* (bride price), the *intonjane* (girl's rite of passage to womanhood) and the *ukwaluka* (boys' rite of passage to manhood by means of circumcision), by their

[169] Martin Lubbe, "North Meets South in Medical Missionary Work: Dr. Neil Macvicar, African belief, and Western Reaction" in *South African Historical Journal*. Volume 61, Number 12. June 2009, pp.336-356.

converts and potential converts. Wallace Mills, a historian writing about the Xhosa, showed that if the Methodists and Anglican missionaries first tried to combat such practices, later in the twentieth century they compromised and ended up tolerating the traditional religions. They realized that the *ilobolo* gave dignity to women and cemented marriage. They also acknowledged that the young Xhosa men were forced to be dishonest, as they hid the fact that they were undergoing the *ukweluka* ritual. The *Intonjane* ritual disappeared without much pressure from the missionaries as it was expensive to be undertaken.[170] Let us note though that what the missionaries were worried about were the rituals which were suspected to be connected to witchcraft and ancestral connection.

That antagonistic attitude towards the so-called witchdoctors was widespread among missionaries and colonialists. Shula Marks mentioned a Free Church of Scotland medical missionary who trained African nurses in the Eastern Cape in the 1930s, and who was opposed to traditional healing as evil and heathen:

> Similarly, for Neil Macvicar, the Free Church of Scotland mission doctor who pioneered western training for African nurses in the Eastern Cape, 'the hospital stood for science against superstition, for fresh air, cleanliness and temperance., as against overcrowding, dirt and … infestation and for Christian helpfulness and simple trust in God as opposed to the fear, the selfishness, the malevolence of heathenism.[171]

The combat of witchcraft and evil was one of the issues which motivated the missionaries, along with the zeal to spread their religion in southern Africa through the use of biomedicine, especially at the beginning of the twentieth century. Shula Marks has devoted a large space in her book to this matter. For example she wrote, "Like colonial authorities, the missionaries saw western medicine as part of an onslaught against black 'savagery' and ignorance; in the first decades of the twentieth

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[170] Wallace Mills, "Missionaries, Xhosa Clergy and the Suppression of Traditional Customs" in Henry Bredenkamp and Robert Ross (eds.), *Missions and Christianity in South African History*. Witwatersrand University Press, 1995, pp.164 -167.
[171] Shula Marks, *Divided Sisterhood*: *Race, Class and Gender in the South African Nursing Profession.* Witwatersrand University Press: Johannesburg, 1994, pp. 4, 81.

century, whatever the denomination or nationality, the message was much the same."[172]

The Lutheran missionaries, like the colonial agents, attempted to change the worldview of the indigenous African people by portraying their own way of life, especially their health system, as being the best and superior to the indigenous ones. Some of the African people interviewed appreciated the presence of mission hospitals in their midst. Two of the interviewees, Dean Mthethwa and Sister Ruth Bauseneick, mentioned that some missionaries opposed traditional healing and did not tolerate its practice on the mission stations. Dean Mthethwa who worked at Ntunjambili mission station responded thus:

CM Not at all. They were not allowed to come into the mission station. Dr. Astrup was feared and did not want to see any healer here.

RN Did the people not go to consult traditional healers outside the mission station?

CM You cannot ask that, the people were going privately at night.

Sister Bauseneick of Itshelejuba Mission Hospital was less sympathetic to traditional healers, referring to their profession as "Satan". Asked whether the *sangomas* helped the people, she replied:

RB Sometimes yes, when they get medicine from plants. But when they put their trust in the bones, do the bones help without medicine? Oh no! That was not mine … but when the sangoma saw his patient coughing and something … and provide some plants to make tea or so, that is ok; that is a herbalist. No, to the bones! Mfundisi Weber told me [that] *sangomas* became christians and burnt their *umuthi*. Nothing to do with Satan anymore!

Nomy Arpaly, a professor of philosophy in the USA, proposed a theory of motivation in her book *Unprincipled Virtue: An Inquiry into Moral Agency*. Her theory can be applied to the medical missionary doctors' and nurses' dedication to black people in southern Africa. Arpaly distinguished three aspects in the phenomenon of motivation. These aspects are generally associated with moral concerns and concerns for morality,

[172] Shula Marks, *Divided Sisterhood*. Witwatersrand University Press: Johannesburg, 1994, p.81.

which boil down to doing the right thing. For the purpose of this study, we shall closely look at the first feature, about 'motivation', since it is relevant to this section. In the first place, why did the medical missionaries leave their homes for the service of people of other races in far away lands? Arpaly's description of the motivation of a dedicated person will help in understanding the Lutheran missionaries' motivations. He wrote:

> But what I say about such concern also holds true for more particular moral concerns—for example, concern for happiness of others, concern for justice, and even more specific moral concern. The first feature of concern I wish to mention is a motivational one—what can be called the "diehard" quality of stronger concerns as motivators. It appears to be the case that the more you care about something, the more it would take to stop you from acting on your concern. Other things being equal, the person who cares more about the football team will show up for a game on a stormy day while the person who cares less will stay at home. Both go to games for the same reasons, but one of them does so from a deeper love of the team. Thus, other things being equal, the person who cares very much about morality (again, the *de re* sense of morality), or about any specific moral consideration, would tend to be motivated to action by it in situations in which the rest of us would not.[173]

One can think of hundreds of missionaries who could fit this description of "diehards", in particular the nurses and doctors who established the hospitals, and those who prepared the hospitals to be recognized by the government as centres of health provision.

As has been mentioned earlier, it is easy to observe the dedication of a person to the particular cause they have chosen. At the same time, it is difficult to appraise the motivation, unless specifically stated, of a person who has chosen to do something to alleviate the suffering of others. Even when a motive has been specifically stated, it does not necessarily mean that it is not clouded by undisclosed motives. Motives like greed, adventure, pursue of self-glory, and building of one's empire, may be looked upon judgmentally if stated openly. It is argued here that it is not easy to know the

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[173] Nomy Arpaly, *Unprincipled Virtue: An Inquiry into Moral Agency*. Oxford University Press: Oxford, 2003, pp.85-86.

undisclosed motives of the mission nurses and doctors and others, but their dedication and commitment can be recognized and relevant conclusions draw.

We should bear it in mind that some medical missionaries who came to Southern Africa had already been exposed to descriptions of black people as child-like adults who were incapable of development, and who needed constant assistance from the developed race of European origin.[174]

Another motivation that moral agents may find immodest to disclose openly is the one of fulfilment. The medical missionaries may have discovered that the way to find fulfilment and happiness was to serve those who had no means to help themselves out of difficult situations like diseases, heathenism and the evil forces brought by the so-called witchdoctors. While pursuing the programme of combating the evil of the "witchdoctor" and eradicating diseases to alleviate suffering, the mission doctors and nurses also derived happiness out of their service. Richard Warner, a professor of Philosophy at the University of Southern California, described the fulfilment derived from helping the suffering Blacks, irrespective of the possible unhappiness that could befall the helpers when they rendered such help. Warner explained this paradox as follows:

> To feel happy one must have a certain sort of experience, and one must have an experience of an appropriate sort yet not be leading a happy life: one morning I find myself in a euphoric mood, but when you remark that you have not seen me so happy in a long time, I paint a paint a bleak picture of my circumstances and prospects. My euphoria is just a brief bit of cheerfulness in my otherwise unrelieved misery at my failures. I feel happy but I am not leading a happy life. Conversely, one can be leading a happy life at a given time without feeling happy at that time. You might correctly regard yourself as leading a happy life even though you are momentarily depressed; you see your depression as a mere transient mood occurring against the background of a way of life that as a rule you find fully satisfying.[175]

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[174] Scott Houser, "American and English Missionary Perceptions of the Zulus in the Era of Levelling the Mountains, Bridging the Oceans, Civilizing and Christianizing the 'Heathen'." PhD Dissertation at Baylor University: Waco, Texas, 2004, p.250.

[175] Richard Warner, *Freedom, Enjoyment, and Happiness: An Essay on Moral Psychology*. Cornell University Press: London, 1987,p.17.

In the 1930s, the situations of loneliness, homesickness, depravation, long distance travelling, exposure to tribal disputes, and later the lack of safety of their children in rural areas, where most mission hospitals were established, were some of the discomforts missionaries experienced. Kurt Bergter of Itshelejuba was divorced by his first wife as a result of what she regarded as a dull rural life of Itshelejuba mission station but he still kept on working at Itshelejuba.[176] Coming from the big city of Berlin, Sister Evelyn Sommerfeld and other German missionary nurses in Emmaus sometimes felt miserable in the remote and lonely Emmaus mission[177] station near Bergville in the then-Natal. However, as Warner wrote in the above quotation, despite their challenging conditions, these missionaries did not make it their habit to complain. They probably felt satisfied in dispensing what they saw as their duty.

Missionary Wilhelm Weber of Itshelejuba was probably fulfilled, as his childhood dream of becoming a physician was realized through his founding of the hospital. He found fulfilment in the fact that he could serve in ways other than that of being a medical doctor. His services were being appreciated and as a result he could find himself affirmed.

Although Weber did not become a doctor, he was instrumental in preparing the ground for doctors to work in Itshelejuba. Friedrich Dierks may have also felt fulfilled by his work in the founding of the Botshabelo Clinic near Lichtenburg and as the only chairperson of the MELFC Hospital Committee until nationalization.

What is often written about the dedication of the missionaries, are the sacrifices that they had to make and the sufferings that they had to endure in order to bring the Good News and the much-needed help to the indigenous people that they went to evangelize. In the above quotation, Warner shows that in fact the sacrifices they made and the suffering they endured were temporary as they contributed to the whole scope of a happy and fulfilled life.

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[176] Kurt Bergter interviewed by Radikobo Ntsimane at Bad Oeynhausen, Germany on 28 August 2002.
[177] Evelyn Sommerfeld interviewed by Radikobo Ntsimane at Walsrode, Germany on 5 August 2002.

Some nurses and doctors stayed longer than others in the mission field. Others experienced more hardships than others. Matron Evelyn Sommerfeld mentioned in the interview[178] that they received little money as salary and still could not spend it on pleasure as there was no place to spend it at Emmaus and surrounding villages. Sister Ruth Bauseneick had to pay out of her pocket for the purchase of medical supplies for the Itshelejuba Mission Hospital.[179] Having returned home and established a private practice that could easily flourish in an affluent suburb, Kurt Bergter chose to come to South Africa as his second venture into the mission field after India. He argued that his services were under-utilized, as the people who came to him were not really sick. They would over-indulge on food and beverages and come to him the following morning to "heal" them of their after-party conditions.[180]

Undoubtedly Bergter did not derive happiness from the service he rendered to the people of his own country. Since it was not money that drove him—he left a lucrative private practice in Germany—it is likely that he was driven, like other mission doctors, by the pursuit of happiness. Having had the opportunity to work in India, Bergter knew that his medical services were appreciated. He would find happiness helping people out of suffering and misery. The feeling of compassion for those who are suffering from diseases and of doing something to alleviate that suffering can be a great source of happiness, especially when it is likened to Jesus' response to the suffering and misery of the people that he met. When one's service to others is appreciated, one's worth is surely affirmed and one is happy and would seek to continue doing good deeds.

Another Lutheran mission doctor in Botswana, Ulrich Schmidt, explained that he and his wife had to suffer separation from their children who went to school in Namibia for long uninterrupted periods of time. They would look forward to the arrival of their children from school and be happy for their return. This is understandable, as they had parental responsibility towards their children. However the sense of duty towards the Balete and other people of the then-Bechuanaland Protectorate justified

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[178] Evelyn Sommerfeld interviewed by Radikobo Ntsimane at Walsrode, Germany, on 5 August 2002.
[179] Ruth Bauseneick interviewed by Radikobo Ntsimane at Bleckmar, Germany, on 5 August 2002.
[180] Dr. Kurt Bergter interviewed by Radikobo Ntsimane at Bad Öynhausen, Germany, on 28 August 2002.

the temporary separation from their children. Like Dr. Bergter of Itshelejuba, acting on the compassion that they felt for the sick was enough to keep them in the mission field. To show that this was not unique to Lutherans, Gerrit Ter Haar a Reformed Church missionary from the Netherlands, also narrated that he had to endure hostilities from his co-workers after Transkei attained its independence from South Africa in 1976. Almost all missionaries can give accounts of their suffering while on the mission field. Did they not stoically face the hardships because that way they would find happiness and fulfilment—their ultimate goal? This can be seen as a way of self-fulfilment.

Pakendorf mentioned the humble background of European missionaries with examples from the BMS, as a motivation for going to the mission field in the nineteenth century. He wrote:

> A radical differentiation between German and other missions in nineteenth century South Africa would not get one very far. The vast majority of missionaries from all European countries of origin came from relatively humble backgrounds, they were members of the petty bourgeoisie, mostly artisans with little or no higher education; but all were imbued with a strong desire for upward social mobility which appeared increasingly difficult to achieve in the big city environment of industrialized Europe, but which seemed eminently possible in the colonial situation.[181]

Jean and John Comaroff also approached this subject from a socio-historical point of view, in the first volume of their 1991 book *Of Revelation and Revolution: Christianity, Colonialism, and Consciousness in South Africa.* They questioned the credentials of those missionaries who came forward as a result of speeches given by visiting missionaries from the field. Who were these missionaries who were prepared to lose their lives in order to gain it? Maybe they had already lost it even before they went out to lose it. They were 'nobodies' who could not make it among their own people, against whom there was going to be fair competition in pursuance of status, happiness and fulfilment. About the LMS and the Methodists from Britain working in southern Africa, the Comaroffs wrote thus:

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[181] Gunther Pakendorf, "For there is no Power but of God: The Berlin Mission and the Challenges of Colonial South Africa," in *Missionalia*. Volume 25, No. 3 November 1997, pp.225-273.

> And most of them had very little education, theological or secular. Sixteen of the seventeen, moreover, would fit Hobsbawm's description, that is, of persons caught between the rich and the poor, either indeterminate in their class affiliation or struggling hard to make their way over the invisible boundary into the bourgeoisie. Five came from peasant stock, five were from artisan backgrounds or had been artisans themselves, three had been petty clerks or traders, and three had emerged directly from the ranks of the labouring poor. Many, like Moffat and Livingstone, were from families displaced from the countryside. For all these men, the church conferred respectability and a measure of security in their special positions, even though it did not enrich them materially.[182]

Unlike their Scandinavian counterparts, the German HMS and MELFC missionaries were from as poor a background as those of the British of the LMS and the Methodists. Louis Harms who founded the HMS, recruited missionaries during his revival services in the nineteenth century in the farming areas of Lüneburg, near Hannover. Those farmers recruited for theological training had so little formal education that they did not qualify for university training like the Harms brothers. Such institutions preferred candidates with a better academic background.[183] Hermannsburg and Bleckmar, the headquarters of the HMS and MELFC, are situated in farming districts. Going into the mission thousands of kilometres away from home was just not for everyone. Those who answered to the call of going to Africa gained respect from their people. They may have been seen as heroes when they went back to Germany on furlough to speak about the challenges of the mission. These were men and women who dedicated their lives to preaching the Gospel beyond the oceans. They were the ones who were prepared to lose their lives so that others might gain theirs.

Can the comfort left behind by missionaries and the degree of discomfort they endured in the mission field, serve as a measure to determine their "diehard" status as Arpaly claimed? Arguably no one can deny the fact that the missionaries wanted to serve those in need of salvation and to cure for their illnesses. They sacrificed a lot for the sake of the indigenous people that they had come to serve. For some, the

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[182] Jean and John Comaroff. *Of Revelation and Revolution: Christianity, Colonialism, and Consciousness in South Africa.* Volume 1. The University of Chicago Press: Chicago, 1991, pp.84-85.
[183] Hartwig Harms. *Concerned for the Unreached: Life and work of Louis Harms, Founder of the Hermannsburg Mission*. Ev.-luth. Missionswerk Niedersachsen: Hermannsburg, 1999, pp.23-24.

imbalances in their "die-hard" type of commitment ended just as a dream or became counter-productive when they faced the reality in the mission field. The initial compassion felt for souls that would perish in hell unless preached to, and for bodies that suffered affliction was overtaken by a sense of self-interest. There was disillusionment when the realities in the mission field became too hard to bear. In the century before the one under research, David Livingstone of the LMS left mission work to sell his experience of the African interior to a private company. Nosipho Majeke mentioned in her polemical book, that an LMS missionary, Rev. W. Edwards, who in 1801 went to Bechuanaland to do mission work, went instead into trading.[184]

Affected by their service to the indigenous people, some families of missionaries disintegrated. As has already been mentioned, Dr. Kurt Bergter's wife left him for another man when she found it impossible to cope with the demands of being a medical missionary at Itshelejuba.[185] Others took positions as civil servants to work for the government in sectors that involved the governance of black people. Some missionaries alienated the converts from their own people and provided them with alternative places to stay on the mission stations, especially in Natal and Zululand.[186]

The HMS at that time was worried that the actions of their missionaries might be misinterpreted as attempts to become lords over the Blacks and to alienate the converts from their rulers. One HMS official Ernst Karberg, wrote in the *Jahrbuch* of his church in 1985 about the fear of Lutheran missionaries bossing the indigenous people.[187] Like the missionaries who left aside their "initial calling" to pursue more lucrative engagements like trading, medical missionaries left rural Bantustan health

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[184] Nosipho Majeke, *The Role of the Missionaries in Conquest*. APDUSA: Cumberhood, 1952, p.88. The first HMS missionaries, who went to Bechuanaland and consequently cut off from their colleagues and supplies in Natal, started trading when they ran out of supplies. See Hartwig Harms, *Concerned for the Unreached: Life and works of Louis Harms*. Ev.-luth. Missionswerk in Niedersachsen: Hermannsburg, 1999, p.63.

[185] Dr. Kurt Bergter interviewed by Radikobo Ntsimane at Bad Öynhausen, Germany on 28 August 2002.

[186] Nosipho Majeke, *The Role of the missionaries in conquest*. APDUSA: Cumberhood, 1952, p.25.

[187] Heinrich Voges, *Vision: Global Congregation*. Ev.-luth Missionswerk in Niedersachsen: Hermannsburg, 2000, p.115. Appendix 3 on the Position of a missionary regarding segregation politics. "With the historical fact that the Whites made themselves the lords of this country, God gave them the duty to let the natives share in the blessings of Christian education and Western culture and not to make them objects of ruthless exploitation." Voges quoted this old text in his 2000 book. Karberg in a hindsight confession for the failure s of the HMS in Southern Africa, points to what happened to missionaries who attempted to assume a position that undermined the traditional leaders.

centres after the "nationalization" of mission hospitals in the mid 1970s, to work in South African government-controlled health institutions.

The missionaries who controlled their converts found it easy to exercise control over them with the resources that they had at their disposal. The missionaries wielded power over their converts and instead of serving them as were their initial goal, they end up being served in many ways.[188]

John and Jean Comaroff have also written about the power wielded by missionaries over the people they were meant to serve. They had divided loyalties by serving as spiritual fathers of the "natives" and also as advisors of the colonial authorities on how best to subjugate their spiritual "children". Dr John Philip and Rev John Mackenzie of the LMS are well-known for having initiated "treaties" that undermined them for the benefit of the British colony.[189] This co-operation between missionaries and the colonial powers goes a long way back in history. By law the missionaries were supposed to serve as some sort of informers for the government against black people as Section 7 of the law enacted by the government of Transvaal in 1860 states:

> All missionaries are obliged to pay careful attention as to whether any plans and plots are made against the State or its inhabitants by Coloureds of their stations or of the tribe under which they fall and to notify the government or their next officer; if they fail to do so they will be regarded and treated as persons who are implicated in these plans and operations.[190]

3.4. Financing the Hospitals

Finances play a most important role in the establishment and the running of a hospital or any medical facility. They cover medical and surgical needs, salaries of personnel from nurses and doctors to administrative crew, maintenance needs, among others.

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[188] Louis Harms wanted the HMS missionaries to use their hands to work the fields in order to inculcate in them the fact that they were going to serve the people and not vice versa. Louise Harms, 1999, p.26.
[189] Nosipho Majeke, *The Role of the Missionaries in Conquest*. APDUSA: Cumberhood, 1952, p.120.
[190] Heinrich Voges, Vision: Global Congregation. 1999, p.114. Appendices: Document 1 as translated from German originals, in *Erinnerungen aus dem Missionsleben in Südost-Afrika 1859-1882* by A. Merensky, Bielefeld und Leipzig, 1888, p. 487.

As was the case with other missionary ventures like schools and churches, the mission societies at least in the beginning often carried hundred percent of the financial obligation of the hospitals they established. Humphrey Mogashoa[191] and Richard Lubawa[192] have written at length on mission societies and finances in their respective doctoral dissertations.

Without subsidies, the medical ventures would have remained as dispensaries run from missionaries' wives kitchens. We have seen how Ka-Shile Hospital in Mbabane, Swaziland, operated on donations from friends in Germany for a long time until it was forced to close due to the Second World War. The Berlin Mission Society did not see health as part of its mission in southern Africa. With regard to the Botshabelo Hospital, Friedrich Dierks of the Mission of the Evangelical Lutheran Free Churches obtained a government subsidy from the onset.

In this sub-section I shall look at the role played by money in influencing the development of the mission hospitals and how they were run. I shall show that the development of the hospitals constantly needed financial injection for structural extensions and new machinery. These developments were acute, especially in the 1960s and the 1970s when tuberculosis swelled the number of patients who were admitted and needed long-term treatment. Money played a pivotal role in power relations around the hospital setting. The medical missionaries needed to expand the hospitals and it appears that they did not mind where the money came from. The government was willing and provided the needed finances but later claimed control of the health institutions.

When dependence is created those who are in need of the resource will gather around the owner or the controller of the resources to benefit from them, while the owner is free to dispense such resources at will. The mission hospitals depended on the mission societies for funds and later when such funds were not forthcoming at the desired

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[191] Humphrey Mogashoa, *South African Baptists and Finance Matters (1820-1948).* Unpublished University of Natal PhD Dissertation, 2004.
[192] Richard Lubawa, *The missing link: Indigenous Agents in the Development of the Iringa Diocese of the Evangelical Lutheran Church of Tanzania (ELCT) 1899-1999*. Unpublished PhD. Thesis, University of Natal, 2002.

speed, the government offered its resources. These resources gave the government the freedom to inspect the hospitals and decide how resources were to be utilized.

The English adage say He who has gold, makes the rules and He who pays the piper calls the tune. Let us look at the four mission stations under research and their mission societies to see to what extent do the two adages hold true. We shall see that resources played a crucial role in the relationship between the various people connected to the hospitals, for example the health seekers and the health providers—who were doctors and nurses. The same resources played a crucial role between leaders of the mission hospitals, like doctors who were heads of the hospitals, and the boards or councils who had overall control of these institutions. Simply put, the resources needed to run the mission hospitals determined how the various interested parties related to each other in relation to the mission hospitals. Blacks were not part of bodies that determined how funds were to be raised and spend. They were excluded until nationalization took place. At Itshelejuba, the first administrator was Mr. Jabulani Mdluli in the 1970s.

We shall see in the sub-sections below that missionaries constantly had to find ways to raise funds; both from their home mission societies and from the government. It was the financial assistance from government that created the dependence of the mission hospitals on government subsidies. Blacks were not part of the hospital leadership and were thereby excluded from the struggles of keeping the hospitals afloat.

3.4.1. Bamalete Lutheran Hospital

Established by Emma Pfitzinger and her brother Heinrich, the hospital called Harmshope in 1935 reportedly spent £111.1.3 of the £114.4.9 received for medicines.[193] Emma Pfitzinger's handwritten 1936 report mentioned that the

[193] Report dated 26 January 1937 held at HMS Archive in Hermannsburg, Germany in Folder A: AS Ausland Südafrika File II, H.Pfitzinger 1932-1939.

government (Bechuanaland Protectorate) pledged 10 Shillings per patient. "This", Emma wrote in the same report, "allowed her to treat patients without charge."

Due to limited financial resources, there was a need to inculcate in the community the culture of paying for services. Emma Pfitzinger decided that any patient, who asked for a home-call and was not present when a nurse arrived, was to be charged a shilling.

As a way of digression one can observe that Western culture was so much assimilated by the Batswana that monetary payment was required to pay off debts. The introduction of a monetary economy was a necessary foundation for the functionality of a Western life-style. Acculturation is discussed at length in chapter four of this present study.

Another report stated: "Of the £193.13.1 received for medicine £174.16.6 the medical facility was expanded and dedicated by Superintendent Jansen of HMS in 19 June 1939."[194] Since an undisclosed large portion of funding for the new facility came from Alsace, the hospital was called Alsatia.[195] That idea of "our name for our money" shows how much influence donors had on mission hospitals. It is also possible that the recipients felt an obligation to honour the donors with the name. It possible, that the naming of the Ramotswa hospital followed the trend in South Africa, where colonists named local places after their European places of origin. German missions were notorious for that practice, with names like Augsburg, Harburg, Wittenberg, Uelzen and Hermannsburg.

As was the case with the support of Dr. Magdalene Schiele of KaShile clinic in Mbabane in Swaziland, Emma's salary was paid by her home congregation in Alsace. When mission director Wickert came to southern Africa for a visit, he enquired about the source of Emma's salary. HMS was not privy to the information despite the fact that Emma was sending reports; otherwise the director would have established this

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[194] Ramotswa mission station report of 1938 to the HMS headquarters in Germany written by H. Pfitzinger on 19 June 1939 held at HMS Archive in Hermannsburg, Germany in Folder A: AS Ausland Südafrika File II, H.Pfitzinger 1932-1939.

[195] *Er botente, dass der groesse Teil der gaben von missionfreunden aus dem Elsass stemmten, und dass darum das Krankenhaus den Namen „Alsatia" erholten habe.*

from his office in Hermannsburg. This information was necessary, since the mission society was planning to send two nurses into the mission field. The salaries for the two nurses were going to be the first direct involvement of the HMS in the medical field in southern Africa.

There was a steady rise in financial support from overseas for the medical work of Alsatia hospital in Ramotswa. This had a negative impact on the development and the sustenance of the medical facilities under the mission society because in later years, when such financial support dwindled for whatever reason, the dependency created was difficult to overcome. This pattern of increased financial support and ambition for growth is observable in the other three hospital establishments under investigation in this research.

Emma Pfitzinger wrote in the 1937 to the mission society that she received £142.7.5 of which £124 Pounds was designated for medicines and stock.

In the 1938 report by Missionary Penzhorn, from Kroondal near Rustenburg (which at that time formed one district with Ramotswa), £193.13.1 was received, of which £174.16.6 was spent for medicines and requirements.[196] There are no written reports for the 1939 and 1940 mission station activities. The 1941 report was written by Missionary Pfitzinger and makes no reference to hospital matters. It deals with congregational matters and the arrival of the Namibian Hereros settling in Lentswelatau village. The 1942 report is dedicated to the issue of polygamy among the Batswana. The 1943 report does not mention medical mission work.

The 1944 two-page report mentions a member of the congregation in Ramotswa donating £10 for the use of a hospital building.[197] The 1945 report is just as silent on medical work as the preceding reports. The reason was probably the disturbance

[196] 1938 Report of the Ramotswa Mission Station by Missionary Penzorn working from the Kroondal Mission near Rustenburg, South Africa. Report is kept at HMS Archive in Hermannsburg, Germany in Folder A: AS Ausland Südafrika File II, H.Pfitzinger 1932-1939.
[197] 1944 Report of the Ramotswa Mission Station dated January 1945 and held at HMS Archive in Hermannsburg, Germany in Folder A: AS Ausland Südafrika File III.

caused by the war in which Germany was involved.[198] The 1946 report was written by hand on two small pages by Missionary Lange, who came from a place called Manahaim, probably a mission station in the Lehurutshe area.[199] He wrote that a little money was donated but refrained from mentioning the source and its designation. The 1947 report is also devoid of medical interest.[200] In the subsequent reports of 1948 and 1949, Missionary Lange mentions the outbreak of smallpox and tuberculosis but no financial intervention either from government or the HMS.[201]

The visit of the Mission Director D. Elfers in October 1951 to the mission station, brought about change in the hospital work. Sister Emma Pfitzinger and her brother (promoted to superintendent) had departed from Ramotswa and Missionary Lange wanted to enlarge the medical work. It is surprising though that no follow-up was done on this matter, as the reports of the two following years are silent on it.[202] The reason could be that the new missionary, Holsten, who wrote the reports, did not immediately see the value of reporting on medical work as Missionary Lange did.

Holsten's 1955 and 1956 reports are silent on medical work and its finances.[203] In 1955, the amount of £503-23-5 was raised but no mention is made of how much of that money was designated for medical work. Holsten was transferred when Botswana became a protectorate governed from Mafikeng, in 1958. An active man who supported medical mission succeeded Holstein. His name was Bernhard von Scharrel. He and some sisters had to go to Mafikeng and solicit funds for the hospital, thereby making the hospital vulnerable for a take-over.

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[198] 1945 Report on the Ramotswa Mission Station by H.Pfitzinger dated January 1946 and held at HMS Archive in Hermannsburg, Germany in Folder A: AS Ausland Südafrika File III.
[199] 1946 Report on the Ramotswa Mission Station by Missionary Lange dated 9 January 1947 and held at HMS Archive in Hermannsburg, Germany in Folder A: AS Ausland Südafrika File III.
[200] 1947 Report on the Ramotswa Mission Station.by Missionary Lange and held at HMS Archive in Hermannsburg, Germany in Folder A: AS Ausland Südafrika File III.
[201] 1948 and 1949 Reports on the Ramotswa Mission Station by Missionary Lange held at HMS Archive in Hermannsburg, Germany in Folder A: AS Ausland Südafrika File III.
[202] 1953 and 1954 Reports on the Ramotswa Mission Station by Missionary Holsten dated 12 January 1954 and held at HMS Archive in Hermannsburg, Germany in Folder A: AS Ausland Südafrika File III.
[203] 1955 and 1956 Reports respectively dated 12 January 1956 and 19 January 1957 on Ramotswa Mission Station by Missionary Holsten and held at HMS Archive in Hermannsburg, Germany in Folder A: AS Ausland Südafrika File III.

As in Itshelejuba, Blacks were kept apart from the financial management of the hospital both with regard to raising the funds and to controlling them. In the control of finances Blacks had no say even after they were put in charge of the mission churches. That ensured that Whites would remain in control for a long time. As already mentioned in the previous sub-sections, the medical missionaries constantly struggled for funds in order to keep the hospitals afloat. As they were excluding Blacks from participating in the management of the health facilities, they also excluded them from financial management. The constant lack of funds led to the mission hospitals' dependence on government subsidies. This was a recipe for the take-over of the hospitals and for their handing over to the Bantustans in the 1970s.

3.4.2. Untunjambili Mission Hospital

Untunjambili Mission Hospital was founded as a private initiative, like the KaShile Hospital in Swaziland. Sister Lillian Otte ran the hospital on a very low budget according to her daughter Solveigg Otte. MaYangwe was not employed by the American Lutheran Mission, as her husband Karl was, and had to raise funds privately to run the hospital:

> But the government grant was so little and the…she tried to get a little bit of money sometimes you know just to cover some of the expenses from the people. If they had they would give a few shillings, sometimes they would bring a chicken, you know something … so that we could carry on. But it ran on a smell of an oil rag really, for a while. But she was a … she was very good at getting things and she used to get…order powders I remember, certain powders. And I think she may have had some contacts with the McCord Hospitals because I know she was in close contact with Dr. Taylor. But she used to get the things and get recipes of how to do this and that, you know.[204]

Mr. Eli Makhoba also confirmed the financial problems the hospital faced while he was working as a bookkeeper at the headquarters of the regional church, later called South East Diocese of ELCSA. Makhoba responded in an interview:

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[204] Solveig Otte interviewed by Radikobo Ntsimane in her home in Mayors Walk, Pietermaritzburg on 8 May 2007.

> Well, I don't know the running of the hospital because we always had a problem of fighting. We also had a problem of finding sufficient funds to run the hospital properly. So there was also the government (which) has money … the government did mention to the Americans … they were going to build a hospital near … Newcastle which is now called Emalahleni … but again it is a question of …[205]

As early as the 1950s, the government gave financial grants for the running of the hospital. Solveig Otte remembers what her mother told her regarding finances: "She never got anything herself. But she got … I remember her telling about the government grant. The government gave her so and so much. But she had to be very, very careful with that. And I do remember telling people that please bring something for … you know to cover the costs."[206]

Ms. Solveig Otte also remembers that her mother used to write letters till late into the night to encourage people in America to support the work on the mission in Untunjambili. The situation was worsened by the fact that the health seekers did not have enough money to cover the costs of medication. When the LMF took over the Lutheran Medical services in 1960, they also conducted the legal and financial affairs of the mission hospitals in Natal and Zululand.

3.4.3. Emmaus Mission Hospital

According to Bishop Richard Schiele, Emmaus Mission Hospital work was supported from the beginning by the Swazi Freundekreises, which had supported the KaShile Hospital initiatives as well.[207] In 1951, support for the hospital was not forthcoming because, according to the government, Emmaus Mission Hospital was "not within our regional plan."[208] Over and above that refusal to support the Emmaus medical work, the government declared that all medicines from outside South Africa, even those that

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[205] Mr. Eli Makhoba interviewed by Radikobo Ntsimane at Untunjambili on 19 July 2000.
[206] Solveig Otte interviewed by Radikobo Ntsimane in her home in Mayors Walk, Pietermaritzburg on 8 May 2007.
[207] Bishop Richard Schilele interviewed by Radikobo Ntsimane in Scottsville, Pietermaritzburg on 13 May 2000.
[208] Letter of Dr. Magadalene Schiele to Ms. Alice Bühring of the BMS, dated 2 October 1951 and kept at the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-11988).

were not produced in large quantities, were not to be imported without an import licence (*Einfuhrgenehmigung*).[209] This move was no doubt meant to inconvenience the medical mission so much that eventually they would consider closing down the institution.

Fortunes changed in favour of the BMS when, in 1952, the government resolved to recognize and support the medical work done at Emmaus.[210] Taking advantage of that recognition, Bernhard Schiele applied for funding from the government to extend the hospital buildings.[211] In a letter addressed to Oelke, Bernhard Schiele expressed anxiety that being recognised required regular inspections of the hospital by the government. The recognition bore fruit when the provincial government pledged £1 500 on a Pound-for-Pound basis, while the Union of South Africa Health Authority promised to build a ward for contagious disease (*Ansteckende Krankenheit*), which one can deduce to be tuberculosis.[212] Besides government funding, lump sums came from BMS and other donors.[213]

In 1954, the BMS Committee resolved to no longer support the Emmaus Mission Hospital financially. The black people were now constituted as a church body and in charge of their own affairs. As an autonomous body the church had to take care of the financial needs of the hospitals.[214]As if this move was not frustrating enough, someone from the BMS office wrote to Bernhard Schiele that all future medical requests from Dr. Samuel Müller of Tübingen should be channelled through their office. The BMS was tightening control by withdrawing resources from the regional churches. The mission body was quite aware that the newly-established church bodies

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[209] Letter of B. Schiele reporting to Director Brennecke the proceedings of the meeting of the Medical Mission Provincial Authority of Natal held in early November. Letter is dated 22 November 1951 and kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-9261).
[210] Letter of Director Brennecke expressing joy to B. Schiele for the news. Letter is dated 18 July 1952 and kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-8566).
[211] Letter of B. Schiele to Oelke dated 2 December 1952 and kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-9261).
[212] Letter of B. Schiele to Oelke dated 29 September 1953 and kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-9261).
[213] 10 000DM came from Dr. Samuel Müller of Tübingen mentioned in the letter of South African *Dezernat* to B. Schiele dated 17 June 1954. The Lutheran World Federation donated £10 000 US for Emmaus Mission Hospital work mentioned in the letter of Director to B. Schiele dated 18 January 1955 and kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-9261).
[214] Letter of BMS to B. Schiele dated 19 July 1954 and kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-9321).

could not financially sustain the medical work unaided.[215] When the Black church leaders were in charge, the dedication of the mission society to maintain hospitals seemed to dwindle.

There is no evidence that Missionary Bernhard Schiele made a request through the BMS office for the amount of DM3 000 sent to Emmaus by Samuel Müller for medicines.[216] At that stage, the government had lifted the import duty previously imposed on medicines from outside South Africa.[217] In that relationship, both the government and the BMS could exercise control by withholding or withdrawing resources when their demands were not met by the mission hospital management.

The control that the mission societies exercised over the hospitals in the mission field can be seen in the relationship that the BMS had with Emmaus Hospital. The BMS was aware of the strong dependence that the hospital had on its resources and used that dependence to its advantage. The threat of financial withdrawal as a result of the establishment of the independent church bodies was driven by the paranoia of losing control, and maybe identity. From the beginning, the relationship was not based on mutual respect but on a mother and daughter type of relationship, where the mission knew what was best for the mission field and supported it. This relationship so frustrated Bernhard Schiele, that in one report he mentioned four times in dismay the fact that the officials back home (*Heimat*) had no clue of the needs in the mission field (*hier drausen*).[218]

Showing that she and other nurses could do their work without big salaries, Matron Evelyn Sommerfeld said that the nurses had no use for money at Emmaus as there were no theatres and restaurants to spend it on. They used it chiefly for buying petrol. However, Bernhard Schiele argued in favour of an increment for the Emmaus nurses,

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[215] Letter from BMS office to B. Schiele dated 25 January 1955 and kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB MBW/1-9321).
[216] Letter of South African Dezernat to B. Schiele dated 28 April 1955 and kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB BMW/1-9321).
[217] Letter of B. Schiele to Oelke dated 6 July 1955 and letter of South African Dezernat to B. Schiele dated 28 April 1955 and both kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB BMW/1-9261).
[218] Over 4 page report in File 4061 (1942-1946) Vol.2 and kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB BMW/1-9261).

when he learnt of the discrepancies between them and those working at the Bergville government clinic. He requested the BMS to raise the monthly salaries from £15.16.8 to £30-35 as the Bergville nurses were paid £50 per month.[219]

We can see that lack of finances was a constant challenge facing the management of the various hospitals. Mission societies had obviously dedicated the funds to other projects of the ministry, or they wanted to frustrate the new Black leadership that had inherited the church that rose out of the efforts of the mission societies. Other mission hospitals, as we have seen with the Bamalete Lutheran Hospital in Botswana, also found it a big challenge to fund all their projects. When Matron Evelyn Sommerfeld was asked what she wished she could have changed while working at Emmaus, she replied that it was finance: "It was not frustrating; I could not say it was frustrating. We had so little money that we could not do things that were necessary to do. If we had more money we could have done more."[220] Yet, the presence of mission hospitals brought about social development in the various communities among whom they were established.

3.4.4. Itshelejuba Mission Hospital

Soon after Sister Ruth Bauseneick completed her training in Germany in 1953, Mission Director Adolf Blanke sent her to South Africa in a special church service ceremony. Despite this public recognition of Sister Ruth's work in the mission field, MELFC did not back it up this recognition with financial support. She used part of the £5 that she was receiving on a monthly basis to purchase hospital medicines and support ten persons.

It was when she was already in the field that Sister Ruth went about encouraging German farmers and business owners to contribute towards the work done at Itshelejuba Mission Hospital. Beds, linen, furniture, and patients clothes were some

[219] Letter of B. Schiele to Oelke dated 2 April 1956 and kept in the BMS Archives in Kreuzburg, Berlin in Germany. (ELAB BMW/1-9361).
[220] Evelyn Sommerfled interviewed by Radikobo Ntsimane at Walsrode, Germany, on 5 August 2002.

of the needed items acquired from the generosity of Lutherans.[221] Sister Ruth remembers that for admission to the hospital patients had to pay R5.00, and for out-patients R2.00 was required after 1960.

The financial needs were felt so acutely that Mission Superintendent Christoph Johannes requested Friedrich Dierks, the then- Chairperson of the Mission Hospital Committee, to apply to the government for a grant for Itshelejuba Mission Hospital.[222] This grant was also o be used to pay salaries of auxiliary staff and nurse Nester Dlamini. Sister Ruth's interview shows the government's intention to control the use of its money. She said that the grant was only offered after an inspection was conducted by a certain Dr. Eisler. It was in 1958 that the grant was received. Other funds were raised through the talks that Sister Ruth conducted in various congregations in Germany. In 1962, money was received from the congregations where Sister Ruth spoke.[223] Later, congregations and women's groups of various congregations in Germany contributed money—which they sent from time to time—for the purchasing of a stove, a fridge, and linen which they sent from time to time.
When asked what the registration and recognition of the hospital by the government meant, Sister Ruth replied, "Financial. Money! And they sent the people to look around if everything was ok!"[224] As with other mission hospitals in South Africa and Bechuanaland, when the government subsidised the hospital work, it became directly involved in inspecting whether or not things were run according to its expectations. This shows the diminishing power of missionaries over the control of their hospitals and the increasing power of the government in controlling what was happening in the mission hospitals. As we shall see below, support for medical missionary work came from other bodies like Brot für die Welt but did not necessarily translate into diminished control of the hospitals. Unlike other sources that supported the medical mission work, the government of South Africa wanted to implement segregated medical care.

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[221] Ruth Bauseneick interviewed by Radikobo Ntsimane at Bleckmar, Germany, on 5 August 2002.
[222] Friedrich Dierks interviewed by Radikobo Ntsimane at Bleckmar, Germany, on 18 July 2002.
[223] Ruth Bauseneick interviewed by Radikobo Ntsimane at Bleckmar in Germany, on 5 August 2002.
[224] Ruth Bauseneick interviewed by Radikobo Ntsimane at Bleckmar in Germany, on 5 August 2002.

In 1968, when Sister Ruth left, Itshelejuba had grown to one hundred and ten beds in about fifteen years. It grew from a small out-patients rondavel with a stretcher, one chair, and one small table to a large hospital. The growth of the hospital in size was not only the result of the recognition of the hospital by the government. One major donor organization called Brot für die Welt, made major contributions to many and possibly all Lutheran mission hospitals in Southern Africa. In Itshelejuba Brot für die Welt built the maternity ward and together with the government, built the tuberculosis section of the hospital and the X-Ray machine. Brot für die Welt also bought a generator.

4. Mission Hospitals as Development Projects

When asked to comment on the development brought about by mission hospitals among his people, Dean Mthethwa replied: it was very, very good, it was like the coming of light in the darkness.[225] This "light" referred to by Mthethwa in the case of Itshelejuba Hospital which expanded mainly as a result of the prevalence of tuberculosis in the surrounding areas, needs to be discussed.

With the establishment of the Itshelejuba Mission Hospital, competition arose between it and the local health providers. Although not necessarily an open and antagonistic competition, the local people had to choose one system of health against the other. In the 1960s the outbreak of tuberculosis popularized the hospitals, as there was no known cure for it among the Zulu and the Swazi in and around Itshelejuba. The government's demand for taxes, and the loss of confidence in the produce of the land, forced young men from the Itshelejuba area to flock to the industrialized and mining areas of the country to seek employment.

The research done by Mamphela Ramphele and Francis Wilson on poverty in South Africa is helpful, as it sheds light on the issue of tuberculosis and migrant labour:

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[225] Dean C. N. Mthethwa interviewed by Radikobo Ntsimane at KwaMbonambi near Empangeni on 19 November 2002.

> The evidence indicates that, more than any other historical process, it was the development of the mining industry which, by increasing the inflow of Europeans infected with tuberculosis who then worked together with black miners under dusty, damp, and poorly ventilated conditions, set the scene for infection of these black workers, who had no resistance and poorly fed and housed.[226]

Furthermore, the authors explained why Itshelejuba and the other rural mission hospitals had to face the challenges of treating tuberculosis, which was previously unknown in those areas but became a major health crisis. They conclude that women and children became infected as a result of men's visits back home, thereby completing the cycle of infection.[227]

Before the outbreak of tuberculosis, the Itshelejuba Mission Hospital and other mission hospitals employed black people for menial jobs while the missionaries performed the "sophisticated" roles. That was the trend in missionary societies, or at least amongst their agents on the ground, who delayed the training and mentoring of black people to perpetuate their grip on power and influence. The excuse, since the early 1900s, was always that Black people were not ready to take leadership, while in fact the missionaries resisted the idea of empowering Blacks.[228] In the MELFC, some black pastors: like Piet Mokone and Thomas Modise among the Tswana and both Daniel Mkhaliphi and Absalom Sibiya among the Zulu were only ordained in during the respective periods of the two world wars, when German missionaries were under restrictions.[229]

The number of infections from tuberculosis made the continued grip on power and knowledge impossible to sustain. Ramphele and Wilson mentioned that tuberculosis constituted sixty one per cent of all notifiable diseases in the 1980s.[230] This shows that tuberculosis was gradually spreading as the mining industry was growing. The

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[226] Francis Wilson and Mamphela Ramphele, *Uprooting Poverty: The South African Challenge*. David Philip: Cape Town, 1989, p.116.
[227] Ibid.
[228] Jerome Sikhakhane, "The Beginnings of Indigenous Clergy in the Catholic Church of Lesotho" in Philippe Denis (ed.) *The Making of an Indigenous Clergy in Southern Africa*. Cluster Publications: Pietermaritzburg, 1995, p.117ff.
[229] Eleven pages document produced over the years by Dr. Wilhelm Weber entitled, "Nampa ababengabafundisi beKerike noma iMishane elithiwa the Hannoverian Free Church Mission."
[230] Francis Wilson and Mamphela Ramphele, *Uprooting Poverty: The South African Challenge*. David Philip: Cape Town, 1989, p.116.

reservation of better positions for White missionaries in the budding hospitals was no longer practical. The demand for tuberculosis treatment far exceeded the supply of health provision. There were other historical and ecclesiological developments that demanded that local people were empowered through training and more responsibility.

The 1960s saw the creation of the national Churches, especially in the Lutheran family in southern Africa. The MELFC facilitated the constitution of a Black Church—the Lutheran Church in Southern Africa (LCSA)—in 1967, under the episcopacy of a missionary, Georg Schulz. Four dioceses were constituted with four local pastors as deans and four German missionaries as their deputies. The mission societies had no apparent withdrawal plan. They were going to stay on in the mission field and continue to give guidance. The development of personnel and the relinquishing of leadership positions probably developed in missionaries the fear that local leaders might destroy the structures that their forebears had set up.

The demand for more nurses to cope with the proliferation of diseases enabled black women to receive training in local hospitals. During this training, there was constant conflict among the White authorities on whether or not such training was necessary, and as to how much authority was to be given to the qualified Black nurses. When Black nurses took leadership in secular and mission hospitals, a new imbalance in power relations was observed. They became authoritarian and emulated the White matrons in the strict observance of rules. As we shall see in the next chapter, the assumption of leadership positions by nurses trained in government hospitals contributed to the alienation of the hospital from the Church. The government expected efficient management of resources and time, something the Church did not emphasized in the 1970s.

The words of Dean C.M. Mthethwa regarding the hospitals—"like the coming of light in the darkness"—become evident when one looks at the photographs kept in archives, in missionaries' families' private collections and in books and periodicals.[231] When one sees the people gathered at the entrances of out-patients centres and around

[231] Solveig Otte, "Where to now? A Journey Woven with Adventure." Undated self-published book.

the mobile clinics' vehicles, no doubt is left that indeed, the indigenous people of southern Africa had adopted biomedicine as one of their ways to health restoration. Of course the photographic evidence does not shed light on where else these health seekers went for help. The photos do not show where they were before coming to the "rondavel", nor do they show where else they will go after visiting the "rondavel".

When critiquing biomedicine and mission hospitals, it is important to recognize the experiences of those who sought and found help at those hospitals. There were people who suffered from elephantiasis and who could not find assistance anywhere, since that was a new disease. The boy who had a lump as big as his head hanging from his neck would doubt the sincerity of anyone telling him that medical missionaries had insincere motives. The women who lost their babies at birth due to primitive methods used by some midwives, no doubt appreciated the work of MaYangwe, who, according to her daughter, delivered over three hundred babies with no deaths, despite the fact that she had no prior training but was guided only by a manual.[232]

Mr Edward Motswaledi shared his near-death story with the readers of a pamphlet *Lutheran Medical Mission at Ramotswa Botswana 1934-1984*, prepared for the commemoration of the fiftieth year of medical mission in Ramotswa. His story is titled, "I cried for help", and it is quoted *in toto* for clarity's sake:

> It was the 25th of December, 1973. Then I was a herdboy looking for my parents' cattle together with other boys. Early in the morning this day I was called to the herd where one of the cows had just calved. I was warned of the cow but still went to drive it together with other cattle. Suddenly, I don't know how, it actually happened, I found myself pierced up by the cow's horns which went through my shoulder. I cried for help and eventually was freed by another brave boy. I was bleeding horribly, but was too far away from the clinic at an isolated cattle-post. As the boys who were with me would not know what to do with me they sent for my parents. They came the following day and carried me on their backs for over 20 km to the Lutheran Clinic at Ramotswa. And still I was bleeding and suffering from pain. At the clinic I was treated by Sr. Pfitzinger and she managed to heal

[232] Solveig Otte interviewed by Radikobo Ntsimane in her home in Mayors Walk, Pietermaritzburg on 8 May 2007.

> me in the weeks that followed. After 5 weeks I was able to return to the cattle-post.[233]

There are countless such-stories which are still told in the villages where mission hospitals were built; they are stories of gratitude and admiration; they are stories that tell of mission hospitals as the light shining in the darkness. There are other stories, undoubtedly. The stories that perhaps negate the light witnessed to above. Let us now look at the role played by the Boards and Councils that were in charge of the direction and the future of these "lighthouses". We shall look at the Boards and Councils in the next chapter, in relation to the question of power relationships and how they ran the hospitals until they were nationalized.

5. Chapter Summary

This chapter attempted to show the various scenarios that led to the establishment of the four mission hospitals under investigation in this research. When one perceives that there were diseases of various sorts which the people in Southern Africa could not heal, one can only appreciate the introduction of biomedicine through mission hospitals. This chapter has also attempted to show the dedication of the nurses and the doctors who at great disadvantages to themselves and their families, provided help where it was needed. This dedication was often not matched with the indispensable financial support, which created a negative dependence on those who provided it, like the governments of Bechuanaland Protectorate in the case of BLH and the Union of South Africa. The Lutheran mission societies, the missionary nurses and doctors delayed the training of the indigenous people in financial participation in mission hospitals until the governments' intervention in the 1970s. Racial discrimination in the management of the mission hospitals can be seen as the mirror of how South African multi-racial society was organized and related under apartheid. One can conclude that the racial discrimination practised in the hospitals indirectly served as a preparation for nationalization. We shall see in the next chapter that it was easy for the Lutherans to let go of their hospitals when nationalization was legislated.

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[233] When Mr. Motswaledi told the story, he was sixty years old and still working as a plumber at the BLH.

CHAPTER SIX

MISSION AUTHORITIES AND THE NATIONALIZATION OF MISSION HOSPITALS

1. Introduction

The purpose of this chapter is to discuss hospital boards locally as well as their role in the entire medical mission enterprise. This chapter will also examine the roles that various boards, committees and councils played in the nationalization of the mission hospitals. The roles of these bodies will be interrogated in relation to the nationalization of the mission hospitals or, in the case of Bamalete Lutheran Hospital, its partnership with the Botswana government. Why, in the presence of those boards and committees, did the Lutherans in South Africa let go of their hospitals without much resistance? The answer may lie in the apartheid policies of the government.

We have seen that where mission hospitals were founded, people used and embraced them and depended on them as part of their health systems. The possibility of treatment for various diseases, some of which traditional medicine could not cure like tuberculosis, attracted people to the mission hospitals so much that the government increased its subsidies to boost the capacity of the mission hospitals for health provision. In the 1960s and 1970s drastic changes took place as the South African government changed its health provision authorities. Such changes should be seen in the light of a new approach enforced by the government in the 1950s. The government had already put into gear its agenda for total control of the lives of Black people through legislation. In 1950 the Group Areas Act had designated areas in which the different race groups could live separately from each other. Soon thereafter the Bantu Education Act of 1953 was promulgated mission schools were nationalized. With the health authorities being from the mission societies to the national government, power relations changed. Let us now consider first the roles and authority in the four mission hospitals as represented in a diagrammatic scheme before considering the nationalization process.

2. Mission Hospital Boards, Councils and Committees

The scheme below is an attempt to show how each position influenced the power relationships within a hospital setting. We shall consider first the Itshelejuba Mission Hospital, then the Lutheran Medical Foundation which managed Untunjambili and Emmaus Mission Hospitals, and finally the Bamalete Lutheran Hospital from the beginning of the 1960s.

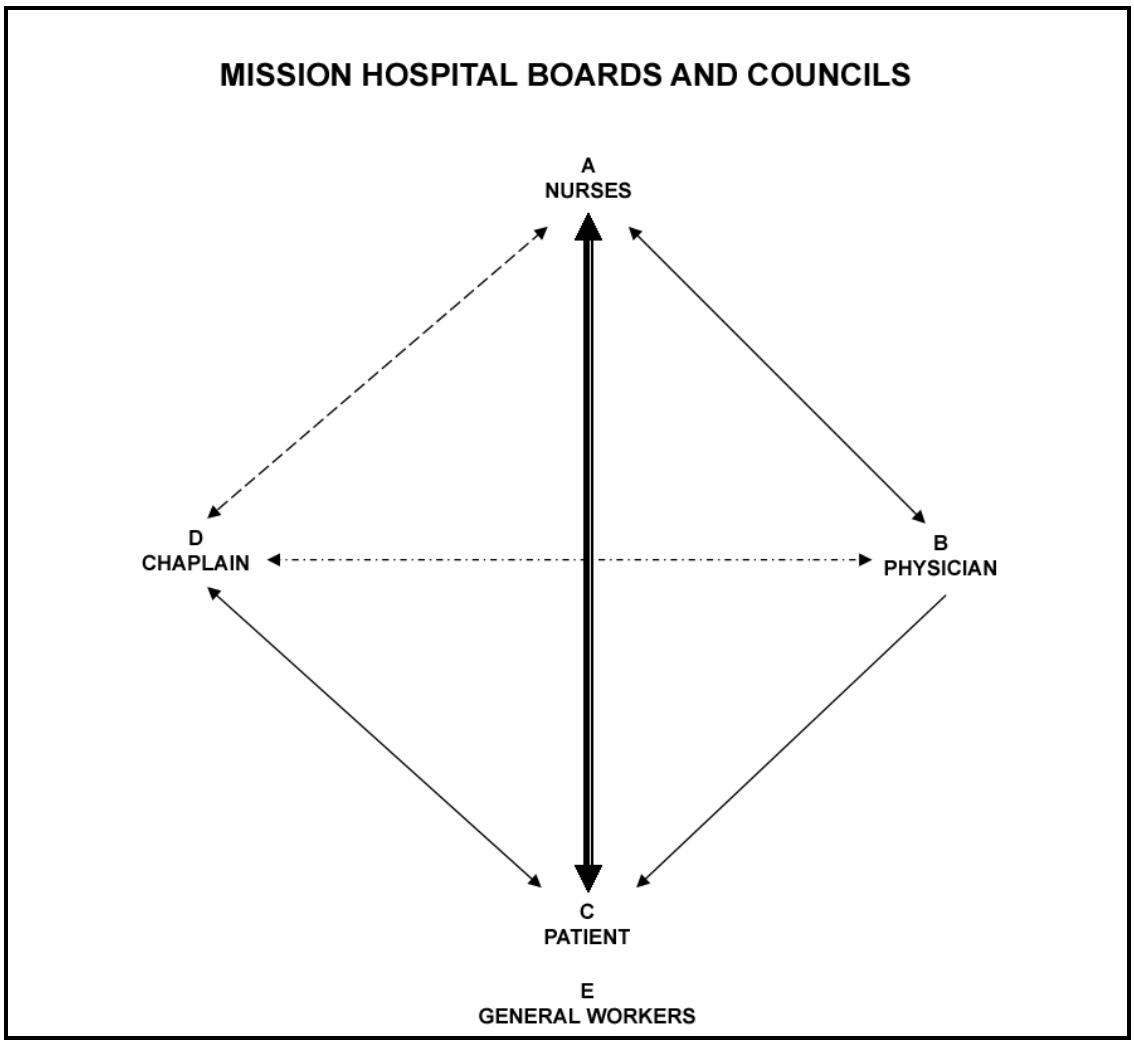

Figure 4

2.1. Key to Figure 4

A-B: Bold solid line with to-and-fro arrows indicate co-operation between the nurses and the physician. Though the nurse appeared on the mission hospital scene earlier than the physician, the physician wielded more power in the hospital setting by virtue

of his qualifications and possibly the prevailing androcentrism of the time. Co-operation between the nurse and the physician was easy and cordial because they had been trained in bio-medicine and needed each other to function properly. In Itshelejuba, however the co-operation was problematic and Sister Ruth Bauseneick[1] had a not-so-cordial relationship with Dr. Bergter, the superintendent. Generally, the lines of authority were easily recognized and respected for the sake of creating a harmonious working environment.

A-C: The bold bipolar arrow indicates an easy communication between the Black nurse and the Black patient. Though Black nurses manifested a tendency to over-control, Black patients, as will be argued in this chapter, the cultural similarities with the Black patient made communication manageable. The thin solid to-and-fro line indicates that the White nurse, often despite her attempt to speak Zulu, had a communication barrier caused by cultural dissimilarities. With regard to authority, the nurses exercised power by virtue of their qualifications. Since they had demonstrated knowledge and the potential to cure diseases, they were accorded respect.

B-C: Similarly, the bold to (but-not-fro) arrow indicates the authority the physician had over the patient. By virtue of his qualifications and his position, the physician was the most influential person in the mission hospital. It would not be incorrect to conclude that he was the custodian and executor of the biomedical hegemony on health provision. He decided who would be admitted or rejected by virtue of the rules and knowledge he espoused. Often the physician was also the superintendent or the manager of the hospital. Dr. Kurt Bergter and Dr. Ulrich Schmidt were managers and superintendents of Itshelejuba and Ramotswa respectively. Emmaus was an exception with the missionary Bernhard Schiele being the manager while his wife Dr. Magdalene was the local physician. Maybe the Berlin Mission Society found it easy to deal with a man they had trained, as demonstrated by the many letters exchanged between him and the mission authorities regarding the mission hospital.

[1] Sister Ruth Bauseneick interviewed by Radikobo Ntsimane at Bleckmar, Germany, on 5 August 2002.

D-C: The bold bipolar arrow indicates the working relationship between the chaplain and the patient. The chaplains, all of whom were Black, were in good position to help the patients. Jacobeth Mookodi Rangongo of Ramotswa became an evangelist in the 1960s, long before the debate on women ordination arose. She was commissioned as evangelist after she had served as a chaplain at the Bamalete Lutheran Hospital at the request of the HMS missionaries.[2] At a time when chaplaincy became popular in hospitals run by the LMF, smaller hospitals had un-ordained *manyano* women conducting prayers. Though their training in counselling the sick was limited at that stage,[3] they had the opportunity to listen to the patients who shared their culture. In this case communication was crucial. They could talk and understand each other even if they did not agree: the chaplain represented the dominant religion to which the patient did not necessarily subscribe. While the chaplain was important, he or she was not indispensable. The mission hospital that was founded on the biomedical health system could easily operate without a chaplain, and it did.[4] Dr. Erling Hestenes, who served as a mission doctor in Hlabisa Mission Hospital and also as head of the Lutheran Medical Foundation (LMF) in 1967, wrote about the poor relationship between the chaplains and other hospital employees and about the difficult situation chaplains faced in the mission hospitals as if they were not part of the team:

> We open the doors of our hospital to the church. We invite the church to use the hospital for evangelistic purposes. We provide a chapel and perhaps housing for a chaplain. Then we sit back and wait for the church to do its duty. And when a chaplain is placed at our hospital, he comes as something additional; he comes into a rather forbidding scene, he works quite alone, he receives no special help from us, he is rarely invited into our general hospital discussions, perhaps he receives hindrance in his work from members of hospital staff. He is given no orientation. He must find his own way. He is really not part of the team.[5]

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[2] Jacobeth Mookodi Rangongo interviewed by Radikobo Ntsimane in her home at Ramotswa Botswana on January 2002.

[3] Chaplains were introduced mainly during the time of the Lutheran Medical Foundation in the second half of the 1960s. Dr.Vivian Msomi interviewed by Radikobo Ntsimane in his office on 25 May 2005.

[4] After Rev. Absalom Sibiya, the first chaplain of Itshelejuba Mission Hospital, Rev. Johannes Khumalo was assigned to serve the congregation from the hospital manse. Although Johannes Khumalo may have helped with services for patients he was not assigned as a chaplain. After Khumalo, the next pastors served Itshelejuba from the nearby village of Belgrade.

[5] Erling Hestenes, "Hospital Staff Involvement." in, *The Report of the Umpumulo Consultation on the Healing Ministry of the Church*. Lutheran Theological College: Mapumulo, Natal. 19-27 September 1967, p.119.

Patients of a different religious persuasion like Muslims and the unconverted could choose not to use the services of a Christian chaplain. The mission societies believed that Christian prayers and counselling make their hospitals unique as they combined biomedical healing with prayer to God who provides health.

A-D: The dotted bipolar arrow indicates that the nurse and the chaplain could work together amicably, despite their different training and orientation. In the case of the Black nurses, culture and language played a significant role although the nurse occupied a higher rung in the hierarchy. Due to her training the nurse was better acquainted with Western medicine and the hospital operations than the chaplain. Together they could alleviate the fears of the patients. The mission, through its hospital superintendent or manager paid the salary of the nurse and therefore had the final say as regards her work.

D-B: The broken bipolar arrow indicates the turbulent relationship between the physician and the chaplain, even after the introduction of the Clinical Pastoral Education course. Although CPE improved the skills of the chaplains, the hospital setting remained a terrain of contest between the chaplain and the physician. The unequal levels of qualification and the fundamentally different types of training between the two professionals created animosity, a situation which caused problems when it came to rendering holistic service to the patients. The physician's basic responsibility for the patients was to cure their illness so that they could be healthy and free from disease whereas the chaplain's fundamental responsibility was to help the patient recognize the presence of God in their illness, if they were not cured, and prepare for death.

The physician was the superintendent who paid the chaplain's salary and, when he was on duty he could easily interrupt the chaplain. It is when patients are very sick that both the physician and the chaplain pay special attention to them. Since the physician has the legal obligation to account for the death of any patient admitted in the hospital, the chaplain invariably plays a secondary role in health provision.

E. General Workers: Although no hospital can be run without general workers such as porters, cleaners, gardeners, drivers and launderers, this study will not devote much

time and space to their role. They will be referred to briefly when we discuss finances later in this chapter. As far as power relations were concerned, general workers occupied the lowest stratum of the hospital pyramid of power. Since most had little or no training whatsoever regarding the job they performed, they could be dispensed of easily.

There is not much written about general mission hospital workers despite their valuable contribution to the day-to-day running of the hospital. Dr. Erling Hestenes indirectly observed their often obscured value, when he wrote about the situation of a patient:

> From the time a patient arrives at the hospital until he leaves again, he is seen, talked to, taken-care-of, and treated by various members of the hospital staff. He is in a strange surrounding and perhaps a bit afraid. He is ill and is seeking aid. He is not a number. He is not "that patient with a certain disease." He is a human being and a complex individual who has placed himself in our care. He reacts not only to our food and medical treatment, but also to the friendly or not-so-friendly manner in which our care is given. He will leave the hospital remembering the atmosphere in which he was restored to health.[6]

In some cases the general and the junior workers were given training and when the mission hospitals were later "nationalized" they were given more responsibility as in the case of Mr. MacDonald September of Ceza Mission Hospital.[7]

Dr. Ulrich Schmidt tells an amusing story about how a man named Ralukase Mongae carried out the responsibility of dispensing pills. Mr. Mongae was the driver of the ambulance and used to visit out-stations on a regular basis:

> *Ja*, Ralukase Mongae was a very trustworthy driver and very…he was doing the driving … excellent, excellent driver. And he was our dispenser. He did it very well and at a later stage we found out (laughing) that he couldn't read prescriptions. And we still don't know how he knew what to hand out. Probably the nurse helped him out to

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[6] Erling Hestenes, "Hospital Staff Involvement." in, *The Report of the Umpumulo Consultation on the Healing Ministry of the Church*. Lutheran Theological College: Mapumulo, Natal. 19-27 September 1967, p.116.

[7] Märta Adolfsson and Anna Bernsston, *Ceza: A Roundabout Way to the Goal: Three Decades of Medical Missionary Work in South Africa.* Ljungbergs Boktr: Klippan, 1984, p.172.

> explain which of the bottles he had to use. *Ja,* but as I say it was a very simple way. We had no great diversity of bottles of medicines. There were about ten bottles of medicines, the tablets we used to count out ourselves.[8]

Sister Ruth Bauseneick's interview also spoke volumes about the value of some general workers who had no formal training. The mission hospital work in Itshelejuba and other mission hospitals could not have been undertaken without the help of people like those mentioned during her interview by Sister Ruth Bauseneick:

> That was the Swaziland border … She was a family Dlamini. The old father was a chief. And this family, his wife Sarah and her children are Christians. Not he. When I came he had passed away. They were Christians and came to Itshelejuba church. And her girls were helping me, and (she) was married to Ntshangase. And Idah, she was doing the cooking and Ntshangase came and was looking after the cars and after all the good… *Ja*, he was my manager. He made the fence and … he made everything, *ja*! And Thabea Dlamini was helping us, and Dlangamandla. *Ja*! His wife was doing the washing and ironing and so on. Also came … step by step![9]

The position of general workers was that of powerlessness due to their low level of training, if any, and their dispensability. They nevertheless made a significant contribution to life in the mission hospitals and with regard to health service delivery. Let us analyse each hospital and its board or council in order to understand how such power as the staff members had influenced the delivery of health care to those who needed it.

2.2. Itshelejuba Mission Hospital

At its inception the Hospital Committee comprised two senior members, Dr. Friedrich Dierks, chairperson, and Dr. Georg Schulz who was concurrently the Superintendent of the MELFC and bishop of the Lutheran Church in Southern Africa (LCSA). The third member was Mr. Arthur Engelbrecht, a lay person from another church, the Free Evangelical Lutheran Church in South Africa (FELSiSA). According to a letter from

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[8] Dr. Ulrich Schmidt interviewed by Radikobo Ntsimane at Faeri Glen, Pretoria, on 26 February 2002.
[9] Sister Ruth Bauseneick interviewed by Radikobo Ntsimane at Bleckmar, Germany, on 05 August 2002.

Dierks, the Committee came about in a haphazard manner following the wishes of the then superintendent Christoph Johannes:

> After I had just started the clinic and hospital work in Botshabelo and had succeeded in getting governmental subsidies, the Mission-Superintendent Rev. Johannes asked me to help Sister Ruth Bauseneick of the Itshelejuba Mission Hospital to obtain the respective governmental subsidies. He also asked me to supervise the activities at Itshlejuba and also at Dirkiesdorp when the clinic work started there later. All this was done without any formalities. The Mission executive in Germany also contacted me when nursing or an administrative personnel was sent to the different medical institutions of the mission that had come into being. For contact with governmental officials I was advised to use the title: Deputy for hospital work of the Mission. When the first doctor was sent to Itshelejuba Mission Hospital (Dr. Bergter), the executive of the mission in Germany asked Bishop Schulz (who also acted as superintendent of the Mission) to form a 'hospital committee' as governing body of all medical work in the mission and appoint me as chairman. The other members of the committee were Bishop Schulz, Dr. Bergter and Mr. A. Engelbrecht of Paulpietersburg, who was also a member of the mission committee.[10]

The exclusively male and German composition of this committee shows without doubt that the interests of Blacks in Itshelejuba could not be protected. As the time under discussion was in the apartheid era, the Whites were inclined to judge matter with a bias towards their interests. Not a single member of the committee, except for Dr Bergter, lived within a radius of fifty kilometres from the hospital. Another point that stood this committee in a bad stead was that it had no proactive approach to hospital matters. Without a written constitution of its own it held haphazard meetings, necessitated by the prevailing conditions as these came up in the three health centres of the MELFC. This is confirmed in Dierks' letter:

> The "hospital committee" met without a fixed scheme if the necessity arose but at least once a year. Matters pertaining to the work at different institutes were brought forward by the chairman, discussed, decided and written in the minutes.[11]

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[10] Letter of Friedrich Dierks to Radikobo Ntsimane dated 29 August 2002.
[11] Letter of Friedrich Dierks to Radikobo Ntsimane dated 29 August 2002.

In the light of this, one is inclined to conclude that the day-to-day running of the Itshelejuba Mission Hospital was under the leadership of its superintendent, Dr. Bergter.

In his E-mail response to the question of the constitution of the hospital committee of the Itshelejuba Mission Hospital, the retired missionary Rev. Dr. Wilhelm Weber corroborated the information given by Dierks,[12]that the hospital committee was in fact an extension of the Advisory Board of MELFC in South Africa. The matters regarding the rules governing hospitals are mentioned in one of the clauses in the MELFC Constitution dated 21 May 1964. The nine-page document is entitled: "Constitution in respect of the area served by the Mission of the Evangelical Lutheran Free Churches."[13]

It is important to note that all mission societies have a central management or head office in their home country as the MELFC Constitution unambiguously states in paragraph I, "The Mission Management": The Supreme Management of the Mission shall lie with the management of the Evangelical Lutheran Free Churches in Germany."[14] While this was the situation, one would think that the Advisory Board in Southern Africa would have included Black leaders since these were likely to have a better knowledge of the Black people than White missionaries of European origin. As the constitution was written during the era of White 'domination' in South Africa, it reflects the fact that the advisory board was all White.

To show the powers bestowed upon the advisory board, we shall quote paragraph IV on "The Advisory Board."[15] We shall note how the exclusively White male members had the authority of decision-making on property matters and finances including those

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[12] Note that unlike in English, all general nouns in German begin with capital letters even when they do not begin a sentence. Though written in English, the names of the bodies of authority referred to in this constitution are capitalized in error. The English reader may be disturbed when such bodies are written in the capitals. The author has chosen to follow the pattern of the constitution.

[13] This document, found in the Bleckmar Mission Archives in Germany in 2002 put down rules on a plethora of topics such as the Superintendent; the missionaries and the employees of the mission; the Advisory Board; Property Matters,; Intention to Build, Repairs, Renovations and meliorations; the Account of Mission. Since the archives are not organized in any order, it is difficult to reference them properly.

[14] MELFC 1964 Constitution found at the MELFC Archives in Bleckmar, Germany. Paragraph 1. p.1.

[15] MELFC 1964 Constitution found at the MELFC Archives in Bleckmar, Germany. Paragraph 4. p.5.

of the hospitals. A smaller hospital board mentioned above was created out of this Advisory Board, whose stipulations are quoted hereunder:

> IV The Advisory Board
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> 1. An Advisory Board shall assist the Superintendent, which Advisory Board shall consist of at least 2 Missionaries who have been elected by all Missionaries in their circle, with reference to local conditions. The Advisory Board shall advise the Superintendent in respect of spiritual leadership especially the calling of Missionaries and other assistants, in the carrying out of special duties, and in the dealing with disciplinary cases.
> 2. For the carrying out of additional duties relating to combined planning of Mission work, and the carrying out thereof, the Advisory Board referred to in Para 1 above shall be composed of 4 additional members, who shall consist of :
> i. The Präses of the Free Evangelical Lutheran Synod in South Africa.
> ii. The Minister of the Free Evangelical Lutheran Synod in South Africa.
> iii. A layman with knowledge of business methods, who shall be a member of the Free Evangelical Lutheran Synod in South Africa and who shall be nominated by the Synod Meeting
> iv. Treasurer of the Mission.

It is not surprising that during the apartheid era not a single Black person participated in the advisory board which had four additional members, three of whom belonged to the White-only German-oriented Free Evangelical Lutheran Church in South Africa. The duties of the advisory board were among others:

> The acceptance of regular reports of Committees for special purposes (Theological Seminary, Hospitals, Clinics, Literary work, and printing, among others) auditing of the special accounts for these purposes and checking their budgets, as also the acceptance of the reports of the various Treasuries.[16]

The same advisory board had authority over the erection of buildings, renovations and repairs of the hospitals through its hospital committee chaired by Dr Friedrich Dierks.

The constitution is ambiguous with regard to the authority of the advisory board on buildings, under paragraph VI:

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[16] MELFC 1964 Constitution found at the MELFC Archives in Bleckmar, Germany. Paragraph 4, point H. p.54.

> 2. In the same way all building projects by the Mission shall be consented to before they are carried into operation by the Superintendent on the grounds of being building projects, quotations and financial plannings, which have been accepted by the Advisory Board. This refers also to buildings and structural alterations of Churches, Chapels, Schools, Seminary Buildings, Hospitals and Clinics, and the Homesteads for non-White workers of the Mission.

One can see that the MELFC was in charge of its mission activities in Southern Africa through the advisory board headed by the Superintendent. The superintendent sat on the hospital committee which largely depended on the advisory board for the execution of its duties with regard to the hospitals. We shall later consider the power that this committee wielded when the time came to negotiate the role and participation of government especially in the case of Itshelejuba Mission Hospital. Even when the Lutheran Church in Southern Africa became independent from the MELFC, the Advisory Board continued to be exclusively in charge of the mission hospitals. Although the constitution was drafted and accepted in anticipation of the establishment of the autonomous Lutheran Church in South Africa (LCSA) in 1967, it made no provision for the handing over of some of the property that an autonomous church would need for its initial operation. The buildings, even those which were to house "non-White" workers of the Mission, also fell under the advisory board.[17]

The autonomy of the LCSA is not without irony. It fell under the leadership of Bishop Georg Schulz who was simultaneously the superintendent of MELFC in South Africa and consequently the chairperson of the advisory board, for nearly twenty years (1967-1987). Although this subsection does not deal with mission hospital properties, a brief discussion may serve to highlight the lack of meaningful Black participation in the management of the hospital because of the racial divisions in South Africa. The properties, in this case the Itshelejuba Mission Hospital, were never registered "in the name of the Autonomous Church" until the government nationalized the hospital in 1978.[18] The omission of this registration was contrary to the constitution article which stated:

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[17] See paragraph VI and paragraph V Clause 2.
[18] Letter of Friedrich Dierks to Radikobo Ntsimane dated 29 August 2002.

> After the constitution of, and the registration of, the "Autonomous Church" which will grow out of the work of the Mission, such properties, buildings, and the like shall be registered in the name of the Autonomous Church as far as this is legally possible and desirable for the furtherance of the work of the Church. The necessity for this shall be decided upon by the "Mission Management" in Germany after hearing the Superintendent, the Advisory Board, and the Management of the Autonomous Church.[19]

Those bodies, along with the "Management of Autonomous" Church, did not find it "legally possible" nor "desirable" until 1978 to register MELFC properties under the "Autonomous LCSA".[20] The Advisory Board remained in charge of the LCSA until the position of the bishop was separated from that of the superintendent in 1987 to decentralize power. Missionary Gerhard Heidenreich took over the position of mission superintendent.

It is not certain when exactly the nationalization process took place. It was a gradual process. In 1972 Bishop Georg Schulz had already accepted the fact that Itshelejuba was directly under the control of the government and the LCSA and the MELFC had not much say on its buildings. He wrote in an article:

> We must still consider another aspect of the medical mission. The mission hospitals, in which this medical service is rendered, are in South Africa, financed by the State Department of Health. That means that authorities outside the church control their work. Extensions can only be carried out if the government authorities approve of them because, after all, they bear all the expenses involved. This is a fact which cannot be changed. There is almost no mission organization which is in a position to run a bigger hospital according to government health regulations. In this way mission hospitals do not differ from other secular hospitals.[21]

The defeatist attitude of Georg Schulz indicates how helpless the advisory committee was, long before the hospitals were formally nationalized. Nowhere does one see

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[19]Constitution in Respect of the Area Served by the Mission of the Evangelical Lutheran Free Churches dated 21 May 1964. Paragraph V. Property Matters. Clause 2, p.6. Constitution is kept among loose papers in the MELFC Archive in Bleckmar, Germany.

[20] The first Black bishop of the LCSA David Tswaedi, who was in fact its second bishop ever, was inaugurated in 1993 by his predecessor.

[21] G. Schulz, "The Healing and Helping Ministry in the Missionwork" in *Itshelejuba Mission Hospital: Reports and Papers on Mission Hospital Work in South Africa*. 1972, p.19.

attempts by the committee to resist the take-over or at least find alternative ways to the total take-over. We have seen the powers vested in the Whites-only advisory board and its hospital committee. Black voices of protest against or in approval of nationalization are muted in that debate. If Blacks were not excluded from the decision-making structures of the advisory board and hospital committees, we might have known their position with regard to the matter.[22] It was the White men who ran the hospitals of MELFC and who finally decided that they could no longer do so.

It was the committee which according to a Lutheran minister, Rev Titus Phogojane[23] sold the other MELFC hospital in Botshabelo. That board took the decision, long before the tribe was relocated and in the 1970s, subjected to forced removals to Ramatlabama.[24] From the early 1960s to the 1970s and beyond, the South African government passed laws to form homelands based on ethnic groupings and also to remove Black people from the areas which were going to be populated by Whites.[25] The same committee, through lack of foresight, had neglected to make medical preparations of a temporary nature to help the forcefully removed villagers on arrival in Ramatlabama.[26] Mokone observed that the villagers experienced difficulties when they needed medical facilities. The nearest facilities were in Mafikeng, about forty kilometres away. One may ask at this stage, why Dr. Dierks and the MELFC who were so concerned about health provision in Botshabelo, did not show such concern when the tribe moved to Ramatlabama in 1977. To prepare for offering the most needed medical care for the villagers in their new settlement is not the same as collaborating with the homeland system. Instead, it would have been helped to those in need during the transition from Botshabelo to Ramatlabama.

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[22] On powerlessness of Blacks in mission churches' spheres, see Philippe Denis, Thulani Mlotshwa and George Mukuka (eds,), *The Casspir and the Cross*. Cluster Publications: Pietermaritzburg, 1999, p. 8.
[23] Pastor Titus Phogojane interviewed by Radikobo Ntsimane at Ramatlabama on 16 May 2002.
[24] For in-depth study on this topic see Radikobo Ntsimane, "The Response of Lutheran Churches to the Forced Removals in the Western Transvaal and Bophuthatswana," unpublished MTh dissertation at University of Natal. 1999.
[25] For a deeper discussion on the forced removals see Radikobo Phillip Ntsimane's MTh dissertation "The Response of Lutheran Churches to the Forced Removals in the Western Transvaal and Bophuthatswana", unpublished MTh at University of Natal. 1999.
[26] Ms. Mmasaka Mokone interviewed by Radikobo Ntsimane at Ramatlabama on 20 June 1998. (Appendices: Interview Number CIV) in Radikobo Phillip Ntsimane's dissertation, "The Response of Lutheran Churches to the Forced Removals in the Western Transvaal and Bophuthatswana." Unpublished MTh Dissertation, University of Natal. 1999.

The conduct of the MELFC board was not surprising. Since it was not representative of the villagers of Itshelejuba and Botshabelo (before the forced removal), it was primarily concerned with the mission society. It adopted a selfish and paternalistic-type of leadership which led it not to prioritize the welfare of the health seekers. Not a single health patient and not a single employee working daily or directly in the hospitals was consulted when decisions were made. Supposedly, the board thought it knew—in the line of apartheid[27]—what the people wanted even without asking them. One can ask if it was typical of mission hospital boards, which were constituted on the bases of race, to agree to with unilateral and unfavourable measures such as the "nationalization" of mission hospitals by the government.

Throughout the 1960s and 1970s almost all mission societies and mission churches were conducting their operations on a racial basis. The situation in the other churches was similar. The quest of Black ministers for recognition by their White colleagues and mission church leaders led to the formation of pressure groups like the Black Methodist Consultation (BMS) in 1963, St. Peter Old Boys Association (SPOBA), and much later in 1985 the Presbyterian Black Leadership Consultation (PBLC).[28] These two decades were characterized by the intensification of the struggle of the liberation movements against apartheid and the demand for Blacks' participation in the church leadership. It was the time when Black churches were constituted (LCSA in 1967 and the ELCSA in 1975) and the Black clergy was appointed or elected into church leadership roles previously occupied by White missionaries. While such transformation was taking place in the new church, the health sector of the mission societies remained unchanged. In the 1960s, the current ELCSA allowed the regional churches to be led first by White missionaries and later by Blacks. As I have attempted to show in Figure 4 above,[29] there was no opportunity for honest power sharing, especially in the LCSA. Another reason for excluding Blacks from high

[27] Not a single Black person participated in the National Party government when laws with a direct bearing on the lives of Black people were promulgated.
[28] Thulani Mlotshwa, "Struggles from within: The Black Caucuses' Quest for Recognition," in Philippe Denis (ed.), *Orality, Memory and the Past: Listening to the Voices of Black Clergy under Colonialism and Apartheid.* Cluster Publications: Pietermaritzburg, 2000, pp.252-262.
[29] See p. 217.

leadership position in the LCSA could have been the low education standard among the Black clergy.[30]

The decision to sell the Itshelejuba Mission Hospital was only reported to the LCSA for its information, probably because the 1968 Agreement between the LCSA and the MELFC stated in section IX paragraph 38 that "The Church and the Mission bear a mutual responsibility for the Hospitals of the Mission."[31] Although that was put on record, such mutual responsibility was not easy to put into practice. The objections from the LCSA, if any, could never be considered for the following three reasons.

Firstly, the chairperson of the LCSA Church Council, Bishop Georg Schulz, was a voting member of the hospital board, presumably looking after the interests of the LCSA. At the same time the chairperson of the Board, Dr. Friedrich Dierks, was an advisor to Rev. Frans Segoe, the dean of the then Goldfields Diocese of the LCSA. Two thirds of the three-man board was simultaneously members of the LCSA Church Council. It could be argued mistakenly that the LCSA was over-represented in the hospital board.

Secondly, more than half of the LCSA Church Council members consisted of missionaries. The missionaries in the church council were Bishop Schulz, Dr. Friedrich Dierks, Rev. Manfred Nietzke, Rev. Gottfried Stallman, Dr. Wilhelm Weber and Rev. Fritz-Adolf Häfner. Except for Bishop Schulz and Fritz-Adolf Häfner, all the missionaries in the church council served in an advisory capacity for the Black deans, despite the fact that they were younger and had much less church leadership experience than the Blacks. Rev. Dierks was advisor to Dean Frans Segoe of the Goldfields Diocese, Nietzke to Titus Lenkwe, the Dean of the then Western Transvaal Bophuthatswana Diocese, Stallmann to Amos Mdluli, the Dean of the then Eastern Transvaal Diocese, and Weber to Dean Isachar Dube of the then Natal Diocese. Rev. Häfner, the Dean of the Botswana Diocese did not have an advisor, presumably by virtue of being a missionary. I am of the opinion that such an arrangement was based on the supposition that White people are more competent than Blacks and that the

[30] The first Black bishop, David Tswaedi, was elected and took over as the bishop twenty years after the LCSA was constituted as an autonomous church body.
[31] A typed A5 document kept at Bleckmar in Germany in the mission library also serving as an archive.

church could be run better if White leaders were in the majority. In the event of a vote related to the decisions of the hospital board, it was not difficult to know which way more than half the LCSA Church Council would vote. The ratio of six White missionaries to four Black deans favoured the missionaries in the event that voting was to be decided by simple majority. Besides, if it ever came to that, the four missionary diocesan advisors had the responsibility to advise the Black members so that they would make "good decisions." The "good decisions," I want to argue, were to follow the direction the MELFC had chosen for the newly established Black church.

Third and finally, the first generation of Black church leaders was overly respectful of Whites. Their respect was not a question of respect for the sake of respect. Most Blacks had endured hardships such as unjust beatings on farms and in urban areas. Fear had become entrenched under the apartheid system so that no Black person would dream of contradicting any White person and going unpunished. Despite the discriminatory laws, White people could treat badly any Black person with no fear of being brought to court. Not all Whites took advantage of the opportunity to undermine the laws. Given the tense political situation of the 1960s and 1970s in the racially segregated South Africa, it is likely that debate was stifled in the church council meetings. After 1989 when this writer started attending synodical meetings and general pastors' conventions as a probationer minister, he observed an unfair pattern in the decision-making in the LCSA. Both these types of gatherings were chaired by Bishop Schulz. He staunchly believed in consensus, but he had a strange way of reaching it. His practice was to invite one of the older deans to speak when a contentious issue came up, knowing that they were not likely to contradict him. Often, the older deans would also not contradict what had already been agreed upon in preceding Church Council meetings (where the deans were outnumbered anyway). Disregarding one or two dissident voices, the chairperson would ask if the house was in consensus, i.e. voting with one voice. The house would agree in unison with a roaring "Eleeethu!"[32]

[32] Meaning, literally, "it is our collective voice (word)!"

About the hospitals and their nationalization, Black pastors knew very little. Hospitals were established and run by White missionaries. Any objection by Blacks to nationalization was not going to yield any positive results. The Blacks could not sustain hospitals financially, let alone staff them with qualified personnel. Within both the LCSA and the hospital board there was no possibility to oppose the government's move to nationalize mission hospitals. The hospital board took the easy way out, namely compliance.

The nationalization of mission hospitals was a process rather than an event. It began when the national government handed over the responsibility for health to the four provincial administrations. When the Department of Health handed over all health facilities within the Tswana Territorial Authority to the Bantustan authority (later Bophuthatswana) in 1975, the new health authority became responsible for mission hospitals as well. The Statistical Survey by the Surplus People Project (SPP) showed that two private hospitals, four mission hospitals and five government hospitals were managed by the Bophuthatswana government in 1979.[33] One year later, the mission hospitals were no longer mentioned in the survey.[34]

The nationalization of mission hospitals and the subsequent handing over to Bantustan governments and self-governing states indicate that the mission societies abdicated their responsibility. Neither the mission societies nor the government were answerable to the health-seekers who frequented the health facilities. Instead, they answered to dominant structures, far removed from the health seekers' world. Although the SPP did its research later than the period covered by this study, its work shows how the health facilities deteriorated under the authority of the Bantustans. The Surplus People Project observed:

> Bophuthatswana has a lot of unemployment and lack of basic hygiene facilities, with many areas lacking any clean water. This, on personal observation, was definitely the case in the settlements close to Pretoria as well as in many relocation areas. The health standard of the people

[33] Surplus People Project. *Forced Removals in South Africa*. Vol. 5. 1985, p.95.
[34] Ibid.

> would thus be very similar to that in other Bantustan areas, namely poor to very poor.[35]

Although the argument here does not necessarily apply to all mission hospitals, I would emphasize that even the mission hospitals which were not affected by the forced removals suffered disturbance and as a result of the nationalization process, their services decreased.[36]

2.3. The Lutheran Medical Foundation

Before the formation of the Co-operating Lutheran Missions in Natal, each of the five Lutheran mission societies had its own board or council to look after its health centres. In 1966, Ernest J. Holman, who had in the previous year completed an audit of the Lutheran missions in Tanzania, was tasked with an audit of the LMF member hospitals and write a report about their capacity of health delivery and make recommendations. The report was titled *A Report on the Medical Program of the Evangelical Lutheran Church in Southern Africa-Eastern Region Natal Province Republic of South Africa.* Holman shed light on the operations of the various mission hospitals' boards and councils.[37] While there were five Lutheran mission societies in the Co-operating Lutheran Mission in Natal, I shall only look at two of these, viz. the American Lutheran Mission and the Berlin Mission Society, because this study deals with two of their respective hospitals, Untunjambili Mission Hospital and Emmaus Mission Hospital. The interviews conducted complement Holman's report.

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[35] Surplus People Project. *Forced Removals in South Africa*. Vol. 5. 1985, pp.95-96.

[36] Showing the decline of the quality of health provision after nationalization of mission hospitals, Mamphela Ramphele compared the popularity of a former mission hospital Mount Coke and the Zanempilo Clinic which was initiated by the Black Community Programme of the Black Consciousness Movement, in her autobiography called *Mamphela Ramphele: A Life*. David Philip: Cape Town, 1995, p.101.

[37] Ernest Holman, *A Report on the Medical Program of the Evangelical Lutheran Church in Southern Africa - Eastern Region Natal Province Republic of South Africa.* A three volume report commissioned by the Co-operating Lutheran Missions in Natal and submitted in 1967.

2.4. The American Lutheran Mission

The American Lutheran Mission (ALM) had three health centres: Hlabisa, Luwamba and Untunjambili. Holman's description of the structures of the ALM shows that Black people hardly featured in its executive structures and therefore had no influence on decisions regarding the health institutions. He described the power relations in this way:

> Under the authority of the mission, a Welfare and Hospital Committee has been created which acts as the overall governing body for the three units and their related district nursing services. The Welfare and Hospital Committee meets formally once a year and all its decisions are subject to review and possible modifications by the Mission Conference. Membership of the Committee consists of those members-at-large elected by Mission Conference, and ex-officio members including the superintendent and the matrons or superintendents-in-charge of the units. Officers of the Committee include the Chairman, the Vice-Chairman and the Medical Director. The Medical Director acts as the administrative secretary for the Committee and is responsible to implement policy decisions of the Committee as approved by Mission Council.[38]

The composition of the governing structure (Welfare and Hospital Committee) indicates clearly an exclusion of Blacks as the election took place in the Mission Conference which was a structure exclusively for missionaries. Holman further describes the local structures of those three individual units. As the socio-political situation of the time demanded it, Black participation in boards, councils and committees was welcomed as long as it posed no threat to White power. This was made clear in the following quotation:

> Each of the three units, in turn, has a local hospital board with medical Director and ex-officio member of each board. The constitution of the Welfare and Hospital Committee may be amended by a two-thirds majority vote of the members of the Mission Conference of the American Lutheran Mission in South Africa.[39]

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[38] Ernst Holman, *A Report on the Medical Program*. Vol. I, Section V. 1967, p.27.
[39] Ibid.

In the exceptional case of Untunjambili Mission Hospital, a local mission station dweller, Mr. Nason Danis, served in the local committee in an advisory capacity. During the interview, Mr. Danisa told this writer that he did not recall what his specific duties were in that committee.

2.5. The Berlin Mission Society

Holman's report sheds light on the leadership structures of Emmaus Hospital, the only BMS hospital in Natal: "The governing authority for Emmaus is the local Mission Council. This body, in turn, is responsible to the overseas Mission Board and for the most part the overseas body has had the final word in terms of any planning or development of Emmaus."[40] The number of letters, exchanged between missionary Bernhard Schiele and the BMS headquarters in Germany is evidence of the overseas mission board's tight grip on Emmaus Mission Hospital.

When compiling his report, Holman was also interested in the power relations and authority of the local boards in the mission hospitals. Referring to the uselessness of those local boards, he specified those of the Church of Sweden Mission. He wrote: "Each institution is supposed to have a functioning governing board in accordance with the government rules for welfare organisations, but again as with other institutions, these appear to be more 'paper' boards than anything else."[41]

Holman also observed that, with the exception of Ceza Mission Hospital, the internal management committees, meant to advise the Medical Superintendent, were dysfunctional.[42] It is important to note that some leaders might have rendered the committees dysfunctional, especially those whose purpose was to advise and not to make and execute decisions. As indicated in the first part of this chapter, the hospital superintendents were generally powerful by virtue of their positions. They were supposed to know what needs to happen in the hospital. For example, Dr. Ulrich

[40] Holman, *A Report on the Medical Program.* Volume I. 1967, p.42.
[41] Holman. *A Report on the Medical Program*. Volume I. 1967, p.46.
[42] Ibid.

Schmidt of Ramotswa and Dr. Kurt Bergter of Itshelejuba had to design the new hospital structures when they took over as the first doctors. Missionary Bernhard Schiele had to do the same on behalf of his medical missionary wife Dr. Magdalene Schiele. From their previous jobs the doctors who became superintendents brought along a vast experience in hospital management. With such experience the superintendents would have been tempted to disregard the opinions of the advisory committees but to get on with their work. The supervisory boards, in contrast to the advisory boards, were more effective in effecting change in the institutions.

In situations where Blacks were included in the committees as was the case at Ceza Mission Hospital, such committees were according to Holman functional. Of all LMF hospitals based on such structures, Ceza had the only functional internal management committee. The committee had one member elected from the locally trained nursing staff, and one elected from the general hospital staff.[43] It was possible, and yet difficult, for Whites who had the monopoly of power in the mission hospitals to share such leadership with others who were not nearly as qualified to run a hospital as they were. Fifteen years later a missiologist, Clifford Allwood, proposed a model for hospital structure in which the doctors' qualification did not place them elevated above the community, thereby making it difficult for them to deliver health care services:

> We need that working model—the doctor as part of the community, contributing special skills but also being supported and directed by the community. Indeed, judging from developments over the past fifteen years, it would seem that the place of the doctor in mission is becoming that of a servant physician, working ideally in close fellowship with a Christian group. his will undoubtedly raise new conflicts in someone who is used to status, authority and organisational responsibility, but it carries less temptation and frees people from the kind of power which distort their service.[44]

When the LMF was established, there was indeed a need for centralisation of power to deal with the rapidly changing funding conditions and relationships with the government of South Africa. A united force was better suited to face the government

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[43] Ibid. p.58.
[44] Clifford Allwood, "Mission as Healing the sick: Christian Medical Missions in South Africa," in *Missionalia,* Vol.17. No.2. August 1989, p.122.

with a stronger voice and "constituency" than the tiny, largely dysfunctional individual hospital committees.

Unlike the MELFC that did not join the Co-operating Lutheran Missions in Natal as a full member[45], the other Lutheran mission societies in Natal were proactive in engaging the government regarding mission hospital matters. When the South African government began to subsidize the mission hospitals in the 1960s, the member mission societies in the Co-operating Lutheran Missions in Natal formed the LMF.

Their pro-activeness in engaging the government is documented in Section X of Holman's report:

> It is strongly recommended that our church-sponsored medical programmes in Natal organise themselves in an appropriate manner and *insist* on once-a-year formal meetings with government health agencies to achieve fuller integration of our programs with government efforts, to receive information from government on its medical plans, and, in turn, to voice our problems, suggestions and comments to government in a solid, combined approach.[46]

Another concern of the Co-operating Lutheran Missions in Natal was the job description of the executive secretary as defined in Appendix XI (Proposed Constitution and By-Laws) Part V Section 2. i. "Act in unison with Chairman[47] of the Board as spokesman and responsible negotiator with government insofar as Government policy, regulations and proposed legislation pertain to or affect the medical work of the Churches."[48]

In our appraisal of the role of the LMF we shall mention briefly the working strategy of the South African government with regard to health care. In that way we will get a vivid picture of how the LMF was formed for the purpose of interacting with the

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[45] The HMS was intermittently a member, largely due to inability to fulfil its financial obligations to the body.

[46] Holman, *A Report on the Medical Program*. Volume III. 1967. Par.23 under "Interchurch Relationships."

[47] The direct quotation left out the article before this noun. I have chosen to quote the document as it is as any addition of articles here and elsewhere may be tantamount to modifying the content of the document.

[48] Ibid. Appendix XI, "By-Laws" Part V. Section 2 I, p.11.

apartheid government structures in the implementation of that working strategy. At that stage the government of South Africa had chosen to abdicate its responsibility to provide quality health care equally to its people. The activities of the Lutheran mission societies in relation to the government were geared towards picking up "the scraps that fell from the master's table." The government was implementing apartheid in health care as it had done earlier in 1953, when it promulgated the Bantu Education Act to implement segregated access to education. Were the various Lutheran mission societies going to co-operate with the government in their various hospitals? How were they going to deal with the government in order to continue providing health care in their hospitals?

In his report, Holman gave a summary of the responsibilities of the three tiers of the government with regard to health care in South Africa:

> Broadly speaking, responsibility for the health services available to the people of South Africa are presently divided between three government bodies; Central Government, Provincial Administration and Local Authorities. Central Government is generally responsible for mental health services, mental hospitals, tuberculosis hospitals, leprosy hospitals, district surgeon services, health education and preventive health and inspection and registration of certain private hospitals. Provincial administrations are generally responsible for the establishment and operation of general and teaching specialty hospitals (except those under Central Government) within their respective areas, registration, grading, subsidisation and inspection of voluntary agency and mission hospitals, supporting network of radiological and pathological laboratory facilities and provision of ambulance and blood transfusion services. Training doctors and nurses within any of these provincial or provincial subsidised institutions is done under the regulations of the South Africa Medical and Dental Council and/or the South African Nursing Council. Local Authorities are generally responsible for child welfare and health visiting, district nursing, dental service, ante- and post-natal services, immunisation and treatment of infectious and contagious diseases and treatment of alcoholics and drug addicts.[49]

To understand the role played by the LMF we need to consider why it was established in the first place. The LMF was formed in 1966 to look after the interests of the

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[49] Holman, *A Report on the Medical Program*. Volume 1. August 1967, pp.13-14.

Lutheran mission societies in the Co-operating Lutheran Mission in Natal. Five mission societies brought together thirteen hospitals and clinics into the Foundation:[50]

Mission Society		Name of Institution		Location	
1.	American Lutheran Mission	a.	Hlabisa Mission Hospital	a.	KwaHlabisa (Zululand)
		b.	Luwamba Mission Hospital	b.	Lower Umfolozi (Empangeni)
		c.	Untunjamibili Mission Hospital	c.	Kranskop
2.	Church of Sweden Mission	a.	Applesbosch Mission Hospital	a.	New Hannover
		b.	Betania Mission Hospital	b.	Dundee
		c.	Ceza Mission Hospital	c.	Mahlabathini (Zululand)
		d.	Thulasizwe Mission Hospital	d.	Mahlabathini (Zululand)
3.	Norwegian Mission Society	a.	Ekombe Mission Hospital	a.	Nkandla
		b.	Nkonjeni Mission Hospital	b.	Mahlabathini (Zululand)
		c.	Umpumulo Mission Hospital	c.	Mapumulo
4.	Berlin Mission Society	a.	Emmaus Mission Hospital	b.	Winterton (Bergville)
5.	Hermannsburg Mission Society	a.	Ehlanzeni Mission Hospital	a.	Msinga
		b.	Siloah Mission Hospital	b.	Ngotshe

[50] The data in the table is found in Michael Gelfand's *Christian Doctor and Nurse*, Chapter V. and in Ernest J. Holman's *A Report on the Medical Program*. Section V.

The purpose of the Lutheran Medical Foundation according to its constitution was to give concrete expression to the church's care for the sick and suffering. This purpose was to be achieved in the following way:

> a. By fostering and implementing the Christian understanding of healing.
> b. By taking full responsibility for the maintenance, management and development of all existing and future Lutheran medical work within the area of the Evangelical Lutheran Church in Southern Africa (ELCSA-SER), or a wider area as later determined by the Foundation.
> c. By making use of the following channels in its work: The congregations of ELCSA-SER, hospitals and clinics with related training facilities, preventive medical programmes, health education, co-operation with the diaconal work of such congregations, hospital chaplaincies and other activities as decided from time to time.
> d. By conducting such business and undertakings that fall within the scope of its purpose and activities.
> e. By acquiring by purchase, lease, exchange, donation or in any other manner, immovable or movable property of any nature and kind whatsoever and wheresoever situated, or any right or interest whatsoever therein.[51]

While as a proactive move (the creation of the LMF) is commendable, one can look at it from another angle. During the period the government was subsidising the individual mission hospitals, as Mtalane wrote in her M.A. dissertation, a united body was necessary "to take total medical responsibility and the commensurate authority to provide the necessary direction of the Lutheran medical work, in close relationship with the Lutheran Churches in Southern Africa."[52] The challenge was that the mission field was undergoing change. The 1960s was the time when the mission field was being transformed into regional churches run by elected regional bishops. As we have seen with the MELFC, even the ELCSA-South Eastern Region church was under strong missionary influence and as a result the presence of Blacks in the leadership structures was ineffective. To a large extent authority and power remained with the providers of leadership and church finances, viz., the missionaries. Since the LMF was being formed out of the thirteen mission hospitals, it also would establish its own

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[51] Holman, *Report on the Medical Program*, Volume III. Appendix XI, Article II. Section 2.
[52] Lissah Mtalane, "The contribution of the Lutheran mission societies to the development of health services in Natal, 1898-1978 (80 years)." Unpublished MA, dissertation at University of South Africa, 1984, p.181.

governing board, as we have seen.[53] The regional church could inherit other activities and even properties of mission societies such as church buildings, but the medical work was to be handed over to the LMF. The creation of the LMF was strategically important as it would keep medical activities under White influence for a long time.

There were advantages and disadvantages in the creation of the LMF and its functioning as a governing board. The advantage was that, in the 1960s when the LMF was formed, the biomedical work was still a sophisticated sector which Blacks could not manage, without the assistance of those who had a long experience of working in the sector. Two proverbs illustrate this point. The first one is in Zulu: *indlela ibuzwa kwaba phambili*, meaning that, if one hopes to undertake a journey successfully, one has to enquire about its challenges from those who have already undertaken such a journey. Similarly, the second one says in Setswana: *Letlhaku le leswa le agelwa mo go le legologolo* meaning that in the reconstruction of a new cattle enclosure, it helps to build on the existing old structure. For any future handover Blacks would have needed a structure like the LMF. With the formation of the regional churches the new leadership might have been overwhelmed by its multiple responsibilities and the LMF stood in good stead to carry the responsibility for mission hospitals. According to Dr. Vivian Msomi, the newly-established leadership chose to consolidate the congregations, parishes and dioceses and did not look upon medical mission work as a priority.[54] While the Black people in the regional churches could not sustain the hospital work with local resources, the medical missionaries could still garner support for the medical work in southern Africa from elsewhere. For the sake of increased support of the Lutheran mission hospitals, the LMF was in an advantageous position to approach government officials. The apartheid government generally listened to Whites more than it did to Blacks. To provide a context for this development, apartheid was already in full swing, as the government had already begun to recognize the tribal authorities as a way of creating homelands for communities being removed forcefully from their areas—called Black spots.

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[53] Lissah Mtalane. 1984, p.181.
[54] Dr. Vivian Msomi interviewed by Radikobo Ntsimane in his office in Pietermaritzburg on 25 May 2005.

The absence of Black people in the MLF executive committee was a clear indication of disproportionate power relations in the health sector of the mission societies. The exclusion of Black people at that stage would impede the future work of the Lutheran churches in the sector. Another disadvantage of the creation of the LMF was that the medical mission was taken away from Black Lutheran leadership under false pretences. Blacks were denied the opportunity to influence the direction of the medical missions to suit their conditions financially and culturally. Mission hospitals continued to grow through government subsidies in the 1960s and 1970s to a level unmanageable for Black people Instead of intensifying primary health care and preventive[55] methods, sophisticated machinery and specialization was introduced in mission hospitals. In promoting higher training for nurses in the mission hospitals, the LMF was lured by the qualifications standards set by the Nursing Council of South Africa. That quest for qualifications and recognition for nurses' training schools led to exclusion of a valuable cadre of nurse aids and dressers whose training qualifications were determined internally and focussed on local needs.[56]

It should be noted that a community that has good hygienic practices, sound preventive measures against illnesses, and an adequate number of primary health care providers, will need a hospital only for new and major illnesses. Such a community will not depend on a hospital except for major surgery and contagious diseases. It is obvious that health care used a lot of resources which could be applied in other areas to improve the quality of life as Holman rightly noted. He wrote:

> In reviewing Natal province's total anticipated expenditure for 1967-68, this author was astounded to see that out of a total budget of Rand 92 million; almost Rand 30 million will be spent on hospitals, medical, and health services during the budget period. This amount accounts for nearly a third of the total budget and is Rand 12 million more than that of the Education Department.[57]

Holman, in the quotation above, does not enquire how much of the budget for health provision was to be spent on developing health facilities used by Blacks. Due to the

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[55] Ernst Holman, *A Report on the Medical Program.* 1967, p.44.
[56] Matron Evelyn Sommerfeld of Emmaus and Matron Schmidt of Bamalete Lutheran Hospital in Botswana trained nurse aides for local needs.
[57] Holman, *A Report on the Medical Program.* Volume I.1967, p.24.

constant struggle to raise funds for mission medical work, the LMF found relief in the successful acquisition of government subsidies.

While the formation of the LMF was meant to serve as a united front to extract as much government subsidy for Lutheran medical work as possible, it also served a negative purpose. Instead of five Lutheran mission societies listed above, the government could only deal with one body to implement "nationalization."

Undoubtedly there was a need to explore and introduce other forms of health provision, over and above surgery and western curative methods. There are two examples in Natal – one being the Pholela Health Care, and another the national Progressive Primary Health Care Network - which show that there were attempts to counter the apartheid policy of segregated health care. Although they were short-lived, they however serve to show that there were attempts to oppose apartheid health-care, something that the Lutherans did not attempt. Louise Vis commented on the Pholela Health Care, work of Sidney and Emily Kark in Pholela, KwaZulu-Natal in the 1960s. That work was an initiative that was meant to provide the local people with trained heath carers from among themselves.[58] This initiative had to be abandoned when under the pressure of apartheid the Karks went into exile and began a similar project in Australia. The apartheid government with its hostile agenda of arresting any development initiative of the Black people, not only thwarted attempts to help Blacks taking control of their health, but also destroyed the existing institutions at the time.[59] In his brief study of the health needs and disparities in health provision in South Africa, doctor L. G. Wells described in 1974 the alternative of medical auxiliaries, similar to those trained by the Karks of Pholela Health Centre.

> Auxiliaries are less expensive to train and to use. There could be more auxiliaries than the doctors, for the same amount money. If properly deployed, auxiliaries would be better distributed and less overworked in the critical areas. They could be trained to meet specific local needs

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[58] Louise Vis, "*We Sow the Seed": Perspectives of Health Educators at the Institute of Family and Community Health in Durban in the 1940s and 1950s.* MMedSc – Community Health. 2004.
[59] Keegan Kautzy and Stephen Tollmsan, "Perspectives on Primary Health Care in South Africa" in *South African Health Review.* School of Public Health. University of Witwatersrand: Issue 2008, pp.17 – 30.

> and to understand local priorities, whether urban or rural. They could be orientated towards a better balance of prevention and care.[60]

In his dissertation Stephen Ntsoakae Phatlane saw the training of Black people in biomedicine not as a threat to indigenous medicine but instead as increased the medical options for Africans.[61] That I think was the whole idea of the Pholela Health Centre and similar initiatives undertaken in the rural areas.

The government was focused on destroying alternative biomedical health activities geared towards the development of Blacks. In the 1970s, the Charles Johnson Memorial Hospital was constantly visited by the Special Branch police, as a way of intimidating the White staff members who opposed racial discrimination in the treating of Black patients. [62] There was no similar opposition in Lutheran hospitals. There is no evidence of opposing the racial discrimination promoted by the government in its policies.

Large sums of money could have been saved and used for other forms of development. Also the attitudes of the populations around the mission hospitals would have been changed to value healthy lifestyles and not depend entirely on western curative measures. The apartheid-styled exclusion of Blacks from the Board of the LMF irrespective of their qualification was the exclusion of voices that could have contributed positively to the decision-making in this regard. Dr. Erling Hestenes, one time leader of the LMF, blamed apartheid for the exclusion of Black people from decision-making processes in the Lutheran hospitals:

> Dr. Hastenes knows quite well that to stay in South Africa at all, missionary doctors have to abide by South African laws. While the white doctors and African doctors can be the best of personal friends, an African doctor can never be placed over a white doctor or a white nurse. Since blacks and whites cannot be on the same committee, the voting membership of the Board of the Lutheran Medical Foundation

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[60] L.G. Wells, *Health, Healing and Society*. Ravan Press: Johannesburg. 1974, p.50.
[61] Stephens Ntsoakae Phatlane "Poverty, Health and Disease in the Era of High Apartheid: South Africa, 1948 – 1976". Doctoral dissertation at University of the Witwatersrand, Johannesburg. 2006, p.61.
[62] Jon Larsen, *KwaBaka: The story of a Mission Hospital community in Zululand 1930 – 2006*, Cluster Publications: Pietermaritzburg, 2010, p.173.

> must be entirely white. These are some of the laws under which missionary doctors must work.[63]

We shall see in the next chapter that the missionaries struggled to work under the apartheid laws. Having experienced repression under apartheid, the LMF should have prepared better for the time when they would no longer run the hospitals: primary health care and preventive health methods could have alleviated the burden on the struggling hospitals.

In this subsection we have attempted to show that the uncritical embracing of the biomedical health system by the mission societies in combination the exclusion of Black people from the work of the LMF led to people being inadequately prepared to take responsibility for their own health provision. It was going to be imperative under the apartheid new health policies. Having discussed the power structures prevalent in each hospital under review, we shall now consider the roles played by these structures when the nationalization programme of their hospitals was carried out.

2.6. The Bamalete Lutheran Hospital (HMS)

The situation of the Bamalete Lutheran Hospital was different from that of the three South African mission hospitals reviewed in this study. It is unique in the sense that, although established by the Hermannsburg Mission Society, it was not part of the LMF. Furthermore, being in Botswana, that hospital was not nationalized as South African mission hospitals were. Because of its uniqueness we are considering it separately from other Lutheran mission hospitals.

The Bamalete Lutheran Hospital was not nationalized as the three South African hospitals discussed in this study. In Botswana the nationalization of mission hospitals corresponded to a totally different policy to the one in South Africa, as we shall see below. The nationalization of health care meant that the people of Botswana were going to be provided with better health care through the help of the State. The

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[63] Wilfred and Eleanor Bockelman, *The Lutheran Church in South Africa: an Exercise in Compassion,"* Augsburg Publishing House: Minneapolis, 1972, p.100.

government of the newly-independent Republic of Botswana went into partnership with the HMS to provide health care to the population of Botswana. The Balete tribe was actively involved in the activities of the hospital although no mission reports between 1934[64] and 1963[65] make no mention of any board, council or committee that included tribal members. Dr. G. Schneider in the 1963 report wrote that a committee of local village people was necessary.[66] "Since the mission hospital was of the Bamalate, a committee with *kgosi*, a nurse, a doctor, missionary, mission superintendent and a (general) staff member was needed." Considering the fact that in 1963 the doctor, the nurse, the missionary, and the mission superintendent were all Europeans, the committee suggested by Dr. Schneider was surely racially imbalanced. When it came to voting, the *kgosi* and maybe the (general) staff member would to be outvoted, if not ignored. While the idea of a committee that included local people was a good one, it was not going to be easy for the local people to effect change. Schneider ignored the fact that the hospital was established by the HMS for the benefit of the Balete tribe. It was not owned by the Balete tribe. Dr. Ulrich Schmidt noted this problem four years later and referred to the committee 1967 report only as the hospital advisory Board. To quote his report directly he said, "The Hospital Advisory Board met once only and it is not clear what their duty is." Although claimed that the hospital advisory board's duties were unclear, in the next sentence he listed a number of decisions the same board, as well as the ones he wished the board should consider taking.[67]

It may be deduced from Schmidt's report that the board was in fact a token board since some decisions were taken without its input. It is not clear from the report whether or not this board was the committee suggested by Dr. Schneider in 1963. Since no report was sent to the mission headquarters in Hermannsburg, Germany, in 1964 and 1966, we are not able to follow this committee's activities or lack of them. The 1965 report makes no mention of any Board or Committee's activities. We can

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[64] From the report of 1934 written by Missionary Heinrich Pfitzinger on the arrival of pioneer nurse Emma Pfitzinger to the report of 1963 by Deaconess Eva Bartzch. Annual hospital reports were often prepared and submitted at the beginning of the following year.
[65] Report dated 19 February 1963 archived in SA: acc 76.224 in HMS Archive in Hermannsburg, Germany.
[66] She came to the hospital in August 1962 and left within less than two years.
[67] Ulrich Schmidt's 1967 Hospital Annual Report archived in SA: acc 76.224 in HMS Archive in Hermannsburg, Germany.

assume that the committee and the board were the same body that went under different names at different times. When the two names were mentioned, they were never mentioned in the same report.

When Botswana ceased to be a British protectorate and became a republic, the involvement of the government in health matters increased countrywide. The report of 1976 is very helpful in providing an understanding of the arrangement in terms of boards and councils of the Bamalete Lutheran Hospital. Previously the hospital was under the supervision of the missionary in charge of the mission station, the senior nurse and the doctor when available to the hospital. During the presence of missionary Bernhard van Scharell in the 1960s, a team made up of van Scharell, the missionary nurse and the mission superintendent went to Mafikeng in South Africa from where the Bechuanaland Protectorate was governed, in order to request subsidies for the BLH as we shall see later in this chapter. Of course, the mission superintendent could amend the decisions made by the missionary team on the mission station in the interest of the HMS.

Along the same lines as the 1970s Africanization policy in the mission hospitals in South Africa,[68] Botswana government policy was to reserve leadership roles for its citizens and to employ expatriates only where there was a shortage of skills among locals.[69] Work permits for expatriates were given for a maximum of two years.[70] Ironically, Minister Thema, whose new policy seemed to antagonize medical missionaries, was invited to the dedication of the new Bamalete hospital building on 9 August 1969. The government was indeed involved. We shall see later, in the section on finances, how that involvement influenced power relationships within the BLH.

Judging from the annual reports, it seems that the hospital advisory board was really in charge in the 1970s. Dr. Ian Kennedy mentioned in the 1973 report that the hospital

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[68] Dr. Kurt Bergter interviewed by Radikobo Ntsimane at Bad Oeynhausen, Germany on 28 August 2002.

[69] Dr. Ulrich Schmidt's 1967 Annual Hospital Report held in HMS Archive in Hermannsburg, Germany. Dr. Ulrich Schmidt reported that the newly-elected Minister of Health Mr. Thema had introduced the localization policy of the government.

[70] Previously the expatriate missionary nurses took out seven years minimum contracts (1959 Report by Imgard Thielemann).

board had promoted a certain Mrs. Lesetedi to the position of sister-in-charge and four staff nurses to the positions of charge nurses. Though no mention was made of the criteria for such promotions, the power of the board was still obvious in its dealing with personnel matters. The 1975 report[71] clarified the composition of the leadership structure in this way:

> The Hospital Board comprised one member from the following groups and institution: a senior hospital staff, a representative from the Tswana Lutheran Church (headquarters in Rustenburg, South Africa), a representative from the Bamalete people of Ramotswa and a representative from the HMS. There was an Advisory Committee which assisted the Board in local matters.[72]

The board seemed to have included important stakeholders. In its diversity though, it appears that it did not have sufficient familiarity with local matters and needed, as mentioned, the support of an advisory committee. The board's size also warranted the election an executive committee, which was responsible for the everyday running of the hospital.

According to the 1976 medical report, the hospital board consisted of representatives of the Local Authority (tribal), of the Western Diocese of the Lutheran Church (ELCSA-WD), of the HMS, and a senior staff member. The co-ordinator of the Association of Medical Missions of Botswana attended all meetings of the hospital board.

There was also the advisory committee which consisted of the local representatives and dealt mainly with issues pertaining to staff. The decision to create this last structure was important as it was unadvisable for board members who lived and worked far away from the hospital to be decision-makers in a village of which they did not know the power dynamics. Local people would know best how to handle staff issues using in the village the existing internal conflict resolution mechanisms. The imposition of foreign conflict resolution mechanisms brought about by doctors and nurses mainly from Europe had potentially devastating consequences. Perceptions of

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[71] Author of this Report does not appear in the report.
[72] That Advisory Board continues to assist the Board up to this day.

logic and fairness differ from culture to culture and, if ignored, irreparable damage can be done to working relationships within a hospital setting. With rapid staff turnover, the mission hospitals, like BLH depended on community-based structures to provide leadership and maintain harmony in the hospitals.

We shall see below how the hospital board and committees steered the relationship with the newly-formed Republic of Botswana to the benefit of the people for whom the hospital was initially built. The board's composition reflected both the implementation of the localization policy of Minister Thema and the local ownership referred to by Dr. Schneider. We shall consider the role played later by this board in the nationalization of the BLH.

3. The Nationalization of Mission Hospitals

Having discussed the BLH in Botswana at length in the preceding subsection, this sub-section will show how in South Africa the power to control mission hospitals shifted from the missionaries to the apartheid government's provincial authorities and later to the Bantustans and self-governing states. This nationalization policy was informed by the 1955 Tomlinson Commission's report to the Nationalization Policy, to the Africanization Policy, and to the hand-over process beginning in 1973. Furthermore we will show how power moved from one health authority to the next and in the process left the people who needed help in a lurch. Skewed power relations can be observed here as the Health Authority in charge of the mission hospitals became manipulative and took control of the health resources.[73] This chapter will also demonstrate that the situation in Botswana was different when that country gained its independence and changed from a British Protectorate governed from South Africa, to a republic with its own ministry of health in Gaborone, the capital. But before let us look first at the formal roots of nationalization as promoted by the 1955 Commission

[73] Sue Russell, *Conversion, Identity, and Power: The Impact of Christianity on Power Relationships and Social Exchanges*. University Press of America: Lanham, 1999, p.2.

for the Socio-Economic Development of the Bantu Areas within the Union of South Africa.[74]

From the outset, we need to recognize that the Tomlinson Commission recommended segregation. It was the recommendation of separate development that led to the segregation of the living areas of different races, and to the segregation of education and health care. The nationalization of mission hospitals in South Africa was not similar to that of Botswana, in which the policy of the government was to intervene in the mission hospitals in order to improve the quality of health care. With Africanization, which meant placing Africans in leadership positions, the government did not mean to promote Africans in recognition of their expertise but was instead putting them in charge so that the government could have minimal opposition. The mission hospitals, as we shall see later, were handed over to Bantustan authorities who deteriorated the quality of service through poor management and deliberately low budgets from Pretoria.

3.1. First Step towards the Nationalization Policy: the Tomlinson Report

The Tomlinson Report laid the foundations for nationalization of mission hospitals and confirmed the separate development policy in apartheid South Africa. The South African Government adopted the report which, among other recommendations, dealt with matters of health. We shall take time to scrutinize the report as it finally led to the separate development and creation of Bantustans that in the 1970s culminated in the Transkei, Bophuthatswana, Venda and Ciskei (TBVC) states. As has been mentioned earlier, the mission hospitals in the rural areas were nationalized and handed over to these Bantustans.

As the name suggests, the Tomlinson Commission was set up by the apartheid government to seek a way to address the presence of the Black people within the Union of South Africa. The terms of reference of the commission will provide a clear

[74] The commission was later referred to the Tomlinson Commission, after its chairperson Professor F.R. Tomlinson.

picture as to how the South African government viewed the commission in 1951. The terms of reference were:

> To conduct an exhaustive enquiry into and to report on a comprehensive scheme for the rehabilitation of the Native Areas with a view of developing within them a social structure in keeping with the culture of the Native and based on effective socio-economic planning.[75]

Homelands came about as a result of the recommendations of this commission. Of the twelve principal recommendations, Houghton, a contemporary analyst of the report, presents the recommendation on creation of homelands as follows:

> The people of South Africa will have to make a clear and definite choice between the alternatives of the complete integration of the two main racial groups or the separate development. The Commission is convinced that no middle course is likely to be satisfactory (p105)[76] and after careful consideration it recommends that the alternative of separate development be adopted, and considers this the only possible solution (p106).[77]

It seems that the fear of racial integration and of the disappearance of the European race, rather than a genuine concern for the development of the Black indigenous South African, was the motivation. Although the commission recommended that "the people of South Africa" make a clear and definite choice, it implied that Whites would make a choice for Blacks; the commission was driven by racial preference for White people. Under the sub-section "Consequences of Integration", Houghton mentioned the reality which the Whites could not easily accept, viz.: "The ultimate result—though it may take time to materialize – is complete racial assimilation, leading to the creation, out of the original communities, of a new biological entity" This paranoia as regards racial purity and superiority more than any other thing influenced the decision to follow the recommendation of the Commission for Separate Development for White race preservation.

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[75] D. Hobart Houghton, *The Tomlinson Report: A Summary of the Findings and Recommendations in the Tomlinson Commission Report.* South African Race Relations: Johannesburg, 1956, p.1 (preface).
[76] The brackets within the quotation refer to the pages of the official comprehensive report of the Commission.
[77] D. Hobart Houghton, *The Tomlinson Report.* South African Race Relations: Johannesburg, 1956, p.3.

In the chapter on "Health in the Social Services", the commission recommended a general integration or nationalization of all health services in the Bantu areas. Because of the multiplicity of agencies providing health services in the various so-called Bantu administration areas the commission made the following recommendations:

> The Commission therefore recommends that the Union Department of Health, the provincial administrations, local authorities and private undertakings, eventually including missionary societies, should hand over their health services and responsibilities in the Bantu Areas to the Department of Native Affairs. This Department should then delegate these responsibilities to the Union Department of Health. An officer of senior rank in the Department of Health should be appointed to keep the Secretary for Health informed on public health problems in the Bantu Areas and to act as liaison officer with the Dept. of Native Affairs.[78]

The commission made it clear that the mission hospitals should be taken over by a single body that looked after the health of Black people. The likelihood of application was undeniable but the commission neglected to report on the specificities of maladministration in the health agencies operating in South Africa in the 1950s.

When the Lutheran Medical Foundation was established on the basis of the recommendations of the study conducted by Holman in the early 1960s, the process leading to the total nationalization of the mission hospitals had already started with the Tomlinson Commission.

3.2. Africanization Policy within the Mission Hospitals

In addition to the nationalization policy of the mission hospitals the commission recommended what came to be referred to as Africanization of mission hospitals. Africanization should be seen as a suspicious policy in the history of South African health care. Here it sounds positive, "As far as possible the personnel of the Health Service should be qualified Bantu, and the European personnel should be gradually

[78] Houghton, *The Tomlinson Report.* South African Race Relations: Johannesburg, 1956, p.51.

replaced by Bantu."[79] This process of Africanization went along with nationalization and brought about difficulties as it led to the rapid and unplanned exit of medical missionaries from leadership positions and their replacement with Black people. That became evident especially in the 1970s when the creation of Bantustans and the opting for independence by some of these Bantustans was accelerated. That was at the height of apartheid.

Two former mission doctors I interviewed, one a Lutheran, Kurt Bergter of Itshelejuba and another a Dutch Reformed Church , Gerrit Ter Haar[80] of Rietvlei, described the implications of this policy. Dr. Bergter saw Africanization as necessary as it was opened opportunities for Black that had hitherto, under the leadership of the mission societies, been denied them. They could not appreciate the fact that instead of allowing Blacks to be in charge, the government policy was in fact destroying the medical work of the mission societies. They were recognizing the ability and maturity of Black people who would be permitted to only manage hospitals for Blacks. It should be borne in mind that in the 1970s some Black people had already qualified as medical doctors and senior nurses. Their qualifications were only good enough for service in Bantustan-controlled hospitals. The position of Bergter and Ter Haar, one that favoured Africanization, was shared by other missionary doctors who could not see through the reality of apartheid in the policies of Africanization and nationalization.

Ter Haar did not think that the hospitals should be handed over to the Hospital Committee members and the Clinic Committee members. He referred to his experience in the Transkei, but the situation was similar in the other homelands and self-governing states in South Africa. He argued that the members of these committees should be chosen more for their expertise (*bekwaamheid*) than their membership in the church. The LMF had a similar practice which, as Holman observed, rendered the committees dysfunctional. The committees were saturated with

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[79] Ibid.

[80] Although Ter Haar worked as a mission doctor in a mission hospital outside the scope of this dissertation, his experiences during the nationalization and Africanization of mission hospital is valuable in understanding the history of the time.

Black church members who, out of piety and feelings of indebtedness, could not challenge the decisions of their pastors openly.

Apartheid, which Lutheran medical missionaries could not see in the nationalization and Africanization schemes of the government, was too obvious to see. What they failed to observe in the homelands was that the secretaries of the health ministers were in fact working for the central government and that their task was to teach Black people how to govern. The secretaries had the power to make decisions while the Black ministers had the seats. The secretaries had no respect for their ministers as they reported to, and were paid directly by, Pretoria. This situation resonates with the situation of the newly-established national Churches, especially the LCSA where the diocesan deans had missionary advisors that were supposed to help them making decision. There was no way that transformation of hospitals and other church structures could be achieved, provided such transformation was envisaged. The complexion of the leadership was to be changed but the "soul" remained the same.

3.3. Impediments to Nationalization and Africanization Processes

The transformation of the mission hospitals from White missionary-run institutions to Black secularly-run institutions was not going to be a smooth one. The racial discrimination around the control of resources by Whites had entrenched relationships similar to those between master and slave outside the hospital setting. I have already referred to Ter Haar's observation that it was going to be difficult for Whites to serve under Blacks. In addition, some Black people could not assume leadership roles in the mission hospitals despite the Africanization policy destined to give them a chance to take up leading positions.

Material gain and self-preservation seemed to be some of the motivations that drove most of medical missionaries who were sceptical about the wisdom of handing over power to Black people. In deciding whether to serve under new conditions, most mission doctors and nurses chose to abandon the mission hospitals for better working conditions elsewhere. While some medical missionaries left for material gain, we should recognize that others decided not to continue in the same hospitals to

demonstrate their refusal to promote apartheid. Ter Haar argued that if the medical missionaries had stayed on in the mission hospitals after nationalization, they would have forfeited their pensions with their mission societies. He suggested that letting go of their mission pensions was more than relinquishing their salaries and their positions to Black people. Similarly, there are teachers who after 1953, refused to be teachers after the promulgation of Bantu Education Act, as a way of demonstrating their opposition to apartheid.

In this chapter I attempted to show that several events led to the total take-over and control of mission hospitals by the apartheid government. We shall see that the apartheid government policy aiming for total control of the Black people led to the take over of the health care sector. While the hospitals were under the control of mission agencies, it was not easy for the government to use them to control the Black people. Under the homeland authorities who were appointed by the apartheid government, it was going to be easy for the government to direct the lives of Blacks using their appointed homeland authorities.

Since state hospitals and clinics were run by the government, the mission hospitals had to be taken over in order for them to be subsumed under the control of the Bantustans and the self-governing states. The take-over was introduced in a clandestine manner, resulting in subtle control under the apartheid system. The Comaroffs' theory of hegemony helps us understand the situation: "The making of hegemony", they wrote, "involves their control over different types of symbolic production, with things like education, ritual processes, socialization, political, legal, style and self-representation, public communication, health and bodily discipline, and so on."[81]

The apartheid policy aimed at taking control of the lives of Black people. As stated in the above quotation, health was part of that agenda to oppress Black people.

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[81] Jean and John Comaroff, *Of Revelation and Revolution: Christianity, Colonialism, and Consciousness in South Africa.* Vol. 1. The University of Chicago Press: Chicago, 1991, p.25.

3.4. The Process of Taking Over Mission Hospitals

Let us now look at the take-over process. The spread of diseases like tuberculosis, the consolidation of the homelands and self-governing states, the deportations of missionaries, the retreat of mission societies, the opposition to compulsory military conscriptions and the imperatives of financial interventions will be discussed to illustrate how the taking over of mission hospitals proceeded.

The government became involved in the running of the mission hospitals in the 1960s through granting them subsidies for their medical work.[82] Its financial contributions led to the government getting the upper hand in missionary matters. That eventually resulted in the nationalization of most mission hospitals in South Africa in the late 1970s.[83]

The nationalization process was gradual and was caused by a number of reasons that we shall look at individually. The nationalization of mission hospitals had four reasons: medical, financial, socio-political and ecclesiastical. The period between 1960 and the late 1970s in South Africa was volatile. The Union of South Africa was declared a republic in 1960. The Pan Africanist Congress (PAC) initiated anti-pass protests which resulted in the Sharpeville massacre in 1960. As a result of the massacre the World Council of Churches called the Cottesloe Consultation. The Black political parties were banned. The Black Consciousness movement developed in the vacuum left by the banning of the Black political organisations. A moratorium to curb the influx of missionaries of European stock into Africa was called for. There was an increase in the Black clergy in the former mission Churches and the emergence of Black Episcopal leaders in the national Church bodies. Those and other events and changes had a direct impact on the nationalization of the mission hospitals. In the following section will consider events and the conditions in the mission hospitals that caused the mission hospitals' nationalization in the early 1970s. These

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[82] Bishop Georg Schulz, "The Healing and Helping ministry in the Missionwork," *Reports and papers on Mission Hospital Work in South Africa*, 1971, p.19.
[83] The Evangelical Lutheran Church in Southern Africa (ELCSA) keeps the Siloah Hospital up to this day. It was saved from nationalization due to being located on a private farm. The Anglican Church kept St. Aidan's Hospital in Durban for many years after the nationalization policy.

factors, of medical, financial, political and ecclesiastical nature will be discussed in broad sub-sections.

3.5. Medical Causes of the Nationalization of Mission Hospitals

Gelfand neglected to mention by name the "many preventable diseases as well as curable ones"[84] whose prevalence alarmed the missionaries. However, the development of mission hospitals had a great deal to do with them. The report of the National Health Services Commission which was published in 1944 acknowledged that "in the tribal authorities the greater part of responsibility for health was being taken on by Churches."[85] The findings of this commission, in my opinion, opened the door for the government to take over of the mission hospitals.

The report of Ernest J. Holman is helpful in determining some of the causes for the "nationalization" of mission hospitals in the 1970s. For various reasons a certain number of diseases started to increase. We consider venereal diseases, the paediatric diseases and tuberculosis. Holman's list shows the great number of diseases with which the hospitals had to deal. It includes diseases that the African traditional healing methods could not treat successfully. For example, tuberculosis was very prevalent and proved to be a big challenge for traditional health practitioners.[86]

Holman's report is helpful to this study because in its description of the conditions in the various hospitals of the Co-operating Lutheran Missions in Natal, it notes the prevalence of specific diseases in the different geographical areas served by the said hospitals. A list of diseases mentioned by Holman is presented below. Note though that some of the diseases were prevalent through the entire region whereas others were found only in specific areas.

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[84] Gelfand Michael, *Christian Doctor and Nurse*. Mariannhill Mission Press: Mariannhill, 1984, p.300.
[85] Ibid.
[86] See the interviews of Ulrich Schmidt and Evelyn Sommerfeld in the appendices.

Mission Hospitals		Endemic Diseases
1.	Hlabisa	bilharzias, typhoid, amoebiasis, venereal diseases, malnutrition [pellagra and kwashiorkor], gastro-enteritis, tuberculosis
2.	Luwamba	same as in Hlabisa
3.	Untunjambili	amoebasis, kwashiorkor, scabies, congestive cardiac failure, tuberculosis
4.	Emmaus	malnutrition, kwashiorkor, leprosy, enteric, tuberculosis
5.	Applesbosch	bilharzias, gastro-enteritis, malnutrition, tuberculosis
6.	Emtulwa	
7.	Betania	malnutrition, burn cases, tuberculosis
8.	Ceza	malnutrition, typhoid, measles, whooping cough, polio, tuberculosis
9.	Thulasizwe	Tuberculosis
10.	Ehlanzeni	scabies, venereal diseases, tuberculosis
11.	Siloah	measles, whooping cough, tuberculosis
12.	Ekombe	malnutrition [pellagra and kwashiorkor], tuberculosis
13.	Nkonjeni	bilharzias, malnutrition [kwashiorkor], tuberculosis
14.	Umpumulo	bilharzias, amoebic dysentery, malnutrition [pellagra and kwashiorkor], tuberculosis

3.5.1. Venereal Diseases

Venereal diseases like HIV are acquired through sexual relations and are less reported since the infected and sufferers are ashamed to disclose their conditions for fear of being ridiculed. As church institutions, mission hospitals were not the best place to seek help for a disease associated with sexual intercourse. Without doubting the accuracy of the report compiled by Ernest Holman, I argue that there was more prevalence of venereal diseases than stated in the report. Only Hlabisa and Ehlanzeni reported that venereal diseases were prevalent. The report also neglected to identify the venereal diseases whereas it provided specific names of the diseases in the case of malnutrition.

In contrast to what Dr. Kurt Bergter claimed—that it was the TB prevalence that led to the founding of Itshelejuba—Sister Ruth Bauseneick stated that it was in fact the prevalence of syphilis. Of course penicillin drastically brought down the dangers of syphilis and the disease became manageable. She said in this regard:

> Syphilis was not more there…*Syphilis war nicht mere so schlim*! It had reduced because there was penicillin. And it was over! But Tuberculosis! Tuberculosis, when I was driving a car sometimes that child has Tuberculosis…that child has Tuberculosis. And you see them by the eye wimpers[87]… the time is modern you now buy them and put them on. And the skin![88]

3.5.2. Pediatric Diseases

Children are prone to illness and need constant care. Kwashiorkor and pellagra feature in Holman's report as the most prevalent paediatric diseases, caused by malnutrition. Sister Bauseneick also mentioned bilharzias which attacked children playing in rivers and water puddles.

Sibusiso Xulu of Untujnambili explained that the founder of the mission hospital, Lillian Young, went overseas to find medication to help children in surrounding schools.[89] When the government nationalized the mission hospitals in South Africa, it also intended to provide health care to vulnerable children who had previously placed a huge financial burden on the mission hospitals' budget. The plight of children was not different in Botswana. When Dr. Gerda Schneider observed that poor crop harvests exposed children to inadequate vitamin supplies, she proposed that Pro-Nutro and powdered milk be made available to fulfil the children's need for nutritious meals.[90]

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[87] Wimpers are eyelashes

[88] Ruth Bauseneick interviewed by Radikobo Ntsimane at the Mission House in Bleckmar, Germany on 5 August 2002.

[89] Mr. Sibusiso Xulu interviewed by Radikobo Ntsimane at Untunjambili on 22 July 2000. Mr. Xulu said, "*Kwaze kwafika la exhumana nabaphesheya belokhu bemunikeza ke amaphilisis nemithi ayekusebenzisa esekhaya kwakhe ekusizeni abantwana bebandla ezikoleni zebandla lakwa Ntunjambili kanye nawo umphakathi.*"

[90] 1963 Report by Dr. Gerda Schneider archived in HMS Archive in Hermannsburg, Germany, "Auszug aus einem Bericht vom Bamalete Lutheran Hospital, Ramotsa."

Pulmonary tuberculosis featured in all the mission hospitals visited by Holman. It also was prevalent in the Itshelejuba mission hospital. Dr. Kurt Bergter wrote that the mission hospital was established as a result of the prevalence of tuberculosis in the area.[91] Apart from tuberculosis, there were other endemic diseases according to sister Bauseneick, the nurse of Itshelejuba Mission Hospital. She mentioned that syphilis had decreased thanks to penicillin and that malaria was overcome by the use of quinine.[92] There were many diseases that could have prompted the government to subsidise and later nationalise the mission hospitals in South Africa. The mission agencies could no longer get the hospitals to provide adequate health care in the face of a growing number of diseases. The lack of finances resulted in a lack of nurses and doctors.

In Botswana the Bamalete Lutheran Hospital had its fair share of endemic diseases. Droughts led to malnutrition which caused a plethora of diseases. The annual reports compiled by the doctors and nurses of the Bamalete Lutheran Hospital make mention of droughts that the village suffered in 1944, 1949, 1951, 1957. Dr. Gerda Schneider spent a short time (one year in 1963) at the Bamalete Lutheran Hospital but she made important observation about the area. She reported that there was a great need in the village which was "overgrown with thorn bushes" (*übersätz mit Dorbüschen),* and the tribe only succeeded in harvesting grain only once in five years.[93] Food shortages caused children to suffer from vitamin deficiency. According to the same report, the BLH needed DM10 000 per year to buy school children milk powder, protein supplements like Pro-Nutro, maize and vegetables.[94]

Missionary Lange's report of 1949 stated that the villagers suffered from "measles", (*Masern),* "coughing" (*Huste*n) and dysentery. The 1976 report mentioned measles in the case of unvaccinated children, respiratory disease and gastro enteritis as some of diseases treated at the Bamalete Lutheran Hospital. Tuberculosis was not new in Botswana. Pulmonary tuberculosis *(Lungenturberkulos)* had devastating impact in

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[91] "Medical Report" in *Reports and Papers on Mission Hospital Work in South Africa*. 1972, p.5.
[92] Ruth Bauseneick interviewed by Radikobo Ntsimane at Bleckmar, Germany on 05 August 2002.
[93] 1948 Report by Missionary Lange mentioned a good harvest.
[94] 1963 Report by Dr. Gerda Schneider archived in HMS Archive in Hermannsburg, Germany. "Auszug aus einem Bericht vom Bamalete Lutheran Hospital, Ramotsa."

Ramotswa, as it was exacerbated by drought and poor harvests, and caused whole families to die.[95]

3.5.3. Tuberculosis

Southern Africa was all over affected by tuberculosis including in areas like the northern Transkei. Michael Gelfand noted that half the patients of Nessie Knight Hospital were tuberculosis positive.[96] The historical background to the prevalence of tuberculosis in southern Africa will help us to understand why the government eventually intervened, first as a partner and later as the final provider of care in the war against the disease.

> Tuberculosis began to spread in southern Africa by the turn of the last century, with the South African mines serving as an originating point of spread. The disease moved into labour-source areas with lightning speed because men who contracted the disease at the mines were sent home. They spread it to their under-nourished children in the reserves, who suffered the disease in its active form and so spread it further. By the late 1920s 65-70% of mine recruits from Mozambique were infected with tuberculosis, even though twenty years earlier fewer than 2% of new recruits from Mozambique had tested positive for the disease. A TB survey in Transkei in the late 1920s found that 88% of all adult men and women tested positive.[97]

Tuberculosis was not only prevalent in Natal and Zululand but also in the Transkei. As a result the government made an undertaking to combat the disease before it reached pandemic level, especially after World War Two. The politics of discrimination and racial exclusions contributed to the minimal success obtained in combating the disease as an authority and prolific writer on tuberculosis, Randall Packard, observed:

> In short, effort to attack the underlying causes of TB in South Africa after Second World War did little to improve Black living conditions,

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[95] 1949 Report by Missionary Lange kept in the HMS Archive in Hermannsburg, Germany.
[96] Michael Gelfand, *Christian Doctor and Nurse.* 1984, p.176.
[97] Philip Curtin, Steven Feierman *et al*. *African History: From Earliest times to Independence*. Longman: London, 1975, p.502.

> and represented a continuation, on a grander and ultimately more tragic scale, of the politics of exclusion that had marked earlier control efforts.[98]

We shall see in a later section that the Separate Development Act implied that the country's resources should remain under the control of White people. Racial division had negative effects on the Black people both in urban and rural areas as well as in the homelands. Packard thus described the discrepancies in health care:

> These problems affected all TB control efforts in South Africa, but were much more severe among blacks than among whites. This reflected both the differences in the conditions under which the two groups lived and in the allocation of health resources. If one compares the accumulation of black cases on TB registers with the accumulation of white cases during the 1950s and 1960s, it is immediately apparent that the two differed not simply in the number of cases recorded, but in the pattern of case accumulation. TB registers include all reported cases that have not been cured. The rate at which the number of cases on a register increases, therefore, reflects both the rate at which new cases are identified and the rate at which they are cured. A continual accumulation of cases indicates that new cases are being identified faster than existing cases are being cured.[99]

The apartheid government intended to preserve White lives at the expense of Black ones. There were discrepancies in the allocation of resources to both groups. The removal to reserves and homelands for Blacks meant that the Black people were separated from White people, thereby saving them from infections and re-infections with this highly contagious but curable disease. Tuberculosis was so politicised that its treatment did not depend on doctors and nurses but on politicians. The politicians decided on a racial basis those who could access medication. They legislated where people of different races where lived and they decided which population areas were to have what quality of health care. The Blacks were allowed to live near the areas reserved for White people for as long as their nearness improved White

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[98] R.M. Packard, "Holding back the tide: TB control efforts in South Africa" in Coovadia, HM and Benatar, SR (eds.) *A Century of Tuberculin: South African Perspectives*. Oxford University Press: Cape Town, 1991, p.48.

[99] R.M. Packard. "Holding back the tide: TB control efforts in South Africa" in Coovadia, H.M. and Benatar, S.R (eds.) *A Century of Tuberculin: South African Perspectives*. Oxford University Press: Cape Town, 1991, p.49.

peoples' quality of life. Blacks had to provide the labour force in industries and in the homes of White people.

Packard adds that resources were not made available where they were needed most, i.e. in areas where Blacks resided. The number of infections for Blacks increased in spite of the availability of medication:

> In South Africa black TB registers reveal this type of steady accumulation of cases between 1950 and 1960, but white TB registers, by contrast, show an initial increase in cases followed by a levelling off and eventual decline by 1960. Since both black and white populations were subject to case-finding efforts during this period, the difference in the pattern of accumulation reflects the fact that white cases were being cured at a rate which equalled and often exceeded the rate at which new cases were being identified. New black cases of TB, on the other hand, were accumulating faster than existing services could handle them. This difference in cure rates in turn reflected disparities in access to health services.[100]

I would argue that the need to curb the spread of tuberculosis brought about increasing control of mission hospitals by the apartheid government in the 1970s. Anthony Barker, a missionary doctor in the Charles Johnson's Memorial Hospital, Nquthu, noted that besides ignorance, catching tuberculosis resulted from a deficient diet, overcrowding, and lack of sunlight in the homes:

> Although it is not an outstandingly infectious disease, tuberculosis will still spread disturbingly fast if conditions are right for it to do so. Where there is deficient diet; where there is overcrowding; where the sterilizing sunlight is denied access to living quarters; there the soil is right for its dissemination.[101]

Dr. Barker and his colleagues at the Charles Johnson Memorial Hospital in Nquthu, had first-hand experience of apartheid South Africa when they assisted the displaced people, who through forced removals, were dumped in nearby Nondweni to live under difficult and unhealthy conditions.[102]

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[100] R. M. Packard. "Holding Back the Tide." Oxford University Press: Cape Town, 1991, p.49.
[101] Anthony Barker, *The Man Next to Me*: *An Adventure in African Medical Experience*. Harper: New York, 1962, p.141.
[102] Jon Larsen, *KwaBaka: The Story of a Mission Hospital Community in Zululand 1930-2006*. Cluster Publications: Pietermaritzburg, 2010, pp.94-100.

Overcrowding came as a result of displacing African people from their villages and townships to other areas often smaller in size and far removed from their places of employment. They were removed from settlements too "near" to the settlements of White people. When people were crammed in small houses with little or no sunlight, tuberculosis could easily spread. In Northern KwaZulu-Natal most houses were built with small windows through which fresh air and sunlight penetrated only in limited amounts.

In his 1972 medical report, Dr. Kurt Bergter noted that Itshelejuba was established for TB. He further stated that the geographical location of Itshelejuba and the ignorance of people in the area made TB a priority: "Originally, this hospital was meant more or less only for treating patients with pulmonary tuberculosis."[103] The 21, 542 TB patient days, the 205 admitted TB patients and the BCG vaccinations of all new-born babies between April 1971 and March 1972 indicate a high prevalence of the disease.[104] As with other hospitals, Itshelejuba urgently needed staff to do home-visits and check whether patients adhered to their medication.[105]

In his report on Untunjambili Hospital, Holman mentioned the involvement of the government in the expansion and restructuring of the hospital so that it could deal with TB prevalence:

> Furthermore, the tuberculosis unit is stuck off about one-quarter to one-half mile away from the main complex. Those observations are not particularly relevant at the present time, however, the government is in the process of drawing plans to replace the present unit with an entirely new 200 bed complex which will not only eliminate the present Untunjambili, but is also being built in mind to take the place of the non-European government hospital in Greytown, some 25 miles distant.[106]

TB-prevalence being acute in Natal and Zululand, the Transkei and other parts of the country, the government undertook to combat it before it reached pandemic status, especially after World War Two. The politics of exclusion of health seekers based on

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[103] Kurt Bergter. "Medical Report " in Itshelejuba Mission Hospital Reports and Papers on Mission Work in South Africa. 1972, p. 5.
[104] Ibid.
[105] Ibid.
[106] Holman. *A Report on the Medical Program*. Volume I, 1967, p. 38.

their tribal and ethnic origins contributed to the minimal success of the fight against the disease among Black people, as R. M. Packard observed.[107] The government's campaign against TB yielded minimal results because of the insufficient allocation of health resources to Black people. It was the political ideology of the homeland system rather than limited resources that prevented success in the combating of tuberculosis.

Packard observed that the homelands system was in no way geared towards eradicating or even substantially reducing the numbers of TB cases. In fact, he saw the transformation of homelands into self-governing national states with specific geographical borders as a serious impediment in the fight against TB:

> Additional problems were caused by the transformation of homelands into so-called 'national states', each with its own health service, during the 1970s and early 1980s. There are currently no less than 17 separate authorities responsible for health in South Africa with minimal coordination among them. This fragmentation has further increased the likelihood of patient default. As members of a medical team working in the Gazankulu 'homeland' located in the eastern Transvaal noted in 1984: Homeland borders and structures limit us and fragment services. Just over half of our patients come from Lebowa; but we may not follow them up at home, visit their families or organize SAC [supervised ambulatory care] for them. We also cannot trace contacts or defaulters, or do case finding in Lebowa.[108]

This confusion was caused by the lack of access to financial resources meant for health care provision. Those in charge of the financial resources for healthcare were taking advantage of the needy situation of the health seekers. The resources were channelled mainly to White people at the expense of Blacks. In order to legitimise the homelands financing for health services was allocated to them but the strategies on health provision were not checked for suitability. For the control of diseases such as TB, cholera, and measles, the plans in the homelands were not effective.

The Bophuthatswana homeland and KwaZulu self-governing states had jurisdiction in multiple minute spots within South Africa. For example, the Mabopane and Ga-

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[107] R. M. Packard. "Holding back the tide: TB control efforts in South Africa" in Coovadia, H.M. and Benatar, S.R. (eds.) *A Century of Tuberculin: South African Perspectives*. Oxford University Press: Cape Town, 1991, p.48.
[108] Packard. "Holding back the tide." Oxford University Press: Cape Town, 1991, p.52.

Rankuwa townships near Pretoria were part of the Bophuthatswana homeland, while Imbali in Pietermaritzburg and Umlazi in Durban fell under the KwaZulu self-governing state.

3.6. Financial Causes of the Nationalization of Mission Hospitals

As we have seen in the case of the Untunjambili Mission Hospital, the government's involvement in medical missions was already substantial in the early 1970s. Finance has always played an important role in the establishment and the running of the hospitals. The hospital budget covered medical and surgical needs, salaries of personnel, from nurses and doctors to administrative staff, and maintenance among others. As was the case with other missionary ventures like schools and churches, the mission societies carried, at least in the beginning, the totality of the financial obligations of the hospitals they had established.

Without external financial injections the medical mission ventures would have remained at the level of the make-shift dispensaries in the kitchens of the wives of the missionaries. We have seen how the Ka-Shile Hospital in Mbabane, Swaziland, operated for a long time on the basis of financial donations of friends in Germany (Swazi Kreiss), until it was forced to close during the Second World War. The Berlin Mission Society did not see health as part of its mission in southern Africa. For the Botshabelo Hospital, missionary Friedrich Dierks of the Mission of the Evangelical Lutheran Free Churches (MELFC), applied for and obtained a government subsidy from the outset.

In this sub-section I shall examine how the lack of money stifled Black agency in mission hospitals where the control of financial resources played a pivotal role in relations among stake holders. The missionaries decided who was to be promoted to a higher position of service and who was to be sent for further training. Some of them were concerned about their job security and were careful to ensure that they could not be easily replaced.

James McGilvray has dedicated a chapter to how the various mission societies in Africa addressed the Tübingen I's proposal for churches to be healing communities with an integrated health care approach. In countries like Ethiopia, Malawi, Ghana, Zambia, Lesotho, Nigeria, Sierra Leone and Botswana, surveys were undertaken to determine how medical missions should address health needs in partnership with government in relation to mission hospitals. Malawi became a shining example in this endeavour of integrating health care in various countries under the Church-Related Hospitals programme. On this, McGilvray wrote:

> Therefore, it is of special significance that the Malawi programme for national coordination and planning services, together with those which followed it, should have given the highest priority to integrated programmes designed to bring more effective health care to the maximum number of people in the population. In the case of Malawi, the complete cooperation of the government itself was an important factor in bringing this about. The government also benefited from the arrangement, since it dealt with one organization housed in its own Ministry and representing more than 150 separate units.[109]

Although some countries and churches, as already mentioned, tried to integrate their health care activities under the Church-Related Hospitals programme, the endeavour was not a success everywhere. In South Africa, an example of such attempted integration was the Lutheran Medical Foundation, whose parochial efforts were dealt a blow when apartheid health care policy was implemented under the guise of nationalization.

Let us now look at the four mission stations under review and their mission societies, to see how they fared in responding to nationalization. What role did the financial needs of the hospitals determine who would finally take control of them? When the demand for hospital services grew as a result of diseases and the need to procure sophisticated machinery, more finances were called for. There was a perennial need for more personnel in mission hospitals, especially after the governments had

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[109] James McGilvray, *The Quest for Health and Wholeness*. German Institute for Medical Missions: Tübingen, 1981, p.36.

identified mission hospitals as a way of abdicating its responsibility for health care provision from State hospitals.[110]

3.6.1. Bamalete Lutheran Hospital

As was shown in the previous chapter, the HMS in Botswana did not escape the financial upheavals faced by the other Lutheran mission societies in South Africa with regard to health provision. To be able to continue providing quality health services more personnel and financial resources were required.

In order to make the tribe aware of the importance of time and money for the hospital's continued provision of services, nurse Emma Pfitzinger of the Bamalete Lutheran Hospital decided that any patient who asked for a home-call but was not present when a nurse arrived, would later be charged a shilling.[111] In 1950, the Bechuanaland Protectorate gave 4 pence per out-patient to the Lutheran Hospital. Emma Pfitzinger saw that as a blessing as she would now be able to treat poor patients without charging them.[112] The 1951 report mentioned that the number of patients coming to the hospital was increasing. The availability of treatment without charge probably made it possible for more people to access the facilities. The report of the following year lamented the fact that the patients who had promised to pay later were not honest and that as a result the medicines stock was being dented.[113] We need to note the emphasis on resources in this report. When the government made money available to support the nursing station and the medical help became accessible, the number of patients increased. With the increase of available resources, the number of those who wished to access them also increased. Those with resources were automatically in charge and could manipulate those in need of the resources. The government injected the finances to the medical missions.

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[110] Reports from the Bamalete Lutheran Hospitals and the letters of Bernhard Schiele are saturated with request for personnel.
[111] 1936 Report to the HMS by Emma Pfitzinger to HMS dated 26 January 1937, kept in the HMS Archive in Hermannsburg, Germany in Folder A:SA 42 – 339 (1935-1969).
[112] 1950 Report for the Ramoutsa Nurses Care Station dated 1951 by missionary Lange kept in HMS Archive in Hermannsburg, Germany.
[113] 1952 Report dated 15 January 1953 of the Ramoutsa Nurses Station by missionary H. Holsten and kept in HMS Archive in Hermannsburg, Germany.

By way of digression, one could observe that the western culture was so well assimilated by the Batswanas that fines due to western institutions had to be paid in western money. The introduction of monetary economy was a necessary foundation for the functionality of the western life-style.[114]

Like the financial support given by the German-based Swazi Kreis for the medical work of Dr. Magdalene Schiele in Swaziland, the medical work of Emma Pfitzinger was supported financially by her home congregation in Elsass. When the mission director Wickert visited southern Africa he enquired about the source of Emma's salary. As has been mentioned above, one may assume that the HMS was not privy to this information despite the fact that Emma was sending annual reports; otherwise the director could have established Pfitzinger's income from his office in Hermannsburg. Maybe the HMS which had just started to do medical work did not read the reports from the mission field. The information on the salaries was necessary for planning the sending of two nurses into the mission field. The decision regarding the salaries of the two nurses would be the first direct involvement of the HMS in the medical field in southern Africa.

There is evidence that there had been a steady rise in financial support from overseas for the medical work in Alsatia Hospital. My intention is to show the negative impact such increase had on the development and the maintenance of the medical facilities of the mission society. This pattern of increased financial support and ambition for growth is observable in the other three hospital establishments under review, viz., Emmaus, Untunjambili and Itsheleljuba.

There is no report available for the 1939 and 1940 mission station activities. The 1941 report was written by missionary Pfitzinger and makes no reference to hospital matters. It deals with congregational matters and with the arrival in Lentswelatau of Hereros from Namibia. The 1942 report is dedicated to the issue of polygamy among the Batswana. The 1943 report fails to mention the medical mission work, but the rise in financial needs becomes evident in the previous reports. Quality health care could not be sustained with local resources only.

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[114] See the discussion on the acculturation and cultural assimilation in chapter four of this thesis.

3.7. Political Reasons for Nationalization of the Mission Hospitals

For a better understanding of mission hospitals a brief background to the history of the homelands will now be provided. With the National Party's rise to power in the late 1940s, the resistance from Black people against the apartheid regime also rose. The Defiance Campaign of the early 1950s, the bus boycotts, the anti-Pass Campaigns which led to the Women's March to the Union Buildings in Pretoria, culminating in the Sharpeville massacre of 1960, are examples of the resistance against the National Party's apartheid policies. One of the strategies of the National Party government to diffuse the mounting opposition to its racist laws was to balkanize the Black people. Such a process of balkanization led to the creation in the 1970s of four so-called independent homelands viz., Transkei, Bophuthatswana, Venda and Ciskei (TBVC) states. Over and above the TBVC states, six similar, self-governing State structures were created, viz. Lebowa for the Pedi people, Gazankulu for the Tsonga people, KaNgwane for the Swazi people, KwaZulu for the Zulu people, Qwaqwa for the Sotho people and KwaNdebele for the Ndebele people.

It was the resistance against racial discrimination that prompted the apartheid government to create independent homelands, rather than the love which the Whites claimed to feel for the Blacks. The Black people, wherever they were, put up strong resistance against forced removals. Some used legal means to oppose removals while others refused to cooperate with the apartheid system.[115] Whites had found the presence of independently-minded Blacks in their midst uncomfortable and a danger to their safety and welfare. They denied Blacks voting rights, expropriated their land, and drove them away from their areas.

The White regime had responsibilities towards all citizens of South Africa. The creation of independent states was a way of abdicating this responsibility to the Black people. When the Black people saw that the government imposed upon them chiefs like Kaizer Matanzima in Transkei and Lucas Mangope in Bophuthatswana, they rebelled. By virtue of their ethnicity they found themselves stripped off their South

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[115] T. R. H. Davenport, *South Africa: A Modern History*. (Fourth Edition). The Macmillan Press: London, 1991, pp.346 -352.

African citizenship and all its benefits. Small-scale industries like Mandeni for KwaZulu, Babelegi for Bophuthatswana and Ekandustria for KwaNdebele, were started as a way to discourage Blacks from going to South African cities for jobs and settlement. The Blacks who were already in the industrialized areas of South Africa were forced to go back to their ethnic homelands the moment they ceased to be employable due to age or illness. Some of the affected Blacks rose up and opposed the system.

The White community of South Africa was going to benefit from the labour of Black people even while these were in the homelands. Robert Davis and David Kaplan wrote thus about the subtle detrimental nature of that policy:

> The Black "reserve" areas (later known as the 'homelands')—covering about one eighth of the country were set aside for exclusive Black occupation in return for which Blacks were finally barred from acquiring land in so-called "White" areas. The reserve areas were intended to provide a "home base" from which the migrant labour system could operate.[116]

The rationale behind the creation of the homeland system was that, if the Black people had their own governments, the central government would not need to worry about their social welfare, health, security, employment, education, land use, etc. Through the creation of homelands the government found a way of shifting the blame for its failures to puppet leaders they imposed on the Blacks in order to entrench apartheid.

The roots of the homeland system can be traced back to the Native Land Acts of 1913 and the Group Areas Act of 1950. The National Party issued a series of proclamations giving Black people some land to rule and the right to vote in their designated homelands.[117]Through one of these promulgations, the 1970 Bantu Homelands Citizenship Act, the African people were stripped of their South African citizenship and declared citizens of national homes in separate states.[118] It is important to note

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[116] Robert Davies and David Kaplan, "Capitalist Development and the Evolution of Racial Policy in South Africa," in Rita Cruise O'Brien (ed.) *Tarikh: White Society in Africa*.Vol.6. No.2 Longman: London, 1979, p.46.
[117] The 1951 Bantu Authorities Act, the 1959 Promotion of Bantu Self-Government Act, the 1970 Bantu Homelands Citizenship Act, and the 1971 Bantu Homeland Constitution Act.
[118] *A Fund for Free Expression Report: Human Rights in the Homelands*. 1978, p. 17.

the power relations at play in this matter. An increased number of acts of parliament tightened the control over the Black people as they were 'handed over' to unpopular tribal and regional leaders. For example, through the Bantu Homelands Act of 1971 the State President of South Africa was given authority to establish tribal, regional and territorial authorities and to grant varying degrees of self-government to indigenous authorities.[119]

The process of balkanization, establishing homelands and self-governing territories, was dehumanizing as the identities of people were changed overnight at the stroke of the State President's pen. Health care provision was directly the concern of the government in charge. Whether the people in the homelands had access to quality health services was going to be the concern of the homeland governments. The central government practically abdicated its responsibility to provide health care to citizens of the homelands and self-governing states.

When the National Party took over government in 1948, political and economic privileges for White South Africans, especially Afrikaners, started to accumulate. Blacks were moved away from some urban areas[120] and from rural areas deemed suitable for White farmers. Those who remained in the urban areas had to prove that they were there legally to provide labour for White economic development.[121] The rural areas with no potential for agricultural and other economic development were reserved for Blacks. The central government's subsidies to the mission hospitals and their subsequent nationalization were in preparation for the consolidation of the homelands. After they fell in the hands of homeland leaders, the mission hospitals deteriorated. We shall discuss this matter at length in the next chapter.

Because of these measures, the Blacks living in the urban areas lost access to health care services in the cities. Keeping in mind the previous discussion on TB, let us examine how health care was politicized at the time. There were cases where patients living in one area had to receive treatment in a remote homeland area because of their

[119] Ibid. p.19.
[120] Influx Control.
[121] Pass Laws.

ethnic origin. The logic, as Packard suggests, was that the patients' health budget was in their homelands:

> Even where there was space available for black TB cases, it was often difficult for Blacks to receive treatment. The Public Health Act placed responsibility for treatment on the shoulders of the local authority within which the patient resided, with the government reimbursing the authority for half the resulting expenses. The system led to frequent arguments between local authorities concerning who was responsible for treatment since the authorities in the area in which a patient was diagnosed could, and frequently did, claim that the patient's real home was elsewhere.[122]

Such cross homeland border health cases were reported to the Native Affairs Department which in turn repatriated patients to their home areas.[123] The reference to home areas or homelands did not necessarily mean that the patient had lived in that designated area before or that he or she knew people in the area they are being repatriated to. One can see that what the system boiled down to reserving quality healthcare was reserved for Whites. As has been mentioned, the Black people who lived in industrialized urban areas occupied small, crowded houses or single-sex hostels as temporary sojourners to keep those areas economically active.

It is evident that the policy was not thought through. It kept back-firing against those who had designed it. Clever employers would invest in the health of their workers so that they could remain productive and improve or maintain productivity levels. This productivity was translatable into profit. One may assume that the apartheid government acted out of desperation to subjugating Black people to such an extent without realizing the basic rules of economics which dictate that healthy bodies are more productive than unhealthy ones.

It goes without saying that, where health facilities such as mission hospitals and newly-built clinics were available, they were overburdened with health seekers. In order for the government to realize its dream of separate development, the former

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[122] R. M. Packard. "Holding back the tide: TB Control Efforts in South Africa", in H. M. Coovadia and S. R. Benatar (eds.), *A Century of Tuberculosis: South African Perspectives*. Oxford University Press: Cape Town, 1991, p.46.
[123] Ibid.

mission hospitals and newly-built government clinics in the homelands were subsidized in order to keep the Blacks in the rural areas.

Ter Haar, writing in 1999, lamented the transition the South African society had been going through. With regard to political changes in relation to the nationalization of mission hospitals he wrote that:

> In 1976 when the Transkei became pseudo-independent, all mission hospitals were nationalized by the Department of Health of the RSA and in turn handed over to the Transkei Health Department. The same procedure was followed a few years later when the other TBVC countries (Transkei, Bophuthatswana, Venda and Ciskei) accepted their independent status.[124]

In its desire to implement the separate development policy, the South African government subsidised the creation of government departments in the newly-formed tribal states. The mission hospitals were nationalized in order for the government to hand them over to the homelands.

With nationalization as a substitute for medical missions, and decentralization as a way of consolidating the homelands system and separate development, Black people suffered increased health-care disparities compared to Whites. The government badly handled the health care resources necessary to people living in crammed rural areas. After these resources were handed over to the homelands, the people who needed them most found it hard to access them. The homeland authorities did not provide quality health care for the people who had previously depended on mission hospitals. We shall see in the next chapter how people responded to the deterioration of health care in homelands.

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[124] Gerrit Ter Haar. *In the Shadow of Tradition: Contradicting health and healing concepts in Transkei*. (privately published) 1999, p.60.

3.8. Ecclesiastical Causes of the Nationalization of Mission Hospitals

The purpose of this subsection is to examine how the mission Churches handled the changes that swept through the southern African sub-continent. It is clear that racial discrimination played a major role in the changes that happened in South Africa. At the beginning of the twentieth century the Berlin Mission Society reacted negatively to the African quest for independence which was threatening the stability of many mission societies in South Africa. The cautiousness of the BMS was understandable as it had earlier suffered secession by Johannes Dinkwanyane of the Botshabelo mission station in the Transvaal, who left the BMS station and formed an independent church in 1873.[125] When the Union of South Africa was formed in 1910 the number of the Ethiopian-type independent Churches grew and the BMS became vulnerable. Scriba and Lislerud attested to this when they wrote, "Responding to Blacks' aspirations for more autonomy, the Berlin mission, in 1911, constituted five Black synods: Northern Transvaal, Southern Transvaal, Zulu-Xhosa-Swazi, Orange, and Cape. Factors behind this decision were mainly the Ethiopian movement and financial hardship experienced by the BMS during and after the Second Anglo-Boer war."[126] The changes in the ecclesiastical structures continued through the 1960s with Black people seeking both ecclesiastical and political independence from White control. The post-World War Two disillusionment with the National Party's ascension to power and the intensification of racial segregation led to a further increase in the number of independent churches (AICs) and accelerated, in the Lutheran churches, the drive towards autonomy.

The 1960s saw a dramatic change of the South African ecclesiastical landscape. Until then, the church, especially in South Africa, had been far from homogeneous. Describing the ecclesiastical landscape before it underwent the changes of the 1960s, John W. de Gruchy wrote that three alternatives were open to Black Christians by the turn of the twentieth century: either they belonged to the all Black mission church

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[125] I. Hexham and K. Poewe, "The Spread of Christianity among Whites and Blacks in Transorangia," in Richard Elphick and Rodney Davenport (Eds.), *Christianity in South Africa: A Political, Social and Cultural History*. David Philip: Cape Town, 1997, p.131.

[126] Georg Scriba with Gunner Lislerud, "Lutheran Missions and the Churches in South Africa," in Richard Elphick and Rodney Davenport (Eds.*), Christianity in South Africa: A Political, Social and Cultural History*. David Philip: Cape Town, 1997, p.180.

under the control of the Whites, or they belonged to the multiracial denominations of British origin under White domination, or they founded their own churches.[127]

The mission churches mentioned by de Gruchy were called by that name because they had been established by mission societies. By 1960, they were still under the leadership of boards and councils from Europe and North America. They had a missionary leadership in the managerial and in the theological sphere. Among the Lutheran missions in southern Africa, an indigenous leadership began to emerge in the 1960s without experiencing opposition as it had before.[128] The church leaders in the 1960s took a position opposite to that of church authorities at the end of the nineteenth century and at the beginning of the twentieth century. When Johannes Nxumalo of the Pella Mission in Wartburg near Pietermaritzburg refused to take orders from the MELFC leadership, he was relieved of his duties and formed an independent church.[129] Similarly, when Petrus Lamula disagreed with the Norwegian Mission Society leadership he was forced to secede and formed an independent church, the United National Church-Lutheran, which exists to this day.[130] Subsequent to the formation of the Co-operating Lutheran Missions in Natal established in 1910, the regional churches emerged in 1960 from the BMS Black synods of 1911 (Northern Transvaal, Southern Transvaal, Zulu-Xhosa-Swazi, Orange, and Cape) and the 1950s synods viz. the Norwegian Zulu Synod, the Swedish Zulu Synod, the Mankankanana (Norwegian) Synod, the Hermannsburg Zulu Synod and the Hermannsburg Tswana Synod.[131]The former Zulu-Xhosa-Swazi Synod transformed itself into the Evangelical Lutheran Church in Southern Africa, South-Eastern Region (ELCS-SER).

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[127] John De Gruchy, *The Church Struggle in South Africa*. David Philip: Cape Town, 2004, p.40.
[128] On Black leaders in the mid twentieth century see John De Gruchy,"Grappling with a Colonial Heritage: The English-speaking Churches under Imperialism and Apartheid," in *Christianity in South Africa* (eds.) R. Elphick and R. Davenport, 1997. p.163. "The first Coloured chairman of the Congregational Church, C.W. Hendrickse, was elected in 1945; not until 1960 did Anglicans appoint their first Black bishop, Alpheus Zulu, who became suffragan bishop of Zululand; the first Black president of the Methodist Church, the Rev. Seth Mokitimi, was only elected in 1964."
[129] Aaron Ntuli, "Umlando ngebandla lasePella" in E.A.W. Weber (editor) *Fundisani ukugcina konke okuyalwa nguKrsitu: okwaseNhlanhleni 2.* Lutheran Heritage Foundation: Welbedacht, 2007, p.79.
[130] N.J. Mcunu's letter to the editor titled in Zulu, "Ukupuma kwabafundisis babantu, ebandleni lase Lutela Mission" in *Isitunywa*, No.5 (157) of 16 May 1927, pp.26-27.
[131] Georg Scriba and Gunner Lislerud, "Lutheran Missions and Churches in South Africa," in Richard Elphick and Rodney Davenport (Eds.*), Christianity in South Africa*: *A Political, Social and Cultural History*. David Philip: Cape Town, 1997, p.180.

In opposition to the reigning spirit of autonomy at that time, a Swedish national called Helge Fosseus was elected first bishop of the region.[132] Only in 1972 was a Zulu by the name of P. B. Mhlungu elected bishop of this region. The Tswana Region (formerly HMS), under which resided the present North-West Province, parts of the present Gauteng Province and Botswana, was led by Bishop Rapoo. In the Ventersdorp Synod of 1967 the MELFC mission field constituted itself into an autonomous church body called the Lutheran Church in Southern Africa (LCSA)[133] under Bishop Georg Schulz. Schulz was at the same time serving MELFC as its superintendent.

It was during this leadership in the Lutheran Churches that the mission hospitals were nationalized. Mission hospitals were removed from the control of the mission societies and churches at the time when Black people were taking control of the churches. The question is whether this was by coincidence or by design. It was indeed by design, with the government seeking to take over health provision and handing it over to Bantustan leaders. The Bantustan leaders depended on the apartheid government for their leadership and had no other option than to support apartheid. The churches had no capacity to thwart the government from intensifying apartheid in all spheres of life. There is no sign that Lutherans openly challenged the government in the area of mission hospital nationalization. On the contrary they felt appreciated the government's subsidies. They thought that resisting the take-over would lead to the closure of their hospitals. We have already seen that the Lutheran mission societies have no history of opposing the discriminatory laws of the government of South Africa. We recognize the fact that the government was determined to implement apartheid policies, so that no opposition from any quarter would have caused it to change. The ruthlessness with which communities were removed from their land, and the manner in which mission schools were taken over by the government, was enough evidence to intimidate anyone who wanted to resist. Those who resisted the implementation of apartheid in healthcare, like the Charles Johnson Memorial Hospital in Nquthu, were not spared the harassment of the police.

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[132] Märta Adolfsson and Anna Berntsson, *Ceza A Roundabout Way to Goal.* Ljungbergs Boktr: Klippan, 1975, p.225.
[133] LCSA Almanac of 2006, p.2.

With regard to leadership roles, it is not surprising that the missionaries established regional and national churches and 'pretended' to hand over leadership to Black people in the 1960s. It is likely that the momentum of the anti-colonial movements and the attainment of independence by African countries from their colonial masters played a significant role in the changes that took place in the churches of southern Africa.

The World Council of Churches' condemnation of the Sharpeville Massacre of 21 March 1960 may have prompted the Lutheran missionaries to change the complexion of the South African churches' leadership. The mission agents were not committed to the relinquishing of power because, even after the establishment of national and regional churches in the 1960s, they took up leadership positions as bishops.[134]

As has been seen above, especially in the case of the MELFC, the missionaries in the LCSA Church Council were in the majority when it came to decision-making. Numerical power notwithstanding, the missionaries could still influence the direction of the church through the financial resources they brought to the regional and national churches. That was also true in the case of the BMS. The BMS threatened to withdraw its financial contribution towards the mission hospital, claiming that as the regional church had now been established, it was this church's duty to support 'its' hospital.

The discontinuation of financial and other support to the mission field envisaged by the BMS and other missionary societies, coincided with what the African ecumenical movement was advocating in the 1970s. The All Africa Conference of Churches (AACC), at its Third Assembly in Lusaka, Zambia supported a moratorium on missionary funds and personnel.[135]

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[134] Georg Schulz of MELFC held the Episcopal position in the LCSA from 1967 to 1993. Helge Fosseus became bishop of ELCSA-SER from 1960-1972 before P.B. Mhlungu took over. See Georg Scriba and Gunner Lislerud, "Lutheran Missions and Churches in South Africa," in Richard Elphick and Rodney Davenport (Eds.*), Christianity in South Africa*: *A Political, Social and Cultural History*. David Philip: Cape Town, 1997, p.183.

[135] J. Mugambi, "Vision of the African Church in Mission" in *Journal of Theology of Southern Africa*. Vol.24. No.2. August 1996, pp.233-248. Bernard Spong discusses this moratorium especially as it involved missionary personnel in his autobiography, *Sticking Around.* Cluster Publications: Pietermaritzburg, 2006, pp.144-145.

The ecclesiastical context of the nationalization of the mission hospitals shows that the Black church leaders did not have a homogenous understanding of how the Church was to be run. As they were new in leadership, they had not yet thought through the path their church should follow. Although many supported the struggle against apartheid, what is known as liberation theology was not yet popular. The leaders of the newly-established churches sent mixed messages about their preparedness to take control of their churches. While some wanted total independence from their former mission societies, others wanted continued financial and leadership support.

In 1967, the MELFC established the LCSA and in 1975 the ELCSA regional churches formed the five ELCSA dioceses.[136] The objective of being self-supporting, self-propagating did not come to fruition in the Lutheran churches. Scriba and Lislerud described the situation as follows:

> Some blacks feared that the missions would desert them, leaving them to their own spiritual, financial, and administrative resources. Some older Africans, who identified the church with the missionary, doubted that the indigenous clergy were ready to assume responsibility. But to other blacks the time seemed ripe for church independence, which would coincide both with the independence of African states from colonialism and with the South African government's policy of separate development.[137]

While the national Churches had a substantial number of White missionaries in leadership positions, the mission societies remained in control of the mission hospitals until they were nationalized. The government's separate development policy did not allow a situation whereby national Churches left mission hospitals in the charge of medical missionaries. The separate development policy was designed to have Blacks to "be in charge" of their destiny in the homelands. Although referring to Charles Johnson Memorial Hospital in Nquthu, which was taken over from the control of the mission in June 1976, Jon Larsen's point covers almost all hospitals with regard to

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[136] Much later Botswana was granted the diocese status with its own bishop after being run as a circuit under the Western Diocese bishop in South Africa.

[137] Georg Scriba with Gunner Lislerud, "Lutheran Missions and Churches in South Africa," in Richard Elphick and Rodney Davenport (eds*.), Christianity in South Africa: A Political, Social and Cultural History*. David Philip: Cape Town, 1997, p.183.

apartheid laws enforcing separate development through nationalization, "the Department of Health was acting as the agent of the Department of Bantu Affairs, who would hand the hospital over to the KwaZulu Government when the Health Department of that administration was ready to take over."[138]

4. The Take-over of Mission Hospitals

Shortly before the take-over process in 1973, the medical missionaries expressed a number of fears. Prominent among those fears was how to work within a mission hospital now under the Homeland Health Authority. The concern of the mission doctors and nurses was what their status would be and how they were going to remain autonomous under the new political dispensation.

In this context, Michael Gelfand quotes a statement from Anthony Barker,[139] a medical missionary based in the Charles Memorial Hospital in Nquthu who wrote and lectured widely on mission and health issues. The quotation is taken from a lecture given during the Consultative Committee of the South African Medical Missionaries conference of 29-31 January 1974, to medical missionaries who were about to lose their autonomy due to the nationalization of mission hospitals. Barker knew that the nationalization was inevitable:

> It may be that takeover is inevitable, written in the books and unavoidable. If this happens, then we shall have to develop new ways of expressing our Christian concern with the system: all would not necessarily be lost, but to involve ourselves in mankind—ordinary mankind – would become very much more difficult. I counsel that we bargain well with our unquestioned assets.[140]

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[138] Jon Larsen, *KwaBaka: A Story of Compassionate Centre in a Rural Zulu Community*. Cluster Publications: Pietermaritzburg, 2010, p.218.

[139] Dr. Anthony Barker was in constant contact with other medical missionaries especially in Natal and KwaZulu. There were meetings of medical missionaries stationed in close proximity. For instance Barker attended the Umpumulo Consultation in 1967 where he delivered a paper. Barker, like other medical missionaries, was a member of the Natal and Zululand Association of Mission Doctors in the 1960s.

[140] Michael Gelfand, *Christian Doctor and Nurse*. Mariannhill Mission Press: Mariannhill, 1984, p.308.

While the medical missionaries were largely autonomous in the mission societies, their authority to hire and fire among others was going to be curtailed. They were no longer going to answer to an authority far away in Europe and America, but to the puppet Bantustan governments in southern Africa. They were faced with the prospect of becoming civil servants with salaries higher than those of Black people and the possibility of being removed from their hospitals by the Health Department. Anthony Barker's counsel to members of his profession was for them to use their knowledge and skills to bargain well. In a manner reminiscent of the Bantu Education Act and its effect on mission schools, the medical missionaries realized that nationalization was meant to impose brutal apartheid policies on mission hospitals and eliminate those who resisted. Barker does not clearly state how medical missionaries were to express their concern with the "system." One may assume that in the face of the onslaught against mission hospitals, he was urging medical missionaries to choose the side of the poor, or, as he wrote, "ordinary mankind", in the face of the onslaught against mission hospitals. Barker had already chosen and walked the path of standing in opposition to the apartheid laws. In the face of danger to his life he continued to seek ways to resist and undermine the apartheid laws, as his former colleague Jon Larsen has mentioned repeatedly in his book.

Eventually the mission hospitals were nationalized. Untunjambili and Itshelejuba were nationalized in 1978 [141] and Emmaus in 1974.[142] It would be incorrect to think of the nationalization of the mission hospitals as a single event. There was no special function like the changing of the royal guard at the Birmingham Palace in London, or the raising of the new flag at the coming of a new government. The event was gradual. The mission hospitals were taken by the State and handed over to the Provincial Administrations, and finally, most of them to the Bantustan health departments, the last one in 1978.

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[141] Matron Helen Msimanga interviewed by Radikobo Ntsimane in her office at Untunjambili on 27 July 2000. Friedrich Dierks interviewed by Radikobo Ntsimane at Bleckmar, Germany on 29 August 2002.

[142] Evelyn Sommerfeld interviewed by Radikobo Ntsimane at Walsrode, Germany on 05 August 2002.

5. Chapter Summary

After the Union of South Africa was formed in 1910 and established its three tiers of health provision, it gradually increased its support to the mission hospitals. Its successor, the Republic of South Africa, increased the support to the mission hospitals as they were faced with the challenge of combating endemic diseases including tuberculosis. Clifford Allwood calls the era of the increased government support the era of 'a golden age of medical missions.'[143] Of course what he did not realize was that the increased subsidies to mission hospitals was the government's way to prepare for the introduction of a segregated health system that disfavoured Black people. In the middle and the late 1970s especially, the increased government subsidy facilitated the government's nationalization process. The influence that the medical missionaries had over the mission hospitals and therefore over the people who used them, was diminished as the hospital personnel fell under the control of the Bantustans and self-governing authorities. As the authority shifted from the hands of the mission authorities, so did the power to decide on the allocation of resources. The earlier discussion on tuberculosis has made clear that the Bantustan and self-governing health authorities were the ones who decided who was going to have accessed to health care resources. The Republic of Botswana government, through its clear intention of addressing the scarce skills in the country, made it a policy from the time of its independence in 1966 to employ locals in health and other government sectors. Together with the mission societies, the government took added responsibility to enhance the quality of healthcare to its people.

[143] Clifford Allwood, "Mission as Healing the sick" in *Missionalia* Volume 17, No.2, August 1989, pp.115-125.

CHAPTER SEVEN

THE CHURCHES' RESPONSES TO THE NATIONALIZATION OF MISSION HOSPITALS: MOTIVATIONS AND MODELS

1. Introduction

This chapter deals with the responses of the churches to the nationalization of mission hospitals. The nationalization of the mission hospitals by the government brought about changes in the lives of many people that were connected to them. We will consider how the various groups of affected people reacted when the nationalization was finally implemented in the mid 1970s. In relation to this matter it is important to bear in mind that the nationalization of mission hospitals was a process that began with the granting of subsidies. It should be borne in mind that the South African version of nationalization was not geared at taking mission hospitals in order to subsidize them and improve them to provide a better service to the health seekers. On the contrary, the type of South African nationalization was instead a way to take control of all mission health services and use them to divide the Black people into Bantustans. The process culminated with the introduction of staff who contrary to previous practice, were employed by the apartheid government as administrators in mission hospitals. The personnel were to ensure that the apartheid policies of nationalization and Africanization were implemented. The mission societies and Churches who originally had been in charge of the hospitals were excluded from important decisions on hospital matters. Mission hospitals ended up being handed over to Bantustans which were given responsibility to provide health services to the inhabitants. Due to the corrupt nature of Bantustans instead of improved health services, the health cares system deteriorated. The Black people who had during the previous four decades adopted Western biomedicine as a valuable source of health care, experienced difficulties accessing medical services after new Bantustan managements took over the mission hospitals in the late 1970s. This was the era of

high apartheid, where brutal force was used to eliminate all opposition to the implementation of apartheid policies.

2. Responses to Nationalization

As already mentioned, nationalization of mission hospitals was a scheme of the government to control and oppress Black people by destroying the health care provision created by the medical missions and churches. Nationalization of mission hospitals was in fact pseudo-nationalization with supposedly good intentions but with bad results. Similarly to mission schools, the government was introducing apartheid in hospitals. We should note that the Lutheran missionaries had already been practicing apartheid by running separate churches for different races, by training clergy in separate institutions, and by running segregated schools, before the government began to nationalize.

The Lutheran missionaries delayed the training of indigenous clergy and also made little if any preparation for the training of indigenous people as physicians. The HMS missionaries and the MELFC missionaries who split from them, did not follow the stipulations of the HMS' founder Louise Harms that the missionaries and their families were to live among the people they had come to convert and even die among them.[1] The racial lines were not hidden in the relationship between the Lutheran missionaries and the indigenous people that they came to serve. Apartheid in society was apparent in the Lutheran mission churches and in the hospitals. Similarly to other mission societies, the Lutherans did not readily acknowledge the spiritual maturity of the Black converts.

Writing about an earlier period, Scott Houser has argued that the English and American missionaries looked upon the Zulus among whom they worked as children. Where they treated Zulus as adults, they seldom treated them as equals.[2] I have earlier discussed the issue of objectification of the indigenous people by the colonialists and the missionaries. While the objectification of the indigenous people had offered

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[1] Heinrich Voges, *Vision: Global Congregation*. 2000, p.107.
[2] Hartwig Harms, *Concerned for the Unreached: Life and Work of Louis Harms, Founder of the Hermannsburg Mission*. Ev.-luth Missionswerk in Niedersachsen: Hermannsburg, 1999, p.26.

missionaries easy "handle" on work in southern Africa, after 1960s the approach was no longer easy useful because major changes in the African political landscape had taken place. Independence swept through the African continent in the 1960s, freeing a series of states from colonialism and deconstructing the myth the African as the stupid or savage "other".[3]After the independence and the establishment of national churches, the indigenous people no longer fitted the categories designed by missionaries. They were no more the perpetual children the missionaries made them out to be. They were in charge of both their newly independent countries and their newly constituted churches.[4]

It was a rude awakening to the fact that White people were no longer in charge when the authority and the sincerity of two interviewees, Solveig Otte and Gerrit Ter Haar, were challenged by their former "underlings." For various reasons some missionaries, including the medical missionaries, failed to reach their goals of converting the Black people or curing their ills. The expressed goal was to save souls and alleviate suffering. However, in pursuance of that goal, Lutheran and other medical missionaries came to the realisation that their philanthropic efforts were either misdirected or misunderstood.

Solveig Otte[5] was devastated when she discovered that her efforts as a medical missionary in KwaHlabisa Lutheran Mission Hospital and those of her missionary parents were regarded with ingratitude. When people doing good deeds find themselves in such a situation, Robert Spaemann, the German philosopher, advises them to acknowledge their mistakes:

> This feeling can appear in many different guises. The simplest case is that in which we choose to do something as a means to an end, but then it becomes apparent that it was an ill-suited means. We would never

[3] Scott Houser, "American and English Missionary Perceptions of the Zulus in an Era of Levelling the Mountains, Bridging the Oceans, Civilizing and Christianizing the "Heathen". Unpublished PhD. Thesis, Baylor University, Texas, USA, 2004. Chapter 5.
[4] It has been made clear in this thesis with regard to churches, although the same goes for countries, that behind the scenes the Europeans continued to influence the direction of the churches and the countries.
[5] Solveig Otte interviewed by Radikobo Ntsimane in her home at Mayors Walk on 8 May 2007.

> have willed it, if we had known that it wouldn't lead us to our end. We made a mistake—in the normal sense of the word.[6]

When the medical missionaries, or at least some of them, realized that the nationalization and the handing over of the institutions to which they had dedicated their lives did not bring the expected results, they began to oppose the new administration. To use Spaemann's words, the Lutheran medical missionaries had chosen to accept the nationalization "as a means to an end". However, it became apparent that it was "an ill-suited means" when the apartheid government's new administration took control from them and handed it to the indigenous people. One might say that the missionaries became disillusioned when they realized that the government had goals different from theirs. The medical missionaries were of the understanding that the government aimed to raise the medical work they had initiated to a higher level. But instead of improving the healthcare for Black people the government destroyed it. They included the mission hospitals in the grand apartheid scheme and handed them to Blacks to run, with reduced budgets.

Hans Florin, who served as a Lutheran missionary in East Africa, explained why the Lutheran missionaries did not to oppose the decision of the apartheid government to take over mission hospitals. In his book *Lutherans in South Africa*, Florin proposed an ecclesiological theory which Lutherans could have applied to oppose the takeover of the mission hospitals:

> Generally, three forms of resistance are recognized; they are successive steps of increasing intensity beginning with spiritual opposition through prayer, preaching and a confessing Christian witness, followed by a legal opposition and leading to forms of illegal resistance. Wherever such resistance of Christians should take the form of political resistance—legal or illegal—the church as such should not take part, for, otherwise, it would jeopardize one of its essential marks: to be the suffering community in the imitation of Christ. Furthermore, by becoming involved in political resistance the church would become a political party and would thereby lose the marks of its divine character.[7]

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[6] Robert Spaemann, *Happiness and Benevolence*. University of Notre Dame Press: London, 2000, pp.17-18.
[7] Hans Florin, *Lutherans in South Africa*. Lutheran Publishing House: Durban, 1967, p.77.

Simply put, Florin meant that the Lutherans did not want to be involved in politics and therefore refused to see that accepting the so-called nationalization was in fact, an act of collaboration with the apartheid regime. He confined the opposition to the take-over of mission hospitals to praying and to legal action. There is no evidence that the Lutheran churches prayed against the takeover of their mission hospitals. Likewise they did not take any legal action. What is clear from the oral interviews and the written sources is that the Lutherans believed that the government's nationalization programme would improve the delivery of health benefits to the Black in the homelands and self-governing states in the 1970s. In fact Lutherans had, according to what the leader of the LMF reported, already begun to reap the "benefits" by the filling of all vacant posts with doctors from the Netherlands with no difficulty in getting permits for them.[8] This had allowed the mission hospitals to grow beyond their financial capabilities and, thus, allowing the takeover was seen as a solution. They already had the government subsidies running the hospitals. They had already handed over the mission Churches to Black leadership. Maybe they thought it was time to "call it a day" in the mission field.

According to Florin each Christian was called upon to oppose injustice wherever encountered.[9] There were individual missionaries and ministers of different denominations who openly opposed the government for its segregation policies reducing services for Blacks by putting them under the control of homelands and self-governing states. Yet, no Lutheran missionary took a stand against segregation policies in the context of health matters and the homeland system. The government did not tolerate opposition against its policies of segregation. We shall see in the next sub-section how it dealt with missionaries and Church leaders who opposed it.

3. Tensions with the New Hospital Management

In the 1970s a good number of missionaries and pastors from various churches were deemed to be *agents provocateurs* by the South African government and later by

[8] Michael Gelfand, *Christian Doctor and Nurse: The History of Medical Missions in South Africa from 1799-1976.* Mariannhill Mission Press: Mariannhill, 1984, p. 305.
[9] Hans Florin, *Lutherans in South Africa*. Lutheran Publishing House: Durban, 1967, p.77.

Bantustan authorities, and were consequently harassed by the police. Acts of resistance by members of other denominations are an indication of what Lutherans could have done and what their actions might have led to. For example, in Nquthu under the Anglican Church, the mission doctors took the conscious decision to treat both their Black colleagues and the local community with total respect, irrespective of their creed or social standing. The Special Branch of the South African police not only kept a close surveillance of the hospital but also fabricated stories that would tarnish the image of the missionaries and thereby intervene in the work of the hospital. Jon Larson mentioned a number of incidents where the secret police tried to disturb the community life of the Anglican mission hospital in Nquthu in the 1960s and 1970s. The most targeted member of staff was the superintendent of the hospital, Anthony Barker.[10]

The Bantustan authorities' practice of targeting dissenting clergy for deportations, banning and suppression was borrowed from the South African apartheid regime. John W. de Gruchy writes about this practice in his book, *The Church Struggle in South Africa*:

> The 1970s and '80s saw regular government action against church people—pastors, missionaries, leaders, and those involved in Christian agencies and projects. The reason was obvious. If the churches were against the government policy, then it followed that church workers would become involved in programmes that went against what the government regarded as the well-being of the state. Hence there was a spate of deportations of missionaries, and banning, detaining, and imprisoning of South Africans involved in this way.[11]

Graham Leach in his book *The Afrikaners: Their Last Trek,* mentioned by name a number of ministers and missionaries who suffered injustices under the apartheid regime. He mentioned the Anglican's Father Trevor Huddleston of Sophiatown,[12] Bishop Ambrose Reeves of Johannesburg who was deported, and Dean Aubie Gonville ffrench-Beytagh who was put under police surveillance, charged under a

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[10] Jon Larsen. *KwaBaka: A search for Excellence in Caring: The Story of a Mission Hospital in Zululand* 1930-2006. Cluster Publications: Pietermaritzburg, 2010, p.174.
[11] John de Gruchy with Steve de Gruchy. *The Church Struggle in South Africa*. (25th Anniversary Edition) SCM Press: London, 2004, pp.89-90.
[12] The Dictionary of African Christian Biographies mentioned that Trevor Huddleston was recalled to London in 1956 when he was too involved with the ANC. <http://www.dacb.org./>

false pretence and deported.[13] These and many other clerics in South Africa were treated badly because they associated with Black people and their struggle, and as a result they ended up being banned, deported or imprisoned. Among those served with banning orders in the Roman Catholic Church at the same period were missionaries and other activists in the development work like Fr. Cosmas Desmond and Rodney Nelson who protested against the forced removals of people to Limehill in KwaZulu-Natal.[14] There were others whose work permits or visas were not renewed, thereby making it legally impossible for them to return to South Africa.

We do not have examples of Lutheran missionaries who openly challenged the Bantustans or the central government with regard to the expropriation of mission hospitals to the extent that they were threatened with deportation or suffered notable harassments. Pakendorf observed that the Lutheran medical missionaries perceived themselves as guests in South Africa and chose political neutrality out of naivety. He wrote:

> Yet while their Lutheran heritage and their perceived guest status made political neutrality an obvious route for them, in times of conflict or when decisions were required, they consistently chose to side with the white powers that be, often against the interests and aspirations of their black congregants. Their insistence on a strict other-worldliness caused them to be politically naïve and mostly blind to the consequences of their actions.[15]

Nationalization and Africanization brought to the surface opposition and resentment from Black personnel towards missionaries who were suspected of having promoted apartheid in the mission hospitals. Solveig Otte, who worked in KwaHlabisa a former Lutheran mission hospital, mentioned in an interview that some nurses and other hospital workers became very antagonistic towards medical missionaries when they found out that Africanization and nationalization favoured Blacks in matters of power relations. If the missionaries were so dedicated to alleviating the suffering of the

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[13] Graham Leach, *The Afrikaners: Their Last Great Trek*. Southern Book Publishers: Johannesburg, 1989,p.264.
[14] Stuart Bate, 'The Church under Apartheid" in Joy Brain and Philippe Denis (eds.) *The Catholic Church in Contemporary Southern Africa*. Cluster Publications: Pietermaritzburg, 1999, p.175.
[15] Gunther Pakendorf, "For there is no Power but of God," in *Missionalia*. Volume 25, Number 3. November 1997, pp.255-273.

Black people, why did these people not recognize their services as such? Clearly, at that stage most Black people had not reached the point of seeing the White nurses and doctors as being on their side against racial discrimination.

There were attempts before the so-called nationalization and Africanization, where missionaries encouraged Blacks to take leadership for which they qualified. We have already seen how Evelyn Sommerfeld of Emmaus struggled to convince a Black nurse to take the position of matron in the 1970s.[16] The nurse refused because she feared that as a matron she would be seen by her Black colleagues as an informer. A 1975 letter from Anthony Barker at the Anglican mission hospital at Nquthu sheds light on the nature of the relationships between the White medical missionaries and their indigenous colleagues. Barker wrote:

> For 14 years now we have been a training school for the Nursing Council, and in that time seen several hundred young women pass through the hospital, picking up information, a little learning, perhaps, and developing their understanding to a really wonderful degree. A few years ago, no nurse would willingly accept authority over her sisters: she might be afraid to wield that authority, or confuse the wielding of it with collaboration with the whites.[17]

When, after the "nationalization" of mission hospitals in the 1970s the Blacks working in the mission hospitals realized that their position as employees was not threatened by the White missionaries, they openly showed signs of defiance to the few medical missionaries who remained in the former mission hospitals like Solveig Otte in KwaHlabisa.[18] The situation was similar in other former mission hospitals like the Dutch Reformed's Rietvlei hospital in the Transkei. Ter Haar from Rietvlei explained that whites no longer had the power to discipline and were therefore deemed harmless. Lack of discipline in the workforce however led to chaos and deterioration of health service delivery. "They couldn't apply discipline. [The Black hospital staff] would say, 'No, you can't! Only the minister can.' So the people knew we doctors

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[16] Evelyn Sommerfeld interviewed by Radikobo Ntsimane at Walsrode, Germany on 5 August 2002.
[17] Jon Larsen, *KwaBaka: A Story of Compassionate Care in a Rural Zulu Community, 1930-2006*. Cluster Publications: Pietermaritzburg, 2009, p.131.
[18] Solveig Otte interviewed by Radikobo Ntsimane in her home at Mayors Walk on 8 May 2007.

had no longer any power to dismiss (them). 'You can do what you like!' They defied openly."[19]

Ter Haar's statement shows that one loses control when one ceases to have resources to distribute to the people who need them. The White medical missionaries were no longer in charge of scarce resources and as a result became useless to those who saw them as dispensers or providers of those scares resources. The mission societies are not totally blameless as they did not manage change and transition of their hospitals from mission to state hospitals. In the next subsection we shall look at how the newly-established mission churches responded to the "nationalization" of the hospitals.

4. The Response of the Newly-constituted Mission Churches to Nationalization

In this subsection I intend to describe responses of the Lutheran churches to the nationalization of mission hospitals. The Lutheran churches mentioned here became independent from the mission societies in the 1960s and elected their own bishops**.** Leaders who had no experience of the running of complex institutions of foreign origin were suddenly expected to manage mission hospitals from the leadership of which they had been excluded for decades. When, as leaders of dioceses and circuits, they concentrated on consolidating their constituencies,[20] the mission hospitals had remained under the management of medical missionaries. It was around the same time that medical missionaries organized themselves into regional and district associations in order to discuss matters of common interest[21] or common threat, as the government was entering at a fast pace into the affairs of mission hospitals. In 1964, the Transkei and Ciskei Association of Mission Hospitals (TCAMH) was formed with twenty eight hospitals.[22] Later the Natal Association of Medical Missions was founded. In March 1970, the TCAMH sent a delegation to meet the Secretary of Health in Pretoria to address the following issues in the government's new health policy:

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[19] Gerrit Ter Haar interviewed by Radikobo Ntsimane in Pietermaritzburg on 19 November 2007.
[20] Vivian Msomi interviewed by Radikobo Ntsimane in his office in Pietermaritzburg on 25 May 2005.
[21] Michael Gelfand, *Mission Doctor and Nurse.* Mariannhill Mission Press: Mariannhill, 1984, p.289.
[22] Michael Gelfand, *Mission Doctor and Nurse.* 1984, pp.289-290.

- that the government was going to unify all aspects of the health services and to control district hospitals,
- that the Health Department accepted control of individual mission hospitals would continue to be vested in the existing committees and management and their parent churches,
- that appointment and dismissal of staff would continue under the hospital committees,
- that Christian services and ministry to the sick will remain in the scope of hospital activities,
- that salaries would be according to Health Department scales for all except local rate employees,
- that non-pensionable R750 per annum would be available to white medical practitioners employed in the homelands.[23]

Although the delegation represented the TCAMH, the policy they set out to discuss dealt with all the mission hospitals in South Africa where the Department of Health was in authority. The regional mission hospital associations of the Transkei and Ciskei (TCAMH), of the Transvaal and of Natal came together in 1970 to form the Consultative Committee of South African Medical Missions (CCSAMM).[24] It is interesting to note that the Consultative Committee represented only the hospitals and not the churches or missions which could still approach the Health Department individually.[25] It is here argued therefore that the medical missionaries in charge of the mission hospitals were acting outside the scope of the church or mission authorities since they saw fit to unilaterally discuss matters concerning mission hospitals.

On 12 November 1970, during a meeting with the CCSAMM, the policy of the State Government was announced that in all the tribal lands the health services were to be Africanised, i.e., that the White sisters were to be replaced by Black ones where vacancies became available.[26] Soon each hospital in a major tribal area with financial support from the state was obliged to accept the state's Comprehensive Health Scheme and placed under a regional director.[27]

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[23] Michael Gelfand, *Mission Doctor and Nurse.* 1984, pp.290-291.
[24] Ibid. p.291.
[25] Ibid.
[26] Ibid.
[27] Ibid. pp.291-292.

One year later, on 16 November 1971, in a meeting with regional directors and the State Health Department, the CCSAMM was informed that the Health Department in Transkei would become the responsibility of the Bantu Government Department.[28] Less than six months later on 16 May 1972, it was announced that on 1 April 1973 Health Services in the Transkei was to be placed under the Transkeian Ministry of Health.

The church leaders only came into the picture when the government had already decided to take total control of mission hospitals. When the Deputy Minister of the Department of Bantu Administration and Development met the church leaders on 16 June 1972 in Pretoria, he announced that all mission hospitals would gradually, from year to year, become state hospitals with effect from 1974.[29]

When the homelands were about to become independent the government had already decided to hand over the mission hospitals to them as it reported to the CCSAMM on 24 November 1975.[30] The government was so determined to impose the nationalization of mission hospitals that a meeting envisaged for April 1976 with the CCSAMM did not even take place.[31] It seems the take-over was a forgone conclusion and further meetings were of no use.

The Lutheran mission health institutions were not the only ones to be nationalized. The Lutheran response to nationalization was not dissimilar to that of most denominations that saw their mission hospitals were nationalized. They adopted a defeatist attitude.[32] The challenge came from other quarters, like the concerned theologians and church leaders of the Christian Institute, who produced the SPRO-CAS 1 in opposition to apartheid in health matters.[33] The reason for that lack of response can be found in the Lutheran doctrine.

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[28] Ibid.
[29] Ibid.p.293.
[30] Ibid. p.294.
[31] Ibid.
[32] While the Lutheran Theological Institute library has a vast collection of SPRO-CAS publication the one on health is not on the shelves to give a direct quote.
[33] SPRO-CAS has done intensive and extensive studies on the inequalities of South African society under apartheid. Of the many published studies the one exposing the health inequalities in health services provision and by implication opposes such inequalities is on “Malnutrition” by J. V. Reid,

Let us briefly look at how the Lutherans from a doctrinal point of view, envisaged a situation such as the nationalization of mission hospitals. Lutherans are known to distance themselves from socio-political matters as they believe their calling is to deal with matters of the spirit while the temporal governments are ordained to deal with socio-political matters. An interpretation of the Lutheran doctrine of Two Kingdoms is that the church should not interfere with governance while the government is expected not to interfere in Church matters.[34] Quoting Hans Florin who was a German Lutheran author, former American Lutheran missionaries in South Africa, Wilfred and Eleanor Bockelman showed that Lutheran missionaries remained silent for long periods in the face of injustices levelled against Blacks:

> The overriding consideration among missionaries in the past was to avoid all interference in so-called political issues. The stage for this attitude was set primarily by the German missionaries who came for a lifetime service to this country; identified themselves for the most part with European settler population; launched through their families and off-spring, a German community and German churches; and sided—after ill treatment by the British elements of the population during two World Wars—with Afrikaner outlook preserving, however, their cultural identity as they understood it. As a result there has been little socio-political critical witness among Lutherans in the past.[35]

When the mission hospitals were nationalized, there were already established national Churches with their own constitutions and bishops. *De jure* the national churches were responsible for self-determination and they were not answerable to the mission societies that represented their roots. However, the mission societies were in charge of mission hospitals as some missionaries were elected bishops and deans, and the mission societies provided resources of a human, financial and administrative nature to the national Churches. But the demarcation lines were not clear. The ELCSA-SER

Some Implication of Inequality. SPRO-CAS publication No.4: Johannesburg, 1971. A list of all publications shows that no single publication on health was ever produced by Spro-cas. See Peter Randall, *A Taste of Power*. Ravan Press: Johannesburg. 1973, pp125-128.

[34] For further discussion on the topic see Radikobo Ntsimane's "The Lutheran Churches' Response to the Forced Removals in the Western Transvaal and Bophuthatswana (1968-1984)". Unpublished MTh Dissertation, University of Natal, Pietermaritzburg. 1999, pp.11-12.

[35] Wilfred and Eleanor Bockelman, An *Exercise in Compassion: The Lutheran Church in South Africa*. Augsburg Publishing House: Minnesota, 1972, p.18.

regional[36] Church was led by one of the missionaries who was elected to the position as a way of demonstrating the Church's a non-confrontational stance towards the apartheid government. Similarly, the MELFC missionary Georg Schulz was elected as bishop of the LCSA. Since two of the four hospitals under discussion fell within the geographical region of ELCSA-SER, we will consider them first.

The practice of holding on to the mission hospitals even after the indigenous people had taken over the leadership of the churches was not confined to South Africa and Botswana. The example of Zimbabwe in the 1960s showed that the Lutheran Swedish mission was not prepared to relinquish control and to hand over the mission hospitals to the national church leadership. They later relented and handed the hospitals to the new democratically-elected government. Hugo Söderström, a Swedish Lutheran missionary who worked in Zimbabwe in the 1960s, has written on this matter.[37] In accordance with the recommendations of the World Council of Churches for the formation of the Association of Church-Related Hospitals, during the 1960s and 1970s, most missionaries in Zimbabwe willingly handed over their hospitals to the new state. Those associations ensured that the nationalization of mission hospitals benefited wider society. Both the State and the Churches remained in charge of the provision of quality health care.

Instead of the handing over, to national church leaders, the medical missionaries formed the Lutheran Medical Foundation (LMF) to take control of the mission hospitals. The mission societies believed that the leadership of the newly-constituted national Churches would not be able to carry the responsibilities of the mission hospitals. Just as the Blacks were largely left out when boards and councils governing these mission hospitals were established, so were they left out in the discussions on how to respond to the nationalization through the LMF for the ELCSA and the Hospital Committee for the MELFC.

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[36] In the 1960s, the merger of the work of various Lutheran mission societies in Natal and Zululand led to the formation of the Evangelical Lutheran Church in Southern Africa – South Eastern Region. See Hans Florin's *Lutherans in South Africa*. Lutheran Publishing House: Durban, 1976, pp.101-104.
[37] Hugo Söderström , *God Gave Growth: The History of the Lutheran Church in Zimbabwe, 1903-1980*. Mambo Press: Gweru, 1984, p.148.

Melvin Hodges wrote about mission agencies' exit strategies from the mission churches they had established. Although written by an American who never worked in southern Africa, his book is still relevant to the southern African situation and can help us understand the complex mission era of the 1960s. He wrote:

> Having placed men in positions of authority, or having allowed the church to do so, the missionary should be careful not to snatch up reins of authority again and bypass the national leaders. Probably most missionaries have been guilty of this. As the Indian Standard says, "We complain of their lack of independence, and then outvote them whenever they show a spark of it." We teach that the church is to be self-governing, but when some important problem comes up, instead of presenting the matter for the decision of the national leaders, we simply tell them what to do. We disregard their position, set them one side, and do as we think best. Then they know that although we talk about the nationals taking responsibility and assuming leadership, yet in reality we do not permit.[38]

It is not therefore be entirely correct to state that national churches like ELCSA-SER in Natal and Zululand responded to the nationalization of hospitals. The hospitals were run by the LMF and the MELFC's Hospital Committee when they were nationalized. Therefore, instead of dwelling on the responses of the national Churches to the loss of the hospitals, we shall discuss how the mission societies responded to the nationalization of hospitals as their former hospitals were taken over. Let us look at each mission society of the four hospitals in question.

4.1. The Berlin Mission Society

While the responses of other mission and national churches to nationalization, of mission hospital will be referred to, we focus mainly on the Lutheran churches, especially those under review. Just like there was a motivation for establishing the mission societies and mission hospitals, there must have been a motivation for relinquishing the hospitals. The LMF's failure to resist, and indeed their support to the nationalization of the mission hospitals which were under their care, was tantamount to abandoning the communities which needed the hospitals most. I have attempted to

[38] Melvin Hodges, *The Indigenous Church*. Gospel Publishing House: Springfield, 1996, p.72.

show that the handing over of mission hospitals to the government by the Lutheran and other mission societies, who used to be considered as helpers in times of need,[39] was seen, as a betrayal. The unilateral action of the missionaries left the Blacks in a lurch.

Some of the mission societies, like the BMS, later admitted that their decision regarding the mission hospitals was not in the best interests of the Black people. The admission by the BMS in 2000 is important as it is a clearly documented confession from a Lutheran church mission society concerning its direct and indirect involvement in apartheid in South Africa. The confession shows how that involvement relates to the government's nationalization of mission hospitals in the 1970s.

Motivated by the churches' and religious bodies' submissions to the Truth and Reconciliation Commission's (TRC) in November 1997 in East London, the Berlin Mission Society, currently known the Berliner Missionswerk, took the initiative to make a written confession to God and to its partners regarding its role and the role of its missionaries during Apartheid. In an eleven-page document written in English and in German (twelve-page version) called *Statement on the History of the Berlin Mission in South Africa*, the Berliner Missionswerk confesses various mistakes made in South Africa. In relation to the Lutheran doctrine of the Two Kingdoms, the BMS admits its initial inactivity in the face of the apartheid government's racial discrimination policies against Black people. The BMS allowed itself to be entangled in the division of the Lutheran church into racial groupings:

> We preached the gospel of the unity of the Body of Christ as a spiritual certainty, but did not practice it as a community of white and black Christians in a unified church. Even though we have been sent as missionaries to black Christians, we also took over pastoral care of White congregations but did not work towards a unification of the two into a single church—we reconciled ourselves with the racial division even in the church. In spite of the revocation of the apartheid laws and

[39]Dean Mthethwa interviewed by Radikobo Ntsimane, at KwaMbonambi on 9 November 2002 saw the establishment of Untunjambili Mission Hospital as the appearance of light after a long period of darkness.

> many talks on unity, the scandal of having separate black and white Evangelical Lutheran Churches is still with us.[40]

Concerning its indirect support of apartheid, the BMS confesses: "We did not resist the whole of apartheid legislation forcefully enough, the racial separation, the discrimination and exploitation of Blacks, Coloureds and Indians, the forced removals and group areas. Even within the church we obeyed human laws and structures more than God's commandment."[41]

In reference to education and health care (under item V), the BMS acknowledges and laments its passivity when schools and hospitals which were established for the benefit of Blacks were nationalized:

> It was painful for the members of our churches to relinquish mission schools and hospitals to the state. These institutions had been the first to enable blacks to receive an education and thereby status within the white culture. The clinics and hospitals had provided them with their first chance to receive medical care. The surrender of these institutions demanded by the government mostly happened without friction or resistance. Although the missionaries lost many opportunities for work and influence because of this, they also were relieved of a heavy load. The financial situation made it impossible to maintain private schools or hospitals without state subsidies. Even though our decision was considered inevitable for financial reasons, the result was that our partner church lost all influence in educational and health matters and cannot live up to its responsibilities in these areas. Today we recognize and deplore: We did not prevent the apartheid regime's forced takeover of our schools and hospitals because of financial reasons and thereby lost an important sphere of influence in the community for our church.[42]

What the BMS has done through this six-point confession is commendable as it shows sensitivity to its mistakes albeit in hindsight. As the document indicates, this mission society was inspired to confess mistakes made during the apartheid era, by the Truth and Reconciliation Commission (TRC) where some church formations came forward

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[40] Berliner Missionswerk: Statement on the History of the Berlin Mission in South Africa. Section IV. 2000, pp. 6-7. It is a booklet published and distributed among the former mission fields of the BMS as a confession. Copies are kept by individual Lutheran pastors and in Lutheran Church libraries.
[41] Ibid. p.7.
[42] Berlin Missionswerk. 2000, pp. 9-10. Contrary to other parts of the text, the italics are used in the document to indicate what the Berlin Missionswerk recognized and deplored at the time of confession.

and admitted to their direct and indirect participation in the general apartheid scheme of racial discrimination.

4.2. The American Lutheran Mission and the Norwegian Mission Society

The Lutheran Medical Foundation (LMF) gave a general response to the nationalization of the mission hospitals on behalf of the thirteen Lutheran mission hospitals under its care. The American Lutheran Mission (ALM) continued to support their medical missionaries in Ntunjambili and Hlabisa hospitals until their contracts came to an end. Solveig Otte was one of these missionaries. However, it became clear after the nationalization that missionaries would no longer be recruited in big numbers. It seemed that the nationalization of the mission hospitals hampered the enthusiasm of the recruiters. The missionary spirit in the hospitals had changed after nationalization. The bureaucratic approach of the government as well as the arrival of doctors whose motivation was not necessarily that of witnessing to the love of Christ may have de-motivated prospective mission doctors.

4.3. The Mission of Evangelical Lutheran Free Churches

The MELFC did not resist the nationalization of their hospitals. Collaboration with the government started quite early when the chairperson of the hospital committee. Friedrich Dierks applied for a subsidy for Botshabelo in the then Western Transvaal, and later for Itshelejuba in the then-Eastern Transvaal. In Itshelejuba, the Lutheran Church in Southern Africa (LCSA) retained the right to conduct services for staff and patients for as long as the Church wished to. As was the case with the Charles Johnson Memorial Hospital of the Anglican Church in Nquthu, KwaZulu-Natal, the presence of people other than staff and patients within the hospital premises disturbed the security.[43]

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[43] Jon Larsen, "*KwaBaka": A Search for Excellence in Caring*. Cluster Publications: Pietermaritzburg, 2010, p.214.

Unlike the BMS, most Lutheran missions who operated in southern Africa during the apartheid era did not feel the need to acknowledge their negative involvement in segregation policies and practices. In the last part of the BMS confession an acknowledgement of participating in apartheid structures is made.

4.4. The Hermannsburg Mission Society

When Botswana became a republic in 1966, a sense of national identity engulfed its citizens who no longer wished to be identified with the apartheid South Africa. It should be noted, that while Botswana was still a British protectorate, it was governed from the South African town of Mafikeng which later became the capital of Bophuthatswana. Matters of national pride grew in importance when the Bophuthatswana self-governing authority opted for independence and established a republic in 1976. In the spirit of nationhood Rev. Phillip Robinson, dean of the ELCSA Western Diocese, advocated for an Evangelical Lutheran Church in Botswana (ELCB) independent from Bishop Rapoo's ELCSA-WD operating from Bophuthatswana in Tlhabane near Rustenburg.[44] The protracted conflicts and disagreements of the late 1970s led to lengthy court cases culminating in the co-existence of two Lutheran church bodies (ELCB and ELCSA-Botswana Diocese) with direct historical links to the HMS.

The dispute about who was the legitimate representative of the Lutherans in Botswana had negative effects on the Bamalete Lutheran Hospital. At one point the church building close to the hospital was gutted down in the struggle for control. A retired HMS missionary, Heinrich Voges, described these disputes in his book, *Vision: Global Congregation*.[45]

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[44] For a more detailed discussion of the political situation in Bophuthatswana see, P-L Breutz's *History of the Batswana*. Dr.P-L. Breutz: Ramsgate, 1987, pp.30-55.

[45] Heinrcih Voges, *Vision: Global Congregation*. Ev.-luth Missionswerk in Niedersachsen: Hermannsburg, 2000, p.105.

As already mentioned above, the HMS did not confess its lack of opposition to the segregation policies during the apartheid era. However, Heinrich Voges made an individual rather than a society's confession. Voges wrote:

> Looking back on the history of Hermannsburg in South Africa, the following writing of Kurt Dietrich Schmidt applies: "The church is simultaneously a community which is formed by human powers and the history of, which is written by people, erring, mistaken, often failing people." This also applies to the Hermannsburg Mission, since 1977 the ELM, and its messengers, men and women. They were and are partners in the mission of God which calls the church into being in order to preach Salvation to the people, and who commit themselves to the necessary services for the well-being of these people.[46]

Other denominations that developed from mission societies also responded to the nationalization. Like Bishop Zulu of the Anglicans in Natal, the Lutherans had hoped that the opportunity to perform chaplaincy duties in their former mission hospitals could be used to maintain a Lutheran presence in the nationalized hospitals. Larson described the response of the Anglican Church to the nationalization of the Charles Johnson Memorial Hospital in Nquthu. The Deputy Minister of Health A. J. Raubenheimer announced the gradual nationalization of mission hospitals at a meeting with churches held in Pretoria on 16 June 1976. "The churches were silent about this matter on the whole, perhaps thankful that the huge financial burden of the mission hospital would be removed from their shoulders. They preferred to let the mission hospital staffs speak to the issue."[47] The first indigenous bishop of the Anglican Church in Zululand, Alpheus Zulu, spoke to the hospital community in Nquthu at its last annual prize giving ceremony on 26 June 1976. According to Larson he lamented the government's decision to nationalize:

> He acknowledged that the decision of the government was not what we had looked for. He acknowledged they had been paying the bills for the work our hospital had been doing. Then he encouraged us to do all we could to settle down and serve the Lord and the people in these new circumstances. He pointed out that, whoever might be the hospital authority, God's calling on all of us did not change. We were called to

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[46] Heinrich Voges, *Vision: Global Congregation*. Ev.-luth Missionswerk in Niedersachsen. 2000, p.113.
[47] Jon Larsen, *"KwaBaka": A Search for Excellence in Caring.* Cluster Publications: Pietermaritzburg, 2010, pp.184-185.

> preach the good news to the poor in word and in deed, to proclaim freedom for the captives and recovery of sight to the blind, to release the oppressed and to proclaim the day of the Lord's favour—all thoughts taken from the gospel of Luke 4: 18-19. He said that it is the Lord whom we are to serve, and to meet the needs of his people, and that is what we should continue to do—even in government institutions.[48]

In Zulu's quotation one can detect a sense of defeat. He still thought that the church could retain the same presence in the hospitals, preaching the Gospel along with the provision of health care through its doctors and nurses, as before nationalization.

According to the Roman Catholic Church historian Joy Brain, the nationalization of mission hospitals had devastating effects on the quality of health care provision especially in the Bantustans:

> Catholic mission hospitals, which provided the only medical care for hundreds of thousands of rural people, had been in existence in South Africa for over fifty years when the Nationalist government decided to take over hospitals run by all religious denominations. Hospitals in the Transkei were the first to be affected in 1974/75, followed by Bophuthatswana, Lebowa, the Ciskei and finally KwaZulu in 1978/79.[49]

The response of the RCC was in the end the same as that of the other churches: their personnel had to choose where to go. Referring to the disillusionment of the religious sisters who worked in those mission hospitals, Brain wrote:

> When the Department of Health announced its decision to take over existing hospitals as from 1 April 1973, they agreed to take over all their staff. Buildings and other property would be purchased if these had been funded by missions themselves while the administration, records and equipment would be transferred to the state. After the transfer, which caused much heartache, religious sisters gradually withdrew, leaving the state to finance and staff all mission hospitals.[50]

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[48] Larsen, *"KwaBaka":* 2010, p.215.
[49] Joy Brain, "Charitable Works and Services" in J. Brain and P. Denis (ed.) *The Catholic Church in Contemporary Southern Africa.* Cluster Publications: Pietermaritzburg, 1999, p.100.
[50] Ibid. p.101.

The Roman Catholic Church held on some hospitals and ran them on a private basis. Unlike the schools were run on a private basis two decades earlier, those hospitals soon closed down because of lack of funds.[51]

5. The National Lutheran Churches and Missions as Victims

The nationalization of mission hospitals in the 1970s was preceded by the nationalization of mission schools two decades earlier. Surely the Lutherans could have learnt lessons from the loss of their mission schools on how best to respond to such situations. Besides conducting devotions and comforting the sick and dying, the Lutheran churches did not retain much influence on how the hospitals were run after nationalization. In the case of Itshelejuba, the Lutheran Church in Southern Africa maintained a minister on the hospital premises until recently. In Emmaus the church building and the minister's house were removed from the hospital compound so that no such moves were required after nationalization. At any rate, missionary Schiele had a chapel built within the hospital compound. Although there is a clear line of demarcation line indicating where the hospital begins and ends in relation to the chapel building, the chapel is built right by the entrance gate of the former mission hospital. Since the Lutheran churches have lost control of the mission hospitals which are now run by the government, all denominations and individual people are free to visit and conduct prayers for the sick.

At the Bamalete Lutheran Hospital in Botswana the situation was different because the HMS retained control since it carries forty percent of the financial burden of the hospital. Besides conducting prayer services for patients and staff, the pastor of the local Lutheran congregation is a member of the hospital board.

After the government began to subsidise mission hospitals, the White mission doctors and nurses in Nquthu volunteered to accept a salary equal to that of a Black doctor or nurse and gave the surplus to the hospital for running costs. [52] The number of mission

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[51] Ibid. p.102.
[52] Jon Larsen. *"KwaBaka:" A Search for Excellence in Caring*. 2010, pp.143, 245.

doctors at the CJMH was reduced by the government authority, thereby enormously increasing the workload for the remaining few.[53] For the doctors and nurses the objective was to provide quality service for as long as it was possible under the difficult conditions of nationalization policy. One can see that the aim of the government was to destroy the quality of health care delivery in order to oppress the Black people who were its primary beneficiaries.

It would be incorrect to portray the Lutheran mission societies and the Lutheran national churches as helpless victims in the nationalization of mission hospitals. We have seen that the leaders of the Lutheran national Churches chose to concentrate their efforts on establishing parishes and dioceses as if Christian schools and hospitals were not equally valuable. When they took over the leadership of their Churches, the Black bishops and their councils did not try to hold the hospital structures accountable to the Churches. The national Church leaders did not manage the transition from missionary leadership of the church to the indigenous leadership in the 1960s. Overwhelmed by their leadership responsibilities, they failed to allow the Church to keep control of the hospitals. Even in the Bantustans and the self-governing states, the national Church leaders did not attempt to work in their former mission hospitals.

What the church leaders could have done was to negotiate and reassure the mission doctors who left the hospitals that their skills would be needed for a long time to come. The church leaders could also have held the Bantustan leaders accountable for poor provision of health services and exposed their incompetent and corrupt ministries.[54] I want to draw on the experiences of Zimbabwe that also had to deal with many Lutheran mission hospitals after liberation, albeit five years later than South Africa. The prolific author on the medical history of Zimbabwe, Michael Gelfand, wrote about the transition of the control of mission hospitals when the democratic government was about to take over, before the early 1980s. In view of the transition in Zimbabwe and the reaction of the leadership of the mission hospitals to that event,

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[53] Jon Larsen. *"KwaBaka:" A search for excellence in caring*. 2010, p.213.
[54] H. C. J. van Rensburg *et al*. *Health care in South Africa: Structure and Dynamics*. Van Schaik: Pretoria, 1992, p.67.

one could conclude that the South African church leaders might have negotiated a better settlement for the mission hospitals' beneficiaries in the rural areas.[55]

It is true that some missionaries were deported for resisting apartheid, including in the BMS.[56] Although the fear of deportation could be seen as a reason for passivity, the BMS admits in its confession document, that their missionaries also benefited from apartheid in many ways. They exercised the Whites-only right to own land at the expense of Blacks. During apartheid, before and even after the nationalization of mission hospitals in the 1970s, they and their families had access to better equipped schools and hospitals as compared to Blacks.

While the missionaries had from time to time conducted community health awareness campaigns in the villages around the mission hospitals,[57] Black people did not take biomedicine as their 'own', as evidenced by the attitude of the Black church leaders. The health awareness classes conducted by nurses for patients during their visits to mission hospitals and clinics were important education sessions. However, the Black people continued to see biomedicine as a foreign and sophisticated form of health service, provided by Whites and white-trained Blacks.

In contrast to the Lutheran medical missionaries who saw no alternative but to collaborate with the apartheid government in the nationalization of mission hospitals, there were White medical professionals who tried alternative models of health care in collaboration with Black people. Earlier, in the 1940s and 1950s, a government-sponsored project to help Black communities take responsibility for their own health was introduced by Sydney and Emily Kark in Pholela, Natal. The Karks devised a system to help the Black people an understanding of the basics of biomedicine and to take responsibility of their own health. The Karks had initiated self-sustaining and community-driven health centres which could have set the people on the path to lesser dependence on health care.[58]

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[55] Michael Gelfand. *Godly Medicine in Zimbabwe*. Mambo Press: Gweru, 1988, p.124.
[56] Wilfred and Eleanor Bockelman. *An Exercise in Compassion*. 1972, p19.
[57] Kurt Bergter even made a movie which he showed in open air gatherings in and around Itshelejuba area. See appended interview transcript between Bergter and Ntsimane.
[58] Sidney and Emily Kark. *Promoting Community Health: From Pholela to Jerusalem*. Witwatersrand University Press: Johannesburg, 1999, p.22.

Before the introduction of Africanization in the mission hospitals, the government had already begun to implement the recommendation of the Gluckmann Commission that greater community participation should be allowed in local health services.[59] The much praised community health service of Pholela was a government initiative,[60] even though its success was due to the dedication of the Kark couple. Not only were the local communities expected to be directly involved in their health matters, they were also expected to co-operate with other community development sectors in their areas in a multi-pronged approach. "The activities of the individual health centres were to be co-ordinated with those of other local agencies such as the local authority (Native Commission) and the authorities responsible for agriculture and education. Local co-operation and community responsibility were to be developed wherever possible."[61] If already in the 1940s and 1950s the South African government encouraged community involvement in health care centres like Pholela, one wonders why most Lutheran medical missionaries did not encourage similar community involvement in boards and councils that governed the hospitals? Pioneering nurses like Ruth Bauseneick of Itshelejuba, Emma Pfitzinger of Ramotswa and Lillian Young of Untunjambili were aware of the value of community involvement as they worked with limited resources and visited patients at their homes to teach them the basics of good health practices. The proliferation of technology and the centralization of health in government subsidized hospitals in the 1960s reduced the importance of home visits and health education.

Sidney and Emily Kark explained in their book how they succeeded in getting rid of diseases like scabies, pelvic inflammation, syphilis and gonorrhea through the promotion of community participation in health care:

> After five years of the community health programme in the defined COPC areas of the practice, there were no new epidemics of enteric fever and small pox, whereas the health centre team had been called to

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[59] Louise Vis has written extensively on the work of the Karks in her dissertation titled: "*We Sow the Seed": Perspectives of Health Educators at the Institute of Family and Community Health in Durban in the 1940s and 1950s.* MMedSc-Community Health dissertation, University of KwaZulu-Natal. 2004.
[60] Sidney and Emily Kark. *Promoting Community Health: From Pholela to Jerusalem*. Witwatersrand University Press: Johannesburg, 1999, p.22.
[61] Sidney and Emily Kark. *Promoting Community Health*. 1999, pp.21-22.

> outbreaks in surrounding districts during that period. While there were still occasional cases of typhoid fever in sick migrant workers returning to their homes, these remained isolated with no resulting epidemic outbreak, as the patient was immediately reported to health centre staff and the necessary preventive treatment provided.[62]

The Lutheran medical missionaries, through the Lutheran Medical Foundation, were quite aware of developments in the health sector, thanks also to their participation in a medical missionary body called the Consultative Committee of South African Medical Missions, established in 1970 by the three Regional Associations of Mission Hospitals in Transkei, Natal and Transvaal.[63]

Similarly, Lutheran medical missionaries should have been aware also of the medical and hospital journals and declarations made at the international level such as the Bamako Declaration. One of the clauses of the declaration reads, "Individuals and communities should participate in health activities in ways that promote self-reliance and reduce dependencies."[64]

It would be incorrect therefore to see the Lutheran mission societies as helpless victims of apartheid policies who lost property as a result of the nationalization of their hospitals. Instead of collaborating with the government during its nationalization of mission hospitals the Lutheran mission societies could have seen themselves as agents of change and help transform southern African society. J. N. J. Kritzinger has argued that all mission agencies have as their prime agenda to change the societies they work among:

> I understand the "mission" of a religious community as that dimension of its existence which is aimed at making a difference to the world, at influencing or changing society in accordance with is religious ideals. Christian communities are not alone in having a sense of mission. In fact, every religious community has some sense of calling and purpose

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[62] Ibid. p.56.
[63] Jon Larsen, *"KwaBaka": A Search for Excellence in Caring*. Cluster Publications: Pietermaritzburg, 2010, p.155.
[64] *Advisory Committee on Health: Health Research Strategy*. World Health Organization: Geneva, 1986, p.54.

> vis-à-vis society, but they differ from each other in the relative importance they accord to human agency or activism.[65]

The Lutherans and the other churches were in a position to stand on the side of the oppressed during the time of uncertainty which followed on, first, the government take-over, and subsequently, the handing over of mission hospitals to Bantustan governments.

Concerning relationships with the government one may consider the subsidies of salaries and expansion of the mission hospitals in the 1960s as a reason for not challenging the nationalization of the mission hospitals. To do so might have been construed as ingratitude on the part of the mission societies and the national churches that emerged at the time.

It will be remembered though that the Lutheran mission societies were not the only ones that founded hospitals. Many other mission societies established hospitals in urban and in the rural areas, for example the Anglican St. Aidan's Hospital in the city of Durban, and the Presbyterian's Church of Scotland Hospital in the village of Tugela Ferry in Msinga, in Natal.

From within the Lutheran family no evidence emerged of significant opposition to the nationalization of their mission hospitals. The reason could be that the mission societies operating in the South Africa, viz., the MELFC, the MBS and the NMS, did not hand over the hospitals to the national leadership simultaneously with handing over the control of the newly-established churches. As the former Lutheran chaplain Dr. Vivian Msomi said during an interview, the new national Lutheran church leadership did not concentrate on hospitals and how they were run, because they were concerned with consolidating parishes, circuits and dioceses.[66] It is important to add that, besides focusing on the newly formed Churches, the new national leadership had

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[65] J. N. J. Kritzinger, "Studying Religious Communities as Agents of Change: An Agenda for Missiology," in *Missionalia* Volume 23, Number 3 November 1995, pp.366-396.
[66] Dr. Vivian Msomi interviewed by Radikobo Ntsimane in his office in Pietermaritzburg on 25 May 2005.

no previous experience of hospital governance and lacked sophistication[67] in that area. From the beginning the mission societies had excluded the local Church leaders from control over the hospitals. Of course, the HMS in Botswana operated differently. The reason was probably political. The government of Botswana was not shaped by an ideology of racial segregation and by the quest to control people. Various mission societies still run their medical institutions today, for example the Seventh Day Adventist Church in Kanye and the Lutherans (HMS) in Ramotswa.

There is no doubt that the mission societies through their medical missions had a great impact on the lives of the people among whom the mission hospitals were established. These people had benefited from the availability of health facilities in their midst as well as from the employment opportunities created by the mission hospitals. However, they also had experienced the unequal power relations within the mission hospitals. When they realized that the missionaries who continued to work in the mission hospitals were no longer in charge, some treated them differently. The former medical technologist Solveig Otte lamented the changed attitudes of current hospital employees and their lack of appreciation for the work of mission staff after the nationalization:

> Untunjambili is very heartening and Hlabisa is very heartening for me too but sometimes I have been very disheartened when I hear only criticism and I think you know these were human beings and they were … they had their faults. But if they recognized their faults and say well, "I was wrong here. This was our understanding at the time and we did what we could." Then … it makes feel that it will go on, mistake or not. But I just wish that the mission … but what makes me happy is … I don't know there is a woman that you should get to know. Her name is Dudu Biyela, one of the finest matrons I have ever known. She retired … she was one of the Hlabisa she was one of the matrons … and one of my mentors almost when I was at Hlabisa. When I had … you know during the transition period it became very difficult. I had always worked well together with the people and suddenly outside influences came and the people were saying, "O, you

[67] In the newly-constituted LCSA in 1967, the newly elected deans of dioceses (except Botswana) had the MELFC White missionary as their assistant although such missionaries had no previous experience as deans. Titus Lenkwe of the then Western Transvaal was assisted by Manfred Nietzke, Frans Segoe of the then Goldfields Diocese was assisted by Friedrich Dierks, Asser Mdluli of the then Eastern Transvaal Diocese was assisted by Gottfried Stallmann and Isashaar Dube of the then Natal Diocese was assisted by Wilhelm Weber. George Schulz was elected Bishop in 1967 and again on successive election synodical meetings until retirement age forced him not to stand in 1992.

> know …" Saying negative things and saying that I was keeping money from people. It was out of my … out of my thinking that I owed people money. And you know all kinds of things came, with some people who have been hurt I think. And I used to go to Dudu Biyela and talk to her.[68]

Solveig Otte could not understand why people who were kind to her in the pre-nationalization era suddenly manifested a negative attitude towards herself and other missionaries who were supposed to have served them with diligence. Furthermore, the missionaries did not feel that they were able to control the Black staff after nationalization. According to Solveig Otte, doctors in KwaHlabisa hospital trusted a matron called Dudu Biyela to take care of that staff did their work seriously. It sounds as if, after Dudu Biyela's retirement control of the hospital personnel was expected to collapse. "Overseas doctors and other doctors from South Africa would say, 'If Dudu Biyela leaves, I am leaving!' You know! She is … I think she is somebody I would put up there [indicating a point well above her head] in the medical missions.[69]

The nurses reacted decisively against the apartheid segregation that did not recognize their qualification as professionals. From the experience of a medical missionary who remained serving in the Dutch Reformed hospital after nationalization, Ter Haar explained the new attitudes of Blacks in a paternalistic way:

> Then came the wind blowing from overseas particularly from the USA saying 'you must not forget the self, s-e-l-f. The self and then all those slogans came in where we get self-actualisation, self-realisation, which became self-promotion eventually…and then … but all the congress the nurses had gradually this idea of nurses' rights came in. Reinforced later with the unions…now was one of my difficult groups who unionised the nurses and say 'you must stand for your rights nurses! They are underpaying you, you must have this and that and the next thing … and then we had congresses and nurses' conferences which they even asked me to speak at.[70]

As they did in Hlabisa, the nurses of the former Dutch Reformed mission hospital at Rietvlei rebelled against authority. Ter Haar said, "We couldn't bring any discipline anymore because it … they would immediately run to the people in Umtata and say,

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[68] Otte Solveig interviewed by Radikobo Ntsimane in Pietermaritzburg on 8 May 2007.
[69] Otte Solveig interviewed by Radikobo Ntsimane in Pietermaritzburg on 8 May 2007.
[70] Gerrit Ter Haar interviewed by Radikobo Ntsimane in Pietermaritzburg on 19 November 2007.

'hey this White doctor has said so and so to me.' So that became a very difficult issue that was another reason why doctors left."[71]

What Ter Haar refers to as the standardisation of labour regulations in mission hospitals, is by Kurt Bergter of the then Itshelejuba Lutheran mission hospital called Africanization. This was a strategy used for the gradual reduction of the power of White medical missionaries in the mission hospitals in preparation for the total take-over in 1976. Many White doctors and nurses left the mission hospitals to go into private practice in urban areas, away from the control of the Bantustan authorities and away from Black control in the mission stations. They left the patients who most needed their expertise, and the situation kept deteriorating with Black doctors being less and less accountable to White authorities. Ter Haar who remained as a mission doctor under Bantustan authorities until his retirement explained why there was lax in discipline:

> And by a government that did not want to apply discipline because … You ask me today why they don't apply discipline. It's the same story, you don't want to fall out with your friends because you know your friends you've given them a favour and you do me a favour tomorrow and you can't sort of send them out because I am going to say what I know about you. So everybody's hands are tied.[72]

It was not the best way to make use of power. Those who gave favours took control of those who were supposed to exercise power so that the last could no longer manipulate others and were instead manipulated: a powerless position of power. The leader, in this case the nurse who is a matron or a doctor who is a superintendent, acts like a marionette who performs on the instruction of others, for their own benefit and not that of the leader whose knowledge and expertise are needed by the staff surrounding him or her.[73]

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[71] Ibid.
[72] Ibid.
[73] Sue Russell, *Conversion, identity, and power: the impact of Christianity on power relationships and social exchanges*. University Press of America: Lanham, 1999, p.2.

6. The Decentralization of Health Care: the Homelands' Health System's Model as an Alternative

One of the recommendations of the Tomlinson Commission when dealing with the native question was the creation of a homeland system based on the ethnic groupings of the Black people of South Africa. This was a divide and rule strategy of the apartheid system. Of the eight suggested homelands, four gained a pseudo-independent status from the South African government. All four, viz., Transkei, Bophuthatswana, Venda and Ciskei (collectively called the TBVC), had a Department of Health with a cabinet minister responsible for health matters. This system proved to be problematic in a number of ways. The major impediment to an adequate provision of health services was that the homelands were still controlled by the Pretoria central government that had the means and manipulated those who needed those means.

Challenging the insincerity of the White South African rulers with regard to the homelands, Mangosuthu Gatsha Buthelezi, Chief Minister of the KwaZulu homeland, once wrote that, "Totalitarianism represents, in part, an attempt to allocate function without granting control over the resources that the function requires, in order to prevent the growth of independent bases of power in the hands of subordinate."[74] When the central government of South Africa granted independence to the TBVC states, it had no inclination to relinquish control. Instead, it used the homeland authorities as scapegoats for the failures of the system. Let us look closely at what happened to the health service after the mission hospitals were nationalized and subsequently handed over to homelands authorities and self-governing states.

Budgets for the health departments of the homelands were decreased, the numbers of qualified and dedicated personnel diminished, and the staff moral plummeted. Barbara Rogers described the process in these terms:

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[74] Mangosuthu Buthelezi, *White and Black Nationalism, Ethnicity and the future of the Homelands*. Institute of Race Relations, 1974, p.9. Buthelezi was quoting from a 1958 book of Maurice Zeitlin entitled, *Political Power and Social Theory*: a research annual.

> Together with the elimination of experienced and often dedicated medical missionaries, the hospitals suffer badly from being brought under the financial auspices of Bantustan authorities. KwaZulu has been particularly badly hit, partly because of the presence until recently of mission hospitals and partly because of the arbitrary budget cuts by Pretoria of 7% on all hospitals under KwaZulu control in 1978 as compared to the previous year (more in real terms). At this time KwaZulu had taken over 15 former state and mission hospitals and another ten were added to the list.[75]

The situation was so bad in KwaZulu in 1978 that the Minister of Health and Welfare, Dr. Dennis Madide, anecdotally announced, after his department had taken charge of fifteen former state hospital with ten more to be added to the list, that some services would have to be reduced. "My department and the hospitals and institutions under its control", he said, "will make every effort to maintain services at their present level, but it must be understood that this will be an extremely difficult if not impossible task. The moral is: try not to be sick in this financial year."[76] An example was the Charles Johnson Memorial Hospital, which saw its number of doctors going down from 12, when it was under the mission and subsidized by the government, to two when it was under the control of KwaZulu authorities. This situation was prevalent also in the Transkei and Ter Haar could write:

> In 1976 when the Transkei became pseudo-independent, all mission hospitals were nationalized by the Department of Health of the RSA and in turn handed over to the Transkei Health Department. The same procedure was followed a few years later when the other TBVC countries (Transkei, Bophuthatswana, Venda and Ciskei) accepted their independent status). Most of the mission authorities withdrew from the management of the health services, and many of the doctors declined to work under the new conditions of service, especially those with school-going children.[77]

Unless we know how bad the conditions were under which the mission doctors were expected to serve in the homelands' health departments, we cannot appraise their motivation to leave. However, the fact that some White missionaries withdrew when

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[75] Barbara Rogers, *Divide and Rule: South Africa's Bantustans,* (Revised and Enlarged Edition). International Defence and Aid Fund. New Gate Street ECI, 1980, p.72.
[76] Barbara Rogers, *Divide and Rule: South Africa's Bantustans,* (Revised and Enlarged Edition). International Defence and Aid Fund. New Gate Street ECI, 1980, pp.72-73.
[77] Gerrit Ter Haar, *In the Shadow of Tradition: Contrasting Health and Healing Concepts in Transkei*. (privately published), 1999, p.60.

they were supposed to serve under the Black national leadership in the newly-constituted churches, showed that power relations played a role in their decision. Most White people in the 1960s and 1970s, irrespective of their profession, were not prepared to serve under a Black person. It was one thing to refuse to serve in a mission hospital under an apartheid administration and a totally different thing to avoid serving in a church that is under a Black bishop. Hodges explained the racial relationship in reference to the empowerment of the newly-established national churches in Africa and elsewhere and the withdrawal of missionaries from leadership:

> The willingness of the missionary to cooperate with the national leaders is a test both of his humility and of the quality of his missionary passion. As one national minister expressed it: "Many missionaries are willing to serve under the District Council (composed of missionaries) but not under local committees (with nationals) … Unless our missionary friends can extricate themselves from this superiority complex, we are afraid that they will not have much fruitful ministry in our land."[78]

That was the model adopted after nationalization when the mission hospitals were run by homeland authorities. Most medical missionaries left the hospitals instead of serving under Black homeland leaders. How could White National Party officials, placed strategically in the homelands to serve as advisors to homeland leaders create conditions for the development of the Black people? It is no surprise that the quality of health service delivery declined in the homeland health system. After the deterioration of the quality health care service provided during the era of medical missionaries and the failure of the homeland system to restore it, Black people had to find other ways of health restoration.

7. Chapter Summary

The Lutheran church mission agencies that worked in South Africa allowed the mission hospitals to grow big and sophisticated, especially at the time of combating tuberculosis and of increasing subsidies from the government in the 1960s. When the

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[78] Melvin Hodges, *The Indigenous Church*. Gospel Publishing House: Springfield, 1996, p.95.

government decided to nationalize the mission hospitals in order to hand them over to the homelands and Bantustan health ministries, the Lutheran churches and the Lutheran mission societies were so overwhelmed by the sheer magnitude of the costs involved that they did not put up any resistance to keep the hospitals under their care. One might see it as a relief for the Lutherans that they no longer carried the huge responsibility of health care provision, despite the fact that, where it was provided, it was of low quality.

In this chapter an attempt has been made to describe the responses to the nationalization of mission hospitals by the various institutions that were involved in health services provision for the Black people. It has further been shown that the Lutheran mission societies in South Africa could not prepare and plan for alternative health care when their institutions were nationalized because they had already benefited substantially from the government and, according to Hans Florin, alternative model proposition could be construed as being of a political nature.

Officially created, *inter alia*, to decentralize medical health provision, the homelands' health structures were powerless entities that reduced the quality of health care provision instead of enhancing it. It has been here argued that the Black Lutheran church leadership failed to seek alternative ways of providing biomedicine to Black health seekers when the hospitals were nationalized and handed over to homeland governments. Quality health care provision to Blacks, as we have seen in this chapter, could only be accessed as long as the apartheid government and the Bantustan government and their predecessors did not interfere with those who attempted to provide it. The government, one can conclude, embarked on the nationalization of mission hospitals to entrench the policy of apartheid in health care provision.

CHAPTER EIGHT

GENERAL CONCLUSION

1. Conclusion

This study attempted to show that in their endeavour to develop the health provision for the indigenous people of southern Africa, the Lutheran missionaries unwittingly cooperated with the South African apartheid government to consolidate racial segregation. Instead of development through biomedicine, the Lutheran mission societies created a situation where the indigenous people suffered oppression and segregation under the Bantustan governments of the 1970s.

The study argues that in the period between the 1930s and 1978 power relations between the Lutheran missionaries and the indigenous people in southern Africa were one sided due to the fact that the missionaries possessed the biomedicine that indigenous people found helpful in their illnesses. While the Lutheran missionaries' chief aim was to convert the indigenous people into Christianity, the Black people found that there were material benefits to be gained in a relationship with the missionaries. The various Lutheran mission societies founded hospitals and provided biomedical assistance to those who needed it and at the same time attempt to make converts among those who came to seek help in their health system. The study shows that the Lutheran missionaries were not unique in trying to use to their advantage the health care resources from the West. The study acknowledged that not only medical missionaries and physicians could take advantage of health seekers, but other health practitioners as well. The traditional health practitioners from the pre-Christian era, the spiritual-healing churches in the 1950s and even the South African government in the 1970s, saw that, as health providers, they could manipulate the health seekers for as long as they needed the health care provided by them.

The study has attempted to show the situation of Lutheran mission hospitals in southern Africa when the South African government was nationalizing all mission hospitals in the 1970s. It also looked at the mission hospitals of the other mission societies working in the southern African region at the time. The Roman Catholic Church and the family of Dutch Reformed Churches had more hospitals than the Lutheran churches. There were areas where the Lutherans had a larger number of hospitals than other societies, for instance in Natal and Zululand. In a study published in 1984, Michael Gelfand recognized the contributions that the Lutheran mission societies made to biomedical care:

> The Lutheran Church contributed significantly to providing health services for rural Africans. It was probably the biggest group in this field and its medical missions covered a wide area of South Africa, including what is today the Swazi Homeland and, as well, opening one in Bophuthatswana.[1]

The large number of Lutheran mission hospitals shows that the sphere of influence of the Lutheran Church covered a large geographical area in southern Africa.

The title suggested that the study intends to investigate the role played by the Lutheran medical missionaries in the development of the indigenous peoples. In the pre-1930s era, the medical missionaries provided health care to the indigenous people from the mission houses' backdoors. The provision of health care developed into basic hospital buildings in the 1930s and into extended buildings with technologically-advanced equipment in the 1970s.

The medical missionaries were so motivated to give the best biomedical care to the indigenous people that they sought financial assistance from the government for new buildings and for the procurement of the necessary equipment and medications, especially in the 1960s and 1970s. Among other diseases, tuberculosis necessitated that the government intervene to curb its spread by providing subsidies to the mission hospitals.

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[1] Michael Gelfand, *Mission Doctor and Nurse.* Mariannhill Mission Press: Mariannhill, 1977, p.27.

There was some opposition against nationalization from some mission hospitals, like the Charles Johnson Memorial Hospital of the Anglican Church in Nquthu, and the SPRO-CAS study group. Noticing the ruthless treatment that the apartheid government meted to the missionaries who opposed the implementation of apartheid, the Lutherans did nothing to show their displeasure at the new system. They sold their hospitals without resistance and allowed the government to take over. No consultation was entered into with Black leaders who were already in charge of the former mission churches in the 1960s. The Black church leaders were never part of the hospital structures anyway. Wherever there were Black members of the hospital boards and councils, they were few and ineffective in bringing about any transformation in the hospitals.

The ease with which the Lutherans co-operated with the apartheid government can be seen as informed by their interpretation of the doctrine of the 'Two Kingdoms'. They understood that they were not to interfere with the work of the government, since their work was confined to Church matters. Black people have interpreted that as the Lutheran missionaries having abandoned them into the hands of the apartheid regime. The quality of health care provision in the former mission hospitals now under the Bantustan governments deteriorated. Black people were directed to seek health services in health centres that belonged to their ethnic group, even when there was one designated to a different group nearby.

Any mission society that had a hospital in a given area had a visible presence that could easily influence the life of the people coming to seek health from it. Despite the impact that the Lutheran mission hospitals had in Winterton through Emmaus Mission Hospital, Kranskop through Untunjambili Mission Hospital, Piet Retief, Pongola and Swaziland through Itshelejuba Mission Hospital, and Ramotswa in Botswana through Bamalete Lutheran Hospital, there were health providers who contested this influence. Traditional healers of all sorts did not relinquish their profession when the mission hospitals were established in their area of operation. The mission societies were territorial and guarded their sphere of influence jealously. Most of them did not consider working hand in hand with other health care providers like traditional healers and Zionists. Only in the area of identifying tuberculosis patients, did doctors Ulrich

Schmidt of Ramotswa and Magdalene Schiele of Emmaus co-operate with traditional healers.

In some areas such as Ramotswa, the Lutheran medical missionaries antagonised the Roman Catholic Church missionaries who wanted to establish a hospital there. Similarly, in Botswana, the LMS and the Seventh Day Adventists were frustrating each other's initiatives of establishing a mission hospital in Kanye, Botswana in the 1930s.

Chapter four showed how biomedicine came to be accepted and widely used by the Zulu people and the Tswana people in southern Africa. The study attempted to show that the medical missionaries had to struggle to find ways to demonstrate the value of biomedicine to the health of the indigenous people who already had their traditional ways of health restoration. In the 1930s, the men in the Emmaus mission challenged the missionary Heinrich Schumann who wanted to introduce a maternity clinic, claiming that their wives had been giving birth long before the arrival of the missionaries. During the 1960s, missionary Friedrich Dierks asked the women's league members in Botshabelo to help him introduce family planning among the village women. In order for biomedicine to be accepted by the indigenous people, the medical missionaries had to take cognisance of the local belief systems of disease acquisition and health restoration. The indigenous Zulus and Tswanas also had to change some of their religio-cultural practices in order to benefit from biomedicine.

Negotiation between the western and the indigenous cultures took place in order that the medical missionaries and the indigenous people could find out what worked best under the circumstances. Those who first introduce biomedicine in southern Africa had a lot of work to do to lay firm foundations for their work. The foundations of the various Lutheran mission hospitals were laid by pioneers called *Laienmediziner* that did not have formal training in biomedicine. Heinrich Schumann, Wilhelm Weber, and Hanna Otte and Heinrch Pfitzinger respectively founded, Emmaus, Itshelejuba, Untunjambili and Bamalete Lutheran Hospital before and during the 1930s.

There first nurses who worked in the four Lutheran mission hospitals were Hilda Prozesky in Emmaus, Ruth Bauseneick in Itshelejuba, Lillian Young in Untunjambili

and Emma Pfitzinger. Those nurses used the services of district surgeons who made regular visits to the mission stations. The nurses also visited patients in their homes, often far from the mission stations. In the rapid development of mission hospitals' services, the nurses were followed in the mission hospitals by doctors. Magdalene Schiele, Kurt Bergter and Ulrich Schmidt served respectively as the first doctors of Emmaus, Itshelejuba and Bamalete, mainly in the 1960s.

Firstly and foremost the indigenous people had their own forms of health care as shown in chapter three. The indigenous health care systems had inadequacies and could not address all the health needs but that does not mean that they were totally helpless in the face of disease. The scourge of HIV/AIDS shows today that no health care system is adequate to address all the health needs. The introduction of biomedicine in southern Africa did not find a *tabula rasa* where health care was non-existent.

Secondly, the medical missionaries depended on the Black agents in order to provide biomedical service to the indigenous people. The Black agents facilitated communication between doctors and patients, they convinced other Black people of the value of biomedicine as in the maternity clinic in Emmaus and the birth control methods in Botshabelo, and they performed general hospital work. Black nurses, chaplains, drivers and other general workers made the mission hospitals work as a unit. Without the participation of the local black people in the mission hospitals, it is doubtful that the medical missionaries could have provided a service they intended to provide. In the 1960s, Black people were getting formal qualifications both in biomedicine and in professional nursing. Biomedicine was demystified as Black people could learn it and acquire the necessary skills to practice it.

In the 1960s many changes in the wider society and this influenced the nature of the mission hospitals. The banning of black political parties, the emergence of a new leadership in the newly-constituted Lutheran churches and the consolidation of homelands brought far-reaching changes to the mission hospitals. The Africanization of mission hospitals following the recommendation of the Tomlinson Commission was the recognition that Black people were competent enough to provide biomedicine.

At that time, the apartheid government had already begun to entrench the policy of racial segregation by outlawing the mixing of racial groups in one settlement area through the Group Areas Act of 1950, and by radicalizing education through promulgating the Bantu Eduction Act of 1953. The Lutheran medical missionaries eagerly applied and used the subsidies, unawares that the government planned to implement racial segregation in health care provision. In 1974, the government announced that all mission hospitals would be nationalized. Unlike the case in post-independence Botswana, the South African government had no intention to improve the provision of health care for all its citizens. Instead, it wanted to use the nationalization agenda to take over the mission hospitals and to hand them over to the health authorities of the Bantustan governments.

The last chapter shows that there were two different approaches that the Lutheran mission societies could have adopted with regard to the nationalization of the mission hospitals. The primary health care could have been intensified in order that the local people could have been responsible for their own health care. The churches could have remained present in their former hospitals doing other things, so that such hospitals continued to be places where health seekers were treated with respect. After nationalization the quality of health care service in many former mission hospitals dropped to very low levels. In the end, the Berlin Mission Society, which founded the Emmaus Mission Hospital acknowledged its error of judgment when it worked within a segregation framework during the time of apartheid. The BMS produced a twelve-page document of confession and circulated it to its former mission fields like their current partner the Evangelical Lutheran Church in Southern Africa (ELCSA).[2] In a similar way the Hermannsburg Mission Society acknowledged that it had made mistakes during the apartheid era. In their often exclusively white mission and hospital committees, the mission societies took decisions with very little contribution by Black people, if any. The submissions of the various other churches and religious bodies to the TRC might have influenced the decision of the Lutheran mission societies and churches long after the Commission, to acknowledge their irresponsible use of the power during the apartheid era.

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[2] Berliner Missionswerk: Statement on the History of the Berlin Mission in South Africa. September 2000.

As the title of the thesis suggests, the Lutheran mission societies and their medical personnel, through the Lutheran Medical Foundation, were too slow to realize that the hospitals they were handing over to the government were no longer going to provide quality access to health care, as they had been trying to do from their inception. Mission hospitals were turned into tools of the government by which to implement apartheid. Racial discrimination and the imposition of apartheid in health care destroyed the medical missions' health care provision. The Bantustans were the creation of a system that was under the control of the apartheid regime, designed to ensure that Black people would not have access to quality health care. Another noteworthy fact is that both secular and mission health providers were aware that segregated healthcare was not only endangering the lives of Blacks by exposing them to poor quality health care, but even those of White people as a consequence.[3]

2. *Post Scriptum*

This study was prompted by the semi-paralysis of the so-called mainline churches, especially the Lutheran churches, when HIV/AIDS intensified in the late 1980s. The question that came to mind at the time was why in view of its long history of health-care provision in southern Africa, why did the Church not know what to do? Indeed, research has confirmed that among the people who have died, many were members of the Black Lutheran churches. Although they are heirs to the work of the mission societies, the Black Lutheran churches played no role in the leadership of the mission hospitals up to the time when the government nationalized them. One could say that the scourge of HIV/AIDS presents the Black Lutheran churches with an opportunity to become once more involved in health care provision. The HIV/AIDS pandemic is too big to be ignored. When one member of the church is infected, the whole church can be affected.

Despite abundant information on HIV/AIDS, there are still people, especially in the churches, who out of ignorance discriminate against those infected and affected by the

[3] A Tswana idiom which says: *Matlo go sha mabapi* means that when one hut is on fire the chances for a neighbouring one to survive are slim.

pandemic. The Church could be involved in compassionate activities such as awareness campaigns, care, treatment and income generation projects for the less advantaged. With the number of orphans ever increasing, the Lutheran churches could find a way to help. Those who could help as well as those who need help can work together in unity to fight against suffering and illnesses. Maybe the two groups could work together to create conditions that minimize the effect of illnesses and suffering. As the Tswanas say, *bobedi bo bolaya noga*,[4] the recommendation of the World Council of Churches to integrate health care under church-related hospitals can be the goal to combat the spread of diseases and to provide treatment where it is needed most. There are already thousands of community workers organized under Faith-Based Organizations (FBOs) providing basic health care to orphaned children and those living with HIV through Home-Based Care.

[4] It becomes easy to defeat a snake when two people fight it jointly.

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3. Interviewees

3.1. American Lutheran Mission/Norwgian Mission Society

Friedah Nene, Bhekumusa Xulu, Helen Msimango, Solveig Otte, Vivian Msomi, Dean C.N.Mthethwa.

3.2. Berlin Mission Society

Richard Schiele, Evelyn Sommerfeld.

3.3. Hermannsburg Mission Society

Luetkins, Mookodi Rangongo, Peter Schildknecht, Ulrich Schmidt, Magdalene Seabo, Heinrich Voges.

3.4. Mission of the Evangelical Lutheran Free Churches

Ruth Bauseneick, Kurt Bergter, Freidrick Dierks, Titus Dlamini, Lieselotte Gnauk, Jabulani Mdluli, Ndlangamandla, Sindisiwe Zikalala, Wilhelm Weber.

3.5. Others

Caroline Mamba, Martin Prozesky, Gerrit Ter Haar.