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Shaping Swiss Medical Practice in South Africa Before Apartheid (1873–1948)

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This article addresses how Swiss missionaries practiced medicine in the North-eastern Transvaal in South Africa during the decades leading up to the introduction of apartheid. It argues that this secular activity often caused more tensions between the missionaries on the ground in Africa and decision-makers in their headquarters in Europe than has been pointed out. Such turbulence had an impact on the way medical activities were funded and practiced. This was in addition to the challenges faced in the new environment, which by itself was a driving force that shaped the Swiss practice of missionary medicine. While, from the time of their settlement in the region in the 1870s onwards, the medical knowledge acquired in Europe underwent significant change in terms of practices (diagnosis, medical prescriptions, and attitudes towards patients), the Swiss could not avail themselves of these changes: they were torn between bureaucratic shifts at their headquarters and the constraints they faced in their new Transvaal environment.

When Swiss missionaries arrived in the North-eastern Transvaal (NT)[1] in South Africa (SA) in 1873, intending to care for the souls of the people they came to call the 'Tsonga', they could hardly have imagined the challenges that they would face in this new environment. Although they were confident in the powers of the late 19th-century European medicine, which had seen significant progress in diagnostic methods as well as in

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1 The North-eastern Transvaal here refers to the Zoutpansberg district within the future Union of South Africa. It is located in today-Limpopo Province of the Republic of South Africa.

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the search and discovery of new therapeutics,[2] disclosing power and Western medicine's superiority,[3] Swiss missionaries in SA experienced tensions within their missionary society regarding the practice of medicine as secular activity. At the same time, they found themselves confronted by an unhealthy environment, disease, social misfortunes as well as divisiveness and inequality that already existed in all of SA[4] during the decades leading up to apartheid, which came in force shortly after the election of the *Herenigde Nasionale* Party under D. F. Malan in 1948.

The shift in medical practice over time has been extensively investigated in Europe;[5] the adaptation of European medicine to non-Western epidemiology, including the African, has a great venue of inquiry as well, arising new specialities under the large umbrella known as tropical medicine.[6] This article focuses the entanglements of missionaries with both their management and the *milieu*. It examines how the relationship between the missionary headquarters in Lausanne, Switzerland, and missionaries on the field in North-eastern Transvaal affected Swiss mission medical practice in the rural area in consideration. This essay looks at the decades before apartheid, somewhat overlooked, in comparison to the apartheid era, which has hoarded most of the attention and research

2 Charles Farley, Bilharzia. A history of Imperial Tropical Medicine, Cambridge/New York 1991; Megan Vaughan, Curing their Ills: Colonial Power and African Illness, Cambridge 1991; Nancy Rose Hunt, A Colonial Lexicon of Birth Ritual, Medicalization, and Mobility in the Congo, Duke 1999; Sanjoy Bhattacharya, Niels Brimnes, Introduction: Simultaneously Global and Local: Reassessing Smallpox Vaccination and Its Spread, in: Bulletin of the History of Medicine 83/1 (2009), pp. 1–16; Pratik Chakrabarti, 'Living versus Dead': The Pasteurian Paradigm and Imperial Vaccine Research, in: Bulletin of the History of Medicine 84/3 (2010), pp. 387–423; Helen Tilley, Africa as a Leaving Laboratory. Empire Development, and the Problem of Scientific Knowledge, 1870–1950, Chicago/London 2011.

3 David Arnold, Colonizing the Body. State Medicine and Epidemic Disease in Nineteenth-Century India, Berkeley 1993, pp. 213–214 ; Shirley Lindenbaum, Margaret Lock, Knowledge, Power, and Practice. The Anthropology of Medicine and Everyday Life, Berkeley/Los Angeles/London 1993; Mark Harrison, Margaret Jones, Helen Sweet, From Western Medicine to Global Medicine. The Hospital beyond the West, Hyderabad 2009, pp. 3–30.

4 Anne Digby, Diversity and Division in Medicine: Health Care in South Africa from 1800, Bern 2006; Shula Marks, Divided Sisterhood. Race, Class, and Gender in the South African Nursing Profession, Johannesburg 1994.

5 Roy Porter, The Popularization of Medicine, 1650–1850, London 1999; Georges Vigarello, Histoire des pratiques de santé, Paris 1999; Patrice Bourdelais, Olivier Faure (eds), Les Nouvelles pratiques de santé, XVIII^{e}–XX^{e} siècles, Paris 2005; Thomas Schlich, Negotiating Technology in Surgery: The Controversy about Surgical Gloves in the 1890s, in: Bulletin of the History of Medicine 87/2 (2013), pp. 170–197.

6 Randall Packard, The Making of Tropical Disease. A Short History of Malaria, Baltimore 2007; Deborah Neill, Networks in Tropical Medicine. Internationalism, Colonialism, and the Rise of a Medical Speciality, 1890–1930, Stanford 2012; Michael A. Osborne, The Emergence of Tropical Medicine in France, Chicago/London 2014; Gordon Charles Cook, Tropical Medicine: An Illustrated History of the Pioneers, London 2007.

in the history of medicine in SA. It relies on both a local source – the Elim hospital archives, made of patients' records, statistics – and on Swiss missionary archives in Lausanne including missionary periodicals, annual reports, and correspondence. In addition to helping to trace the consequences of contradictory attitudes of the missionaries towards medicine as a secular activity, this archival material allows revisiting the local environment and epidemiology as another source of difficulties, which led Swiss missionaries to adapt their practice of medicine in the way it was done about 75 years before the apartheid policy.

Missionaries and medicine

There has been a great deal written about missionary medicine in Africa. Works have proven the pioneering role of missionaries in introducing Western medicine and public health in Africa, long before colonial states could provide health services to local people.[7] Further re-examinations objected that this was not true everywhere, as missionaries were often part of the early colonial health services.[8] This unfolded into the analysis of the relationship between missionary and states' medical services delivery, pointing out the specificity in each other, and affirming that missionary medicine was rather rural, mostly curative, and the state medicine, urban, both curative and preventive, and somewhat better suited to the needs of people. These debates have gone further, tackling the role of African medical auxiliaries, and turning them from docile and naïve little more than agents to very alert workers who could "translate missionary medicine in ways missionaries could neither imagine nor control".[9]

Our research confirms that the initial intention of medical missionaries in Africa with regards to Swiss missionaries was to win souls for Christianity. The Swiss acknowledged that they "came into Africa in order to save the heathen [sic] through Christ and to lead him on the path

7 Charles M. Good, Pioneer Medical Missions in Colonial Africa, in: Social Science & Medicine. 32/1 (1991), pp. 1–10; Deborah van den Bosch Heij, Spirit and Healing in Africa: A Reformed Pneumatological Perspective, Bloemfontein 2012; O. Akerele et al., Evolution du rôle des missionnaires médicaux en Afrique, in: Chronique de l'OMS 30/5 (1976), pp. 187–193; David Livingston, Missionary Travels and Researches in South Africa. Including a Sketch on Sixteen Years' Residence in the interior Africa, London 1857.

8 Michael Jennings, 'Healing of Bodies, Salvation of Souls': Missionary Medicine in Colonial Tanganyika, in: Journal of Religion in Africa 38/1 (2008), pp. 27–56.

9 Walima T. Kalusa, Language, Medical Auxiliaries, and the Re-Interpretation of Missionary Medicine in Mwinilunga, Zambia, 1922–1951, in: Journal of Eastern African Studies 1/1 (2007), pp. 57–78, p. 57.

of sanctification".[10] That evangelical purpose was clear in the original call to embark on missionary work made on May 17, 1869 by the pioneers, E. Creux and P. Berthoud, students at the Faculty of Theology of Lau sanne.[11] The Synod's decision to create the *Mission Vaudoise* Society on April 28, 1875 served only to legitimize and bless the wider evangelical enterprise.[12] The subsequent establishment of the first Swiss mission station at Valdezia on July 9, 1875 provided a point of entry into the countryside.[13] Four years later, a second mission station was founded in 1879 at Elim, about 20 km from Valdezia. Missionary activities at Elim grew quickly thanks to the work of Rev. Creux and that of African evangelists, such as a newly converted named Jonathan.[14]

The medical activities started in the 1880s at Valdezia, intensified at Elim in the late 1890s. As patients grew at Elim, the space needs quickly outgrew the missionary watermill, which had accommodated the medical work.[15] Although money was in short supply, there was a need to construct a mission hospital. For a number of reasons, including the lack of funds and the fact that the spiritual work was the priority, the introduction of Western medicine to the pre-existing Swiss missionary activities caused tensions within the mission society. Its headquarters in Lausanne did not want to spend much money on secular activities. This looks surprising, as at the time, the organization of medical missions was already an issue of growing interest within Swiss missionary circles and internationally. It was obvious that medical activities would lure people to the faith. In Switzerland, that idea took hold not only in the French-speaking cantons but the Basel Mission in the German-speaking part was also involved in what has been called the *Ärztliche Mission* (medical mission).[16] As Michael Gelfand points out, the appointment of qualified doctors aimed to serve the wider evangelical purpose in rural South Africa like in other parts of the world.[17]

10 Archives du Département Missionaire de Suisse Romande (DMR) 1.4. Rapports du Conseil, 1883–1885, p. 3.
11 Bulletin de la Mission Suisse au Sud de l'Afrique (BMSA), Les premiers pas de la mission vaudoise, 1/1 (1872), pp. 4–7.
12 BMSA 30/382 (1919), pp. 19–20.
13 BMSA 1/17 (1875), pp. 285–294.
14 DMR 1.4. Rapports du Conseil, 1883–1885, pp. 19–20.
15 C.F. van de Merwe, Elim Hospital. The first 100 years, in: South African Medical Journal 91/12 (2001), pp. 1069–1072.
16 Friedrich Hermann Fischer, Der Missionsarzt Rudolf Fisch und die Anfänge medizinischer Arbeit der Basler Mission an der Goldküste (Ghana), Herzogenrath 1991.
17 Michael Gelfand, Christian Doctor and Nurse. The history of medical mission in South Africa from 1799–1976, Sandton 1984.

Yet, most members of the headquarters in Lausanne would have preferred dedicating more time and energy to evangelization although the founders of the Swiss missionary work in the region, Berthoud and Creux, were involved in the provision of healthcare to European missionaries on the field, including non-Swiss missionaries of the Berlin Mission, and to the Afrikaners and the Africans around Valdezia and Elim missionary stations since the 1880s.[18] Consequently, Swiss mission health service delivery was adapted to the situation: it remained small in scale, confined within the Missionary watermill; practices were adapted as well: essentially curative, rather unsuited to the needs of the communities, and without encouragement to seek better biomedical interventions, suitable cures, and the involvement of medical technologies.

Later, a Swiss missionary with formal medical training had to be appointed. G. Liengme, a young man from Cormoret (Jura bernois) received support from the Mission Society to study medicine at Bern and Geneva Universities. He graduated in 1890, and his consecration as a missionary medical doctor took place in Geneva on 12 July 1891.[19] He then went to Africa, first to work in Lourenço Marques and Mandlakazi, Mozambique, before moving to the North-eastern Transvaal in 1895.[20] This corresponded with the progressive increase in health care needs in the region and beyond. Dr Liengme provided medical care to people. But he had to lead the mission station of Shiluvane for a couple of months as well. He finally was asked to settle at Elim where he added his formal expertise to the rudimentary medical activities begun by E. Creux.

As the first qualified missionary medical doctor within the Swiss mission society in SA, Liengme's daily medical practice first consisted of the diagnosis and the care of simple cases of ulceration, Malaria fever, bilharzias, etc.[21] The focus was on anatomical or other local pathologies, because the lack of adequate equipment did not allow in-depth examinations, although this lack of means was not a Swiss specificity.[22] Then he

18 DMR 4.1. Rapports du Conseil, 1883–1885; 1886. The 1886-Swiss missionary report indicated on page 24 that "the most senior of our colleagues has successfully continued his medical proselytization, providing care to both bodies and souls of a number of sick people"; regarding the Mission of Berlin in the region, see: Alan Kirkaldy, Capturing the Soul. The Vhavenda and the Missionaries, 1870–1900 (Pretoria 2005).

19 Hines Mabika, Histoire de la santé publique et communautaire en Afrique: le rôle des médecins de la mission au sud de l'Afrique, in: Gesnerus. Swiss Journal of the History of Medicine and Sciences 72/1 (2015), pp. 136–159, p. 139.

20 BMSA, Lourenço Marques, 8/100 (1891), pp. 361–363.

21 Elim Hospital Archives (EHA), Patients Registers, 1900.

22 Scholars have shown the instrumentality of science and technology to face local hesitation regarding the European influence in new settlements. See: Daniel Headrick, The Tools of Empire: Technology and European Imperialism in the 19th Century, New York 1981.

performed operations, using hypnosis rather than Ether for anaesthesia, and praying before every surgical intervention. Dr Liengme's accounts mentioned that his prayers had made him famous in the region and beyond. But he had to be ready to treat everything, and to practice the most simple as well as the most delicate operation. Because he could not send patients to specialists – there was no other physician in the region –, he needed all necessary instruments at his disposal, but could not get everything from the mission.[23]

Nevertheless, Swiss medical missionaries, like other Western physicians, considered the medical model in which they understood illness as the result of a particular lesion or dysfunction, and "the role of health professional (was) to identify the location and nature of the lesion or the clinical imbalance and to implement appropriate measures to correct the problem".[24] Certainly, late 19th-century medicine, marked by significant progress in methods of diagnosis and discoveries of new therapeutics, provided Swiss medical practitioners with a feeling of confidence in curing and caring for the Tsonga or Shangaan. But, in the field, they could not avail of all the medical tools available in their country of departure and training.[25]

Like their counterparts elsewhere, they also aimed at demonstrating the superiority of Western medical culture that would lead local people to abandon their belief in witchcraft and traditional healers.[26] Also like elsewhere, Swiss medical missionaries first ignored the influence of space, environmental and socio-political conditions of health and disease in SA as enlightened by Randall Packard.[27] As a result, they faced many unexpected challenges to their practice of medicine, including economic, geographical and cultural difficulties.

Thus, in addition to tensions within the Swiss mission society, the practice of Western medicine brought into that rural area not only generated profound changes; it was itself subject to change.[28] The environ-

23 Georges Liengme, Un hôpital Africain, Neuchâtel 1906, pp. 43–50.
24 Stephen Polgar, Shane A. Thomas, Introduction to Research in the Health Sciences (London 2008), p. 9.
25 According to P. Harries, this was one of the Swiss ways of bringing Europe to Africa. See: Patrick Harries, From the Alps to Africa: Swiss missionaries and Anthropology, in: R.J. Gordon, H. Tilley (eds), Anthropology, European Imperialism, and the politics of Knowledge, Manchester 2007, pp. 201–224.
26 Charles M. Good, The Steamer Parish: The Rise and Fall of a Missionary Medicine on An African Frontier, Chicago/London 2004; Kalusa, Language, Medical Auxiliaries, and the Re-Interpretation of Missionary Medicine (9), p. 57.
27 Randall M. Packard, White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa, Berkley 1989, p. xvi.
28 Patrick Harries, David Maxwell (eds), The Spiritual in the Secular: Missionaries and Knowledge about Africa, Grand Rapids 2012.

ment, understood as aspects of the surroundings of the location, the local realm, ultimately influenced local epidemiology as well as medical attitudes and practices.[29] The region was poor and unhealthy. J. Tempelhoff describes the Boers' occupational system of the region, and P. Coquerel reminds us that the Van Rensburg trek soldiers had been decimated by fevers in the Soutpansberg area earlier in the 19th century before they faced the hostility of the indigenous people.[30]

Continuing into the first three decades of the 20th century, syphilis, tuberculosis and malaria fever were widespread in the region.[31] The subtropical climate of Elim village with hot, rainy summers and mild, dry winters was a cause of recurrent flu epidemics and fevers. The illnesses the Swiss encountered in that environment had a momentous impact on their understanding of the epidemiological situation, as well as on their methods of handling the morbidity. In addition, the social and human realm contributed to a lack of hygiene and other skin diseases such as mycosis and ulcers among the people of the area and its surroundings.[32]

These natural and social conditions shaped the Swiss medical practice in many ways at Elim and the broader region of Soutpansberg. But, the manner in which medical practice was shaped has been underresearched for long time in spite of a number of works that helped reconstruct the history of the Swiss missionary society.[33]

Yet, pioneers of the Swiss missionary medicine in the region had undoubted medical skills although no formal training before Dr Liengme.[34]

29 The Oxford Concise Medical dictionary defined the environment as any or all aspects of the surroundings of an organism, both internal and external, which influence its growth, development, and behavior.

30 Johann Tempelhoff, Die okkupasiestelsel in die distrik Soutpansberg, 1886–1899, Pretoria 1997; Paul Coquerel, La nouvelle Afrique du Sud, Paris 1992, p. 46.

31 J.A. Rees, Health Patterns in the Northern Transvaal, 1900–1932, Johannesburg 1992, p.1.

32 EHA, Patients registers, 1900–1915; Georges Liengme, Quelques observations sur les maladies des indigènes des provinces de Lourenço Marques et de Gaza, Bulletin de la Société Neuchâteloise de Géographie (1894–1895), pp. 180–191.

33 Arthur Grandjean, La mission romande: ses racines dans le sol suisse romand: son épanouissement dans la race Thonga, Lausanne 1917; Jan van Butselaar, Africains, Missionnaires et Colonialistes, Les origines de l'église presbytérienne du Mozambique, Leiden 1984; Patrick Harries, Butterflies and Barbarians. Swiss missionaries and Systems of knowledge in South-eastern Africa, Oxford 2007; Hines Mabika, Religion et Politique dans le Bulletin de la mission Suisse dans l'Afrique du Sud, in: Schweizerische Zeitschrift für Religions- und Kulturgeschichte 106 (2012), pp. 85–105; Hines Mabika, La mission médicale suisse au sud de l'Afrique, 1875–1976, in: M.-Cl. Mosimann-Barbier et M. Prum, Missions et Colonialisme: Le Lesotho à l'heure du bicentenaire d'Eugène Casalis, Paris 2013, pp. 167–183.

34 Their skills were elementary. The training was short but intensive enough to allow them to handle health-related concerns before the appointment of qualified medical doctors. E. Creux had spent only one year's hospital training in Edinburgh after his theological studies in Lausanne; P. Berthoud, three years.

They adjusted their ways of performing medicine essentially by adapting processes of diagnosis, which were simplified, as technical investigations were almost impossible owing to the lack of equipment, at least in the early decades of their medical service. In fact, this adaptation was influential in shaping medicine in the rest of that part of SA. Previously, rural people had been almost entirely left to their own fate.

With the introduction of Swiss medical activities, both black and white patients in that countryside could seek health care from Swiss missionary stations.[35] Swiss missionaries had a distinctive medical background, as the professionalization of medicine was processing in Switzerland as it was in most Western countries, reinforced by the new 19th-century biomedical theories of microbiology.[36] Their consideration of illness as a dysfunction similar to a lesion within the human body was rooted into the broader Western medical tradition. By this time, hospitals in Europe – their transformation having recently changed from a place where the dying and destitute awaited their death – had become an important social and medical institution, central to the provision of health care.[37] This hospital-based health care as first established in Europe came to be experienced elsewhere as well, including Africa.[38] Berthoud, Creux, and Liengme left Switzerland for Africa with medical skills entrenched in the hospital and clinical medicine, which was based on both clinical semiology and pathological anatomy.[39] But that Western idea of medicine was soon challenged by the new surroundings of SA.

The first Swiss who reached the North-eastern Transvaal were mostly from the western part of Switzerland where the realities could hardly be more different from the new realm they found in Africa. Malaria, various endemic fevers, the scarcity of the population, and the lack of money

35 DMR 4.1. Rapport du Conseil, 1883–1885, 15–16. According to Paul Berthoud, local people could be made aware of the Gospel, thanks to health-related problems that brought them to the missionaries.

36 Toby Gelfand, Professionalizing Modern Medicine, Paris Surgeons and Medical Science and Institutions in the 18th Century, Westport 1980; Rudolf Braun, Zur Professionali sierung des Ärztestandes in der Schweiz, in: Werner Conze, Jürgen Kocka (eds), Bildungsbürgertum im 19. Jahrhundert: Bildungssystem und Professionalisierung in internationalen Vergleichen, Stuttgart 1985, pp. 332–357; Jacques Leonard, Les médecins de l'ouest au XIXe siècle, Lille 1978; Eliot Freidson, Profession of Medicine, New York 1970.

37 Gunter Risse, Mending Bodies, Saving Souls. A History of Hospitals, Oxford 1999; Harrison/Jones/Sweet, From Western Medicine to Global Medicine; Pierre Guillaume, Le rôle social du médecin depuis deux siècles, 1800–1945, Paris 1996.

38 John Iliffe, East African doctors. A history of the modern profession, Cambridge 2002; Howard Phillips, The Cape doctor in the Nineteenth century: A social history, Amsterdam/New York 2004.

39 Joel D. Howell, Technology in the hospital. Transforming Patient Care in the Early Twentieth Century, Baltimore/London 1995; Charles Lichtenhaeler, Histoire de la médecine (Paris 1975), p. 431.

and infrastructure – all these led the Swiss to adapt their practice, meaning not only the medical processes of diagnosis and treatment, but also attitudes, technical tools, and actions that tended to conform to social norms.

Caroline Currer and Meg Stacey have shown that:

> the manifold problems of communication between doctor and patient derive from their differing conceptualisation, that professionals mistake alternative conceptualisation for ignorance or wilful misunderstanding, or that medical dominance evaluates in the only acceptable understandings of illness being those which are conceptualised in the mode of biomedicine.[40]

The local conception of disease incorporated the local culture, beliefs, society and economy into the explanation and the understanding of illness, leading Steven Feierman to see 'plural healing systems' as that in which several modes of healing knowledge, practices, and agents co-existed.[41] Tsonga people as most Africans had their traditional medical system that relied on an 'animistic faith'. They believed that ill health, most misfortunes, and death, were due to malevolent and unseen action.[42] By the late 1890s, they needed Western medicine as well. Dr Liengme went back to Switzerland in 1898 to raise funds for the construction of a hospital at Elim. To this end, a funding body was created under a private society, the *Société Immobilière*. The records of that organization, including Liengme's writings, are not fully clear about the sources of the capital used to build the first Swiss mission hospital for the Transvaal. For sure, the donations did not come from the missionary society but likely from a few wealthy members of the Swiss Free Churches. Thus, the *Société Immobilière* had to be distinguished from the evangelical mission. Consequently, it became a fund that raised money for the construction of several missionary buildings in the field.[43] The society raised CHF 132,000 for the Elim Hospital. The timely nature of the project is reflected in the fact that the Government of the Republic of South Africa officially offered the Mission, "the necessary capital to build a hospital for White and Blacks".[44] The mission decided for strategic reasons only

40 Caroline Currer, Meg Stacey, Introduction, in: C. Currer, M. Stacey (eds), Concepts of Health, Illness, and Disease. A Comparative Perspective, Oxford/Providence 1993, pp. 1–6, p. 1.

41 Steven Feierman, Change in African Therapeutic Systems, in: Soc. Sc. and Med. 13B (1979), pp. 277–284.

42 Alexandre Junod, The Life of an African Tribe, London 1926; Walima T. Kalusa, Megan Vaughan, Death, Belief, and Politics in Central African History, Lusaka 2013.

43 DMR 1.18. Société Immobilière. Transformation de la Société Immobilière en Crédit foncier, 1893–1908.

44 Ibid. (no. 42), p. 8.

to use the Swiss money it had raised, making Switzerland active in the colonial and imperial context although the country had no colonial ambitions.

Elim Hospital, stone by stone (1899–1948)

The history of Elim Hospital illustrates the co-production between medicine, and the natural and political environment.[45] This was hardly unique compared to other medical missionaries in Africa and Asia at the time.[46] A closer examination, however, shows noteworthy differences. In addition to money obtained from the *Société Immobilière* in 1898, the plans and the architect, A. Thomas, were Swiss, showing the missionaries' preference for Swiss resources. In an effort to minimize the building cost, Thomas advised Liengme to get prefabricated buildings from Europe. Not finding a suitable manufacturer in Switzerland, Liengme asked the architect to look in France. Thomas noted:

> I am honoured to report on what I have seen (in France) as well as on the costs. As a result, I do not think anymore that the prefabricated buildings are the best solution for your hospital at Elim. Even if we choose the cheapest model, the costs remain higher than if we construct with red bricks (a local material) with a metal roof and a ceiling of wood.[47]

The Swiss doctor therefore decided to use local materials, and that meant red bricks made in kilns by local people. Thomas travelled to Elim and started the first building, the African patients' pavilion which was inaugurated in August 1899. A year later, in September 1900, the building intended for the Europeans admitted its first patients.[48] Liengme stated that President Kruger himself was impressed by the work done there, and Sir Arthur Lawley, Lieutenant Governor of the Transvaal, visited the hospital on 14 October 1904.[49]

The Swiss missionary health service delivery in the NT was not without problems. From its very first years, the hospital faced difficulties ranging from the shortage of resources to conflicts between individuals. For example, Liengme was joined by another doctor, J. Borle[50], who came

45 Hines Mabika, History of Hospitals in Africa, in: Médecine Tropicale 69/1 (2009): p. 26.
46 Catharina Nord, Healthcare and Warfare. Medical Space, Mission and apartheid in Twentieth Century Northern Namibia, in: Medical History 58/3 (2014), pp. 422–446.
47 DMR 5.1. Lettre d'Alexis Thomas à Mr. Le docteur Georges Liengme, Château d'Œx, 15 août 1898.
48 EHA, Buildings, 1899–1900.
49 Archives du Château de Penthes – CHP, Rapports de Georges Liengme, 1904, p. 128.
50 A Swiss Physician from the Canton of Neuchâtel who ran Elim hospital from 1906 to 1911, and from 1914 to 1918.

from Switzerland in 1905 in response to growing medical activities at Elim. By April of that year, Liengme expressed some doubts about the morals of his new colleague. This soon turned into a bitter animosity between the two physicians. The following year, Liengme went back to Switzerland seeking a resolution at the headquarters, but instead, he was forced to resign and never returned to Elim.[51] At that time, the Swiss mission headquarters were already considering handing over the ownership of the hospital to the Government of the Transvaal, mainly for economic reasons.[52] The argument on economy hardly overshadowed tensions and Lausanne's unwillingness to implement medicine as part of its missionary undertaking.

The medical practice at Elim did not change immediately after the departure of Liengme. It was typical of hospital-based medicine in Africa. Patients came to the hospital for care, and the reports of the number of patients treated rose over time. In 1906, 87 white patients (including 37 'paupers') were treated, with an average of three patients a day. That same year the number of black patients was 519 with an average of 40 a day.[53] Borle who became the Elim Hospital director in 1906, resigned from that position in 1911, then returned to the hospital from 1914 to 1918.[54] In the short interim, Dr de Ligneris[55] served as the head of Elim Hospital and introduced new medical technologies, including X-ray equipment and a laboratory.[56] This marked a significant change in medical practice especially in the process of diagnosis.

At the same time, there was a need to adapt the hospital to local customs. Thus, *rondavels*, which were the typical style for the traditional homes of the Tsonga people, were built in 1912 at Elim Hospital.[57] These *rondavels* wards aimed at conforming accommodations to local realities. They also responded to two additional concerns: the lack of funds for

51 CHP. Liengme's letters: Dr Liengme's letter to Doctor Borle, April 1, 1906; Dr Borle's response, April 5, 1906; Dr Liengme opened one of the first psychiatric institutions in the rural area of Neuchâtel in 1908, and continued his medical practice up to his death in 1936.

52 DMR 1.18. Société Immobilière de la mission romande. VIII[e] rapport de gestion du Conseil d'Administration, exercice 1907, p. 13.

53 EHA, Booklets IV. Statistics of patients and finances, 1901–1952.

54 Arthur de Meuron, Dr James Borle, in: BMSA 30/392 (1918), pp. 165–166. He definitively left Elim in July 1918 for a private practice in Johannesburg where he died of influenza on October 17, 1918.

55 Dr de Ligneris ran Elim Hospital from 1912 to 1914, and from 1918 to 1928. He is known as the physician who introduced several technological devices linked to the practice of medicine at Elim. He also tried to adapt to the local environment.

56 DMR 5.1. Hôpital d'Elim. Procès verbal de la séance de la Commission de l'hôpital d'Elim, 14 janvier 1913.

57 EHA, Maps. Historical development. Design drawings by Nadine Jacques, 1930.

more elaborate buildings and the need for separate wards to accommodate male and female patients. This gender division took cultural considerations into account and also facilitated such practices as the order in which in-patients received medical visits. Thus, the doctor visited male patients' *rondavels* before proceeding to those dedicated to female patients, disclosing power, sex, and status at the hospital.

When de Ligneris came back in 1918, he was re-appointed as the director of Elim Hospital and served for another ten years. At the same time, new rules about the hospital management created the position of an administrator, besides a medical doctor, and three missionaries to lead the hospital. On this team, designated the Commission, the medical doctor remained very influential, but the missionaries insured that Elim remained a faith-based hospital. The need for more buildings, particularly between 1925 and 1948, demonstrates that local people increasingly used the hospital.[58] For example, in 1937, there were 1,656 black patients treated at Elim compared to 1,475 patients the year before.[59] Although they accepted new medical practices, the African patients also continued to use traditional medicine.[60] Nevertheless, there was a change in the health behaviour of local people, and the hospital now served people living far beyond its immediate surroundings. Patients came from far as Giany and Tzaneene. The growth of patients resulted in the opening of a new hospital in May 1938 including a new maternity ward, which reflected the introduction of specialized care for mothers and infants at Elim.[61] Further evidence of this specialization was the opening in the early 1940s of the ophthalmic ward under Mrs Dr O. Rosset-Berdez. Thus, the practice of medicine became increasingly specialized, mirroring the general proliferation of medical specializations after 1945 in Western medicine.[62]

At the same time, the Elim Board responded to the call from the Indian community for the construction of an Indian ward within the hospital, which was opened in 1949.[63] Further accommodation due to growing demand especially from patients who could not afford to travel from their homes to Elim Hospital was solved by opening several clinics and dispensaries in villages around Elim and beyond, such as in Valdezia, Tlanguelane, Shiluvane, or Masana. Some of these health institutions,

58 DMR 5.1. Hôpital d'Elim. Rapport de l'hôpital d'Elim, 30 septembre 1925, p. 1.
59 Nouvelles de nos missions médicales (NMM), 10 juillet 1938, p. 5.
60 Anne Digby, Diversity and Division in Medicine (no. 3).
61 BMSA, Inauguration du nouvel hôpital des Noirs à Elim 38/561 (1938), pp. 112–117.
62 William F. Bynum and al., The Western Medical Tradition, Cambridge 2006, p. 438.
63 EHA, Elim Hospital Board. Minutes, 1945.

namely Masana and Shiluvane, became full-fledged hospitals in the 1940s. These Swiss achievements in the field of health were part of what has been called the decade of opportunities by Dubow and Jeeves, a "period in which several different worlds were mooted in ways".[64] That South African world of access to health care, unfortunately, was incompatible with the coming regime of apartheid. Indeed, the Gluckmann report of 1945, *The Health of the Nation*, which aimed at assessing the state of health of the people of SA as a nation in order to implement an efficient health system for the whole country, could not get consideration from the new policy.[65]

Shaping Health Agents

The medical work at Elim relied on several agents, namely individuals and institutions that introduced the Western medical culture and/or determined health services delivery in NT villages. The individuals consisted of patients and staff members while the institutional ones included the hospital itself, the Church, the missionary society and the local administration.

Roy Porter's 1985-influential article on the 'patient's view' considers patients to be part of the health enterprise from the perspective of the social history of medicine, even though there are disagreements about the construction of patients as a group with particular historical concerns.[66] Patients as individual health agents within the Swiss medical endeavour in SA comprised the Africans or blacks, the Europeans or whites, and the Asians, particularly the Indians.[67] At Elim, white patients consisted of Swiss missionaries and other Europeans, such as the Berlin missionaries, but also white South Africans, mostly the Afrikaner farmers. Beside the administration, individual Afrikaner settlers constituted

64 Saul Dubow, Alan Jeeves, South Africa's 1940s: Worlds of possibilities, Cape Town 2005, p. 16.

65 Detailed insights on the South African National Health Service are available. See: Shula Marks and Neil Anderson, Industrialization, Rural Health and the 1944 National Health Services Commission in South Africa, in: S. Feierman, J. M. Janzen (eds), The Social Basis of Health and Healing in Africa, Berkley/Los Angeles 1992, pp. 131–162.

66 Michel Foucault, La politique de la santé au XVIII^{e} siècle, in: M. Foucault [and al.], Les machines à guérir. Aux origines de l'hôpital moderne, Paris 1976, pp. 11–21; David Armstrong, The Patient's view, in: Soc. Sc. and Med. 18/9 (1984), pp. 737–744; Flurin Condrau, The patient's view meets the Clinical Gaze, in: Soc. Hist. Med. 20/3 (2007), pp. 525–540.

67 People of Chinese descendants are lacking in the records. This may be due to their numerical insignificance around Elim although they were already part of the population of the Transvaal and of the country. See: Melanie Yap and Dianne Leong Man, Colour, Confusion, and Concessions: The History of the Chinese in South Africa, Hong Kong 1996.

somewhat groups of pressures towards segregation on the way to apartheid. Their presence meant that part of the medical service was expected to be at high medical standards. This progressively became the case with professional knowledge of clinical pathology, anatomy and later, ophthalmology. In addition, Elim doctors often treated white patients at their homes, and some of the letters sent to Dr Liengme indicate that white patients could get therapeutics or treatments without an additional or even a primary diagnosis.[68] Significantly, such medical practices might well have been unacceptable in Switzerland even at the time, as procedures and norms within the practice of medicine were already quite well organized.[69] Hence, this is another example of the influence of local relations on the Swiss medical practice.

In addition to therapeutic procedures, white patients at Elim influenced decisions within the hospital management in other ways. This happened as early as 1900 when Rev. E. Creux asked Dr Liengme to treat leprosy patients. White patients strongly expressed their disapproval of a leprosy clinic at Elim while other European missionaries such as those of the Berlin missionary society would later experience a Leper and Syphilis hospital at Blauberg yet less successfully. Another example was the decision by the Transvaal Provincial Administration in 1915 to build the Louis Trichardt Hospital for white patients.[70] This grew out of complaints by white patients about their hospital fees, which they claimed were paying for the blacks who had no fees. The hospital cashbooks confirm that while black patients paid a total of £476.5 from 1 October 1919 to 31 March 1920, the white patients' fees were four times as much (£1,781.3), although the total number of white patients was a third of the number of black patients.[71] There was recurrent debate on this subject during decades that followed. Although the decision to construct the Louis Trichardt Hospital was taken during WWI, the Transvaal Administration did not act on it until the beginning of the apartheid policy.

In fact, the Swiss hospital had been segregated from the start, and whites, particularly those who paid fees, received better treatment. Their diet was also more balanced compared to the rations offered to destitute

68 EHA, A sample of letters written to physicians at Elim indicates: "Dear Sir [Dr Liengme], I want to let you know again how I am. I still got the pain beneath my heart and round to the Back, and then I have twice been vomiting … When [I] was vomiting it seems like spleen … please, send me again of the medicyne you sent me the first of the white medicyne for my daughter … Yours sincerely, C.M.S., Dreifontein, 22 April 1900".

69 BSNG, La Chaux-de-Fonds 1 (1884), pp. 116–117.

70 DMR 5.1. Hôpital d'Elim. Lettre du Dr Borle à Monsieur de Meuron, 30 avril 1917.

71 DMR 5.1. Hôpital d'Elim. Comptes de l'hôpital d'Elim, du 1er octobre 1919 au 31 mars 1920, p. 9.

white patients and to the Africans.[72] Overall there was a significant increase in the number of paupers or free patients. While 51 of the 185 European patients were so designated in 1922, more than half of the Europeans treated in 1932 (219 of 386) were registered as paupers.[73] This obviously also reflected the bad economic situation at the time but the archives also mention that some of the Afrikaners were registered as paupers even though they owned farms. But, based on the hospital statistics at least, African patients were obviously the most numerous in the health system.[74] The Swiss justified their presence in the region by the necessity to care for the Africans both spiritually and physically.

Beside the patients, health professionals constituted another significant category of health actors. Before the apartheid policy, individual health professionals consisted broadly of medical doctors, nurses, auxiliary nurses, health administrators, and helpers. Although Elim Hospital remained understaffed during the entire fifty years that followed its construction,[75] it functioned well with its limited resources. While at the time of its beginnings, the hospital personnel consisted of one medical doctor and two helpers, Elim could, at the coming of apartheid, claim a team of three doctors, an ophthalmologist, six white nurses, seven white auxiliary nurses, thirty-eight black auxiliary and pupil-nurses, one secretary, one person responsible for the training of nurses, one laboratory specialist, one person responsible for provisions, another person responsible for buildings, and 115 black helpers and manual workers.[76]

This was in addition to local and national governments with their administrations, the various mission societies, Swiss and local churches which were involved in the provision of health service at varying degrees.[77] Beyond the segregated urban state health system-rural missionary health system, the Transvaal Provincial Administration ran public hospitals, schools, health programmes and medical assistance for destitute or 'paupers' like everywhere in the Union of SA. Interactions between the administration and missionaries included health school programmes and medical assistance to white paupers. Moreover, local au-

72 BMSA, 40/522 (1933), 15, 'Poor white' meant anyone white who did not have money in a bank account. He (she) had the right to register as poor even though "he (she) has a farm".
73 EHA, Statistics, 1922–1932.
74 EHA, Statistics, 1922–1942; Elim Hospital patients' registers, 1900–1948.
75 Numa Jacques, Quelques impressions sur l'hôpital d'Elim, 19 décembre 1932, in: BMSA 40/516 (1933), pp. 214–218.
76 EHA, Annual report, Staff, 1948.
77 Caroline Jeannerat, Eric Morier-Genoud, Didier Péclard, Embroiled: Swiss Churches, South Africa, and Apartheid, Zurich 2011, pp. 36–42.

thorities supervised environmental health services such as sewage disposal. Cedric de Beer has also noted that the state provided hospitals and other facilities with grants for dealing with infectious diseases such as TB.[78] As a provider of grants and other subsidies, the Transvaal administration and the South African central government exercised significant influence within the hospital at Elim.[79] The administration was represented within the Hospital Board of Management. But, decisions taken about medical practice and all health services delivery had a kind of 'Swissness', to the extent, they were the product of their cultural and national background.

As the hospital was seen as a faith-based institution, it had to demonstrate the power of God in order to win the souls of local people for Christianity. For that purpose, there was a Chapel within the hospital since 1921.[80] This became one of the most frequently used parts of the hospital where staff and patients attended prayers and related activities. The first black matron at Elim observed that the daily morning prayers were at half past five, and the staff worked longer hours: "We were committed",[81] she said. That commitment and devotion were part of the values, which had to be emphasized, and which characterized Swiss missionary medicine. So, according to a memorandum from a Hospital Board meeting of 1943, as a Christian hospital, Elim "was established and has been kept in being by men and women who gave themselves for Christian work, often at considerable personal sacrifices, and who were determined to follow, as far as lay their power, the example and precepts of Christ".[82] There was a permanent interaction and an obvious absence of frontiers between the spiritual and the secular. Nor was this sentiment absent from the medical staff as seen earlier with Liengme's prayers before surgical operations.[83]

While coping with anything that helped to overcome Swiss limitations, its missionary's worldview tended to ignore the African world and especially the local people's own system of healing. People believed in witchcraft and other diviners, and approached missionary medicine,

78 Cedric de Beer, The South African Disease. Apartheid and Health Services, Yeoville 1984, pp. 18–19.
79 EHA, Cashbooks, 1900–1949.
80 BMSA, 33 (1922), p. 439.
81 Interview no. 1 (PSM1), Elim Waterfall, December 2008 and July 2009.
82 EHA, Elim Hospital Board. Memorandum, 1943, p. 1. See also EHA, Hospital Board of Management, 1940, p. 1.
83 CHP, Dr Liengme: Lettres à sa famille. Dr Liengme's letters to his family often expressed the Boers' admiration towards him, as they had never seen a medical doctor praying before surgical interventions.

knowing that certain misfortunes related to their system of beliefs could not be cured by European medicine. Such beliefs existed in the whole country. Julie Parle has shown how among other South African people, such as the Zulu in Natal, women's mental illness was associated with possession by mal ancestors.[84] These beliefs led local people to approach Western medicine with scepticism.[85]

Furthermore, the mission headquarters and most of the Free Churches in Switzerland did provide the hospital with mainly Swiss staff. Their aim was to further the care of the local African population, which resulted in some dissatisfaction among missionary nurses assigned to the care of the Afrikaners in the 'white hospital'.

The Swiss mission society expected the hospital to support itself.[86] Even though the financial means of the medical mission initially came from Church funders and other donations collected during church activities like Sunday services and sales campaigns, those resources soon revealed themselves to be insufficient.[87] The donations properly designated to the medical mission are difficult to estimate, because they were part of the general donations given to the mission by Christian communities in Switzerland and SA. One figure reported for the general donations was CHF 1,164.90 on 15 May 1948.[88] This was only a small part of the hospital operating budget, most of which relied on significant grants provided by the local administration.[89] That support, in turn, played a large role in persuading the Swiss to make their medical practice conform to the socio-political framework of the state.

Challenges to Medical Practice

Since the end of WWI, Elim Hospital faced many dangers that sometimes brought it close to closing its doors.[90] These included the 1918 influenza pandemic, and the more mundane but perennial problem of

84 Julie Parle, States of Mind. Searching for Mental Health in Natal and Zululand, 1868–1918, Durban 2007.

85 David Hardiman, Healing Bodies, Saving souls: Medical missions in Asia and Africa, Amsterdam 2006. Hardiman emphasizes the fact that such beliefs were not experienced solely in Africa but globally.

86 DMR 5.1. Hôpital d'Elim. 1. Mission médicale de la mission Romande. Balances. Bilans, 1899–1921.

87 NMM, Caisse du fonds d'entre-aide de la mission médicale 24 (1948), p. 15.

88 Ibid. (no. 85).

89 BMSA, 40/522 (1933), p. 214: "This hospital assumes its expenditures with fees paid by white and black patients who can, and significant subsidies provided by the Government of the Union of South Africa and the Transvaal Province".

90 DMR 5.1. Hôpital d'Elim. 7. Rapport sur l'avenir de l'hôpital d'Elim, novembre 1919.

the lack of funds and of staff. The Swiss mission did not directly provide financial means, and most of its operating funds came from a local government subsidy.[91]

The global influenza pandemic of 1918 had a terrible affect on the African continent as it did worldwide.[92] In SA as a whole, the epidemic caused "probably more than a quarter of a million deaths",[93] and in the Transvaal it was reported that medical staffs were particularly affected. Indeed, twenty-one doctors died of influenza in the southern Transvaal, primarily in Johannesburg and Pretoria.

As a rural health institution located in a tiny village in a corner of SA, the Swiss hospital was obviously not prepared to face such an epidemic. The few therapeutic means that were available revealed their inefficiency, as was the case worldwide.[94] As most works have shown it, there was no effective remedy against influenza at the time.[95] Mrs Eberhardt reported in November 1918, that pupils of Lemana, were among the first affected in their area, and despite all the care provided by the Elim medical doctor, it had been impossible to save all their lives: "Pupils were treated by Ms Bory and Mr Thomas; in spite of all care delivered by them and by the medical doctor, and although we have done all we could by providing strengthening food, chicken stock, etc., their state of health was desperate, three of our girls and two boys died."[96] This report suggests that the response was a kind of *bricolage* (improvisation), using changes in diet regimes to treat ill bodies, when the usual medication had little effect. Outside the hospital, oranges, herbal teas, and other fruits were used, as reported by the missionary, Paul Rosset: "Once a day, Miss Demierre and I, we visit all inhabitants in their homes, and my wife pro-

91 BMSA, 40/522 (1933), p. 214. Numa Jacques reported that: "Elim hospital did not get its financial means from the general budget of the Swiss mission". During the colonial era (1902–1961), its funds came mostly from the Transvaal administration.

92 Howard Phillips (ed.), The Spanish Influenza pandemic of 1918–1919: New perspectives, Oxford 2003.

93 Howard Phillips, "Black October": The Impact of the Spanish Influenza Epidemic of 1918 on South Africa, Pretoria 1990, p. XV.

94 BMSA 30/394 (1919).

95 Niall P.A.S. Johnson, Juergen Mueller, Updating the Accounts: Global Mortality of the 1918–1920 'Spanish' Influenza Pandemic, in: Bulletin of the History of Medicine 76/1 (2002), pp. 105–115; G. Chowell, C.E. Ammon, N.W. Hengartner, J.M. Hyman, Transmission Dynamics of the Great Influenza Pandemic in Geneva, Switzerland: Assessing the Effects of Hypothetical Interventions, in: Journal of Theoretical Biology 241/2 (2006): pp. 193–204; Gina Kolata, The Story of the Great Influenza Pandemic. The Search for the Virus that Caused It, New York/London 1999.

96 BMSA, 30/394 (1919), pp. 199–200.

vided us, according to our needs, with medicines, lemonade, milk, stock, etc. We advise people to sleep outside their houses when it is possible."[97]

The lack of a simple and effective treatment for the influenza resulted in complicated and unexpected results. For example, local people often saw the cures offered by the whites as acknowledgement of the effectiveness of treatments that were offered by local herbalists and other diviners, understanding missionary medicine as it was a variation of local medicine, as Walima Kalusa pointed out regarding Lunda people in Zambia.[98] Similarly, the advice to stay outdoors rather than in their houses, which was aimed at minimizing the risk of infection among family members, was often seen by locals as a way to escape from the evil spirits. Meanwhile at the hospital, the need for isolation wards for patients with contagious diseases was an important turning point that helped Swiss medical practitioners to revisit all theories on asepsis and antisepsis. As a result, other medical practices such as surgery started emphasizing sterilization techniques. Another change following the flu epidemic led the hospital to focus more on health education among local people. Dr de Legneris reported that information campaigns were organized in schools and communities.[99]

The flu pandemic highlighted the difficulties faced by the Swiss hospital as a result of its inadequate financial resources, such as its logistic shortages and the lack of knowledge about such diseases. The hospital reports called the period between October 1, 1918 and September 30, 1919, the dark days, with the disease so widespread that "we will never know the exact number of deaths. The government declared more than 150,000 but we are convinced that the number in this district is more."[100] If the reports are less explicit about the total number of deaths registered at Elim Hospital, the staff saw several deaths within the hospital and in its surroundings, including Dr Borle, and other Swiss missionaries such as Leonard Berthoud. For sure, "five pupils from Lemana school, two children around Elim, twelve workers of the Elim farm died, and there were 26 deaths around Makopong since the emergence of the epidemic".[101] One positive outcome of the epidemic was that the local administration and the state increased their support of the hospital.

97 Ibid. (no. 94), p. 198.
98 Kalusa, Language, Medical Auxiliaries (9), p. 57.
99 DMR 5.1. Hôpital d'Elim. Rapport de l'hôpital, 1 octobre 1918 au 30 septembre 1919, p. 1
100 DMR 5.1. Hôpital d'Elim. Rapport de l'hôpital, 1 octobre 1918 au 30 septembre 1919, 3; Phillips, "Black October" (no. 91), p. XV, assumed about 250,000 deaths in South Africa as a whole.
101 BMSA, 30/394 (1919), pp. 196–197.

Within the framework of the Public Health Bill of 1919 the hospital got an increase in its subsidies and in 1920s underwent a reorganization of its management.[102] The South African Union doubled its grant for each black patient from £400 to £800.

Training local people

One important question about Elim Hospital is the extent to which local people were trained and employed. Since the beginning of the Swiss practice of medicine in the country, Africans were hired, first for domestic tasks (cooking, cleaning, etc.), then as health support staff (translators, auxiliaries, etc.).[103] Two decades after the construction of the Elim Hospital, African staff had become indispensable for the hospital's sustainability. The reason was primarily that from the start the hospital struggled with the lack of funding, which did not allow the appointment of white workers.[104] There were questions about training, but once this was solved the number of African workers continued to increase. This included, by the mid-1920s, African health workers performing technical work, as mentioned in the annual report of 1925: "Now we have two well-trained native nurses besides several helpers."[105] These first African nurses were trained in Natal, a Province which led the way in the training of African nurses and then of doctors.[106] The upper levels of the hospital administration were broadly divided about the African staff.

102 The Public Health Bill of 1919 came in force on January 1, 1920. That bill considered it the duty of the government to care for or support the care and the eradication of infectious diseases as well as venereal diseases.

103 Interview FMG1 Elim – SA, December 2008. According to one of the grandsons of the Elim Hospital's founder, Dr Liengme was very close to the Watsonga people. Members of that people were working 'with him (more probably for him) *since* he reached Southern Africa', that is Mozambique in 1891 and the NT in 1895–1896.

104 DMR 5.1.7. Rapport sur la question de l'avenir de l'hôpital d'Elim par le Directeur de l'hôpital, 1919. See also DMR 8.19. Liengme. Correspondance de Mademoiselle B. Liengme, 1924 which has a letter that mentions P. Malanguti as a nurse working at Elim hospital for more than 14 years (since 1910). An analysis of those writings reveals conHradictory statements about the African worker who is sometimes praised for his good work and strong support but also criticized for his incompetence and irresponsibility. Such contradictions raise questions about the psychology of certain missionaries, and their attitudes about the African as the 'other' at the time. According to the article no. 20 in DMR 5.1. Réglement d'administration de l'hôpital d'Elim adopté pour 1924–1925, missionaries working at Elim Hospital were paid £8 to £10 excluding accommodation and pension. See also DMR 5.1. Commission nommée pour étudier la réorganisation de l'hôpital d'Elim, Lausanne, 5 mars 1924, p. 2.

105 DMR 5.1. Rapport de l'hôpital d'Elim pour l'année se terminant le 30 septembre 1925. Personnel.

106 Vanessa Noble, A School of Struggle: A History of Durban Medical School and the Education of Black Doctors in South Africa, Durban 2013.

The Superintendent was pleased with the help they provided within the shortage of health workers. At the paramedical level, however, white nurses in particular were less willing to have local nurses within the profession.[107]

In 1929, the Native Affairs Department agreed to fund the training of black nurses, which began at Elim Hospital on August 1, 1932. The following decades witnessed the training of increasing numbers of African nurses, motivated not so much by the aim of education or social development but rather to fill the staff shortage.[108] Beyond that, the staffing with local people served to tie them to their homes and to contribute to the development of their region, and thus preclude their migration to cities and locations that were prohibited to them.

Recruits came from schools run by missionaries such as the Lemana School. [109] Although they began to train locals for the evangelical ministry, these schools also provided skills that helped students work elsewhere in the new society. So, apart from the study of the Bible, the teachings included reading, writing, hygiene, education, domestic economy, history, geography, and singing.[110] It was from among these 'educated' people that the applicants for training in nursing were found.[111]

The nursing certificate acquired at Elim Hospital initially qualified recipients only to work at that hospital. As early as 1938, however, the hospital sought the recognition of its certificate by the South African Nursing Training Board. This was initiated by Germaine Erb, the first

107 Correspondences of certain missionary nurses stated in the 1920s that: "the Black still (was) an incapable and not responsible. He (did) not want to become responsible."- Although such assumptions were common at the time, they sound particular in missionary writings, as missionary official discourses on Love would not suppose such thoughts. For background, see Marks, Divided Sisterhood (4); Anne Digby, Howard Phillips (eds), At the Heart of Healing. Groote Schuur Hospital, 1938–2008, Cape Town 2008.

108 DMR 8.19. Liengme. Correspondance de Mademoiselle Liengme, 1928. See also, Historical papers, Wits University, Ac 1084 – 41 Report of the Committee appointed to inquire into the Training of Natives in Medicine and public health; DMR Archives Lausanne 5.1 Lettres du Dr de Legneris, 1924. Letters of the Elim Hospital Superintendent reveal that since the end of the 1920s, the Elim Hospital Administration was asking for the training of local nurses within the hospital.

109 DMR 4.1. Rapport du Conseil, 1885, 11. By the mid-1880s, the Swiss sent two young Tsonga to the Berlin missionary Knothe in North-eastern Transvaal and six others to the Paris Evangelical Missionary Society (Morija, Lesotho), expressing interconnections between missionary societies at that time. According to the BMSA 40/517 (1932), p. 92, the Elim School for the Missionaries in the early 1930s had 17 pupils with 12 males and 5 females.

110 DMR 4.1. Rapport du Conseil, 1885, p. 93.

111 B. Chabalala Masumbe, The Swiss missionaries' educational endeavour as a means for social transformation in South Africa, 1873–1975 (unpublished Master dissertation in history of education, UNISA, 2000).

Swiss responsible for the training of nurses at the Elim Nursing School.[112] Her compatriot, Gabrielle Guye, who replaced her after WWII continued the negotiations. Her background was useful in the process of winning recognition for the Elim training programme by the South African Nursing Council, which went into effect in 1948. Indeed, Miss Guye was a daughter of a Swiss missionary in Mozambique who became the General Secretary of the Swiss Mission in Lausanne. She was born in Africa, and was handed the responsibility for the Elim Hospital training of nurses in 1947, after having been trained and worked as a nurse at *La Source* in Lausanne.[113] She had also received training in the management of nursing schools in London.[114]

Despite this success, the second generation of Swiss missionaries warned of the coming policy and the deterioration of the political situation in South Africa.[115] Long before these rumblings, Elim Hospital, like most hospitals in the country at the time, was already a segregated institution with pavilions for white patients and other buildings for the Africans.[116] This segregation among patients within a mission hospital draws attention to a significant aspect of the social history of patients: the way in which racial and racist policies were trigged within faith-based medical facilities. It appears that, just as the Swiss missionaries had adapted modern medical care to the local customs and resources, so too they adapted other hospital administrative practices to the local socio-political environment.

Conclusion

The way in which missionary medicine was performed in the North-eastern Transvaal during the 75 years before apartheid in SA leans on more entangled reasons than it appears at first view. The reluctance of the Swiss mission society to spend money for secular activities overseas had some drawbacks.[117] The Swiss spiritual and medical influence in South Africa was mainly limited to a corner of the Transvaal in the interna-

112 Interview no. 2 (PSM2), Neuchâtel, February 2009.
113 DMR 1.14. La Source. Ecole romande d'infirmières de la Croix-Rouge suisse, Lausanne. This is where most of the Swiss missionary nurses, who served at Elim Hospital, were trained.
114 BMSA 47/622 (1947), pp. 360–361.
115 BMSA 49/629 (1949), pp. 312–316. See also Hines Mabika, "Religion et Politique dans le Bulletin de la mission Suisse" (32), pp. 1–2.
116 Anne Digby, Howard Philipp, At the heart of healing (105); Simone Horwitz, Health and health care under apartheid, Johannesburg 2009.
117 Jean Paul Zorn, Le grand siècle d'une mission protestante: La mission de Paris de 1822 à 1914, Paris 1993.

tional context of interaction and competition involving English, Dutch, American, and German mission societies.[118] Embroilments between missionaries on the field and the mission society in Lausanne made it even worse by expressing preference for the use of energy and money allied to such medical activities in winning people to Christianity, contrasting to the fully-fledged agenda of spreading the good news for both the soul and the body. This had a bad impact on the quality of medicine practiced on the field, as it meant the lack of funds coming in addition to difficulties related to a local environment and epidemiology of great concern.

This study has placed special emphasis on certain features of that setting: turbulent atmosphere within the mission society, the subtropical diseases such as malaria and various fevers, traditional culture and social organization of the local people, lack of resources valued in world markets, as well as unpredictable events like the worldwide influenza epidemic of 1918 that challenged the Western or European medical model. All of these led the Swiss to adapt their ways of tackling health-related problems in Africa, as they realized that illness reflected more than a particular lesion or dysfunction within the human body. Moreover, the hospital as a sustainable base of Western medical care for people revealed itself as difficult to maintain in this new environment. Although local patients and Swiss philanthropists did not have the resources during the first decades of the Swiss health institution to make it viable, missionary pioneers offered and maintained medical services to local people from the very beginnings. With time, however, by considering local constraints, Swiss doctors and staff adapted the process of medical diagnosis to the lack of the latest medical equipment and other constraints until they could get access to new technologies such as X-ray equipment and anaesthetics. Treatments were also reshaped, including after WWI, such basic things as the isolation of patients with infectious diseases. There was a compromise with popular knowledge when that was possible, and small clinics and dispensaries were constructed in the surroundings of the Elim Hospital. Later, these health institutions constituted a kind of health networks and became points of entry into the Swiss missionary health care system. Elim Hospital became a referral institution while other Swiss dispensaries, such as those at Shiluvane and Masana, acquired the status of hospitals, thus extending the missionary rural health care system to more remote areas of the country.[119] All along, the

118 Allan Kiraldy, Capturing the Soul, Pretoria 2005.
119 H.C.J. van Rensburg [and al.], Healthcare in South Africa: Structure and dynamics, Pretoria 1992.

lack of money and the shortage of staff played an ambivalent role – it was not entirely negative as it encouraged the training of local people. Likewise, the later financial dependency of the Elim Hospital on the local government administration contributed to the reformulation of Swiss practice of medicine as practitioners were compelled to face not only the specific epidemiological challenges of the environment but also the socio-political realities that influenced their medical practice. In examining the consequences of tensions between mission and tropical medicine, the case of a Swiss medical mission in South Africa questions the place and role of countries without colonial undertaking within the new imperial history.