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Healing the leper? Mission Christianity, medicine, and social dependence in 20th century Swaziland

McCoy, Jr., William Kent

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Boston University
HEALING THE LEPER?
MISSION CHRISTIANITY, MEDICINE, AND SOCIAL DEPENDENCE IN 20TH CENTURY SWAZILAND

by

WILLIAM KENT MCCOY, JR.
B.A., Point Loma Nazarene University, 2000
M.A., Boston University, 2004

Submitted in partial fulfillment of the requirements for the degree of
Doctor of Philosophy
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First Reader

Diana S. Wylie, Ph.D.
Professor of History

Second Reader

James C. McCann, Ph.D.
Professor of History

Third Reader

Dana L. Robert, Ph.D.
Truman Collins Professor of World Christianity and History of Mission
Boston University, School of Theology
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HEALING THE LEPER?
MISSION CHRISTIANITY, MEDICINE, AND SOCIAL DEPENDENCE IN 20TH CENTURY SWAZILAND

(WILLIAM KENT MCCOY, JR.
Boston University Graduate School of Arts and Sciences, 2015
Major Professor: Diana S. Wylie, Professor of History

ABSTRACT

This dissertation examines global shifts in medical and religious thinking about leprosy, using the southern African kingdom of Swaziland as a case study from the start of British rule in 1902 to the first decade of the twenty-first century. Involving a wide variety of both local and international actors, these encounters were frequently characterized by highly unequal power dynamics, especially between Swazis and Western doctors, bureaucrats, and missionaries. However, it is a central theme of this work that Swazis often turned Western scientific and religious preoccupations with leprosy into assets for their own benefit. Understanding the reasons why and under what circumstances Swazis did so illuminates the processes by which peoples of different cultures adapt themselves to shifting circumstances. Rather than abandoning local cultural ideas in favor of those of more powerful outsiders, I argue that the adaptations enacted by Swazis were coherent within their own cultural perspectives and are best
understood as evolutions of local ideas instead of the byproduct of a foreign value system.

Influenced by the narrative approach of microhistory, this project correlates evidence from three major archival collections, representing chiefly the perspective of British colonial figures and medical missionaries from the Church of the Nazarene, with insights derived from oral interviews conducted with both medical personnel and former leprosy patients in Swaziland. In so doing, it investigates themes related to the transfer of stigma across social and cultural boundaries; the clashing expectations of cultures divided by geography, language, education, and more; the limits of Western science and bureaucracy when attempting to exercise control over other cultures; and the continual negotiations through which all parties pursued their particular agendas. In analyzing the interplay between the primarily scientific and political concerns of the British colonial government and the chiefly spiritual concerns of the Nazarene medical missionaries, the story makes possible an understanding of how Swazis created advantageous spaces for themselves. I argue that they did this primarily by entering into relationships of social dependency, which they understood as creating bonds of mutual obligation between themselves and Westerners.
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Introduction

In the opening decades of the twentieth century, people in many parts of the world had only one way of talking about leprosy, which centered around the perception of the disease as disfiguring, easily transmissible, and incurable. The sinister perception of leprosy, along with its deep connections to biblical texts, made it the focus of substantial attention globally, but especially in those portions of the world connected under the Pax Brittanica, the rule of the British Empire. By the concluding decades of the same century, the narrative regarding the disease was strikingly different. In 1981, the World Health Organization recommended a new course of treatment, known as Multi-Drug Therapy, which is now used around the world and has rendered leprosy routinely curable; furthermore, we now know that leprosy is relatively difficult to transmit. Even many of the disfigurements suffered by leprosy patients, we now know are not directly caused by the disease itself but are the byproduct of the nerve damage that leprosy does cause and that can be either avoided or ameliorated with early treatment. And in contrast to the largely fear driven attention paid to the illness in earlier decades, today one finds leprosy listed by the WHO amongst other Neglected Tropical Diseases like yaws and leishmaniasis.

This dissertation examines the story of these large-scale changes in thinking about leprosy in the context of the southern African country of Swaziland from the commencement of British rule in 1902 to the first decade of the twenty-first century. In telling the story, I highlight both the correspondences and the disconnects between local
and international views of leprosy. The story unfolds as one among many Swazi encounters with Western visions of modernity. As at the gold mines along the Witwatersrand or in the law courts of the British administration, the encounter was one characterized by highly unequal power relationships, which is not to say that Swazis failed to ever seize the initiative. In fact, it is a central theme of this dissertation that Swazis often learned to turn Western preoccupations with leprosy into an asset for their own benefit.

Many of the key ideas behind this dissertation came about as a result of a single interview I conducted in June 2009, with an elderly Swazi woman, known as Gogo Shiba, a former patient at the Mbuluzi Leprosy Hospital, Swaziland’s only institution for the treatment of the disease between 1948 and 1982. First admitted in 1952 while still a young girl, she had required treatment for leprosy over the course of several decades, primarily because of the irregular progression of her condition. Gogo’s leprosy had been quite severe, and as a result, she suffered from very poor eyesight and had lost most of her fingers and toes. At the end of an admittedly rather unremarkable hour, after I had exhausted my supply of questions, I thanked her for taking so much time to speak to me and inquired whether she had anything else she wanted to say to me. The subject of our interview immediately shifted to the deterioration of her quality of life after the Mbuluzi Leprosy Hospital had closed, and patients had been sent back to their homes. Central to her memory was the recollection of receiving meat from the Swazi monarch, Sobhuza II, and of the many visitors who came to Mbuluzi from overseas, bringing with them gifts of clothing and food. Now, she told me, ‘no one cares for us.’ No one cares for leprosy
patients or their families. She especially highlighted the difference between her situation and that of HIV/AIDS sufferers in Swaziland, who in her mind now had many patrons, both local and abroad, who provided them with the same benefits of free food and clothing that she herself had once received.¹ This perceived slight of leprosy sufferers was a source of obvious resentment on Gogo Shiba’s part, and that narrative of loss had become an entrenched part of her life. My contact who had facilitated this first meeting with Gogo Shiba, a former employee of Swaziland’s Leprosy Control Programme, told me that he had heard similar complaints from her in the past, and in follow up contacts with her by both myself and my research assistant during the following year, we heard much the same story from her.

Gogo Shiba’s story helped me begin to think of my research into the history of leprosy care in Swaziland in a new light. In interviewing elderly former patients like Gogo Shiba, I expected to uncover stories – or at least hints of stories – about the experience of isolation resulting from Mbuluzi’s mountainous and geographically remote site, as well as from the stigmas associated with the disease, something I had been led to expect by preliminary conversations with missionaries who had worked in Swaziland and an early reading of the available missionary correspondence. Instead, she spoke of Mbuluzi as a kind of high point in her life, and other patients with whom I subsequently spoke echoed her feelings of fondness for the place and for the people who worked there, though not necessarily the same degree of resentment over their experience after Mbuluzi closed its doors. I recognized, even in the interview, that at some level Gogo Shiba’s

¹ Josephine Shiba, interview by author, 2 July 2009.
memory of life at Mbuluzi was accurate. In reading through the documentary evidence related to the hospital, I had noticed that there were, frequently, visitors of all kinds and from many different places to the Leprosy Hospital, and it was true that they brought many gifts to the people there. In addition, notes found in Dr David Hynd’s personal papers indicate that in the 1950s, Gogo Shiba was one of at least a dozen ‘specially supported cases,’ meaning that a supporter of the Mission to Lepers (now, the Leprosy Mission) in South Africa or London was contributing to the operating fund of the mission in her name and was receiving photographs and other intermittent news about her wellbeing and progress with leprosy treatment.² I also knew that there was some reality to her perception that ‘no one cared” about leprosy patients any longer. As the numbers of leprosy patients dwindled in the 1970s and 1980s, the numbers of people involved in the work also slowly faded, and the attention of people shifted elsewhere, particularly to the pandemic of HIV/AIDS, which from the 1980s onward swamped all other public health concerns. Although I found myself resonating with Gogo Shiba’s narrative about her life, it took me a great deal longer to discern how her insights fit into the larger story of leprosy care in Swaziland.

In the end, as I reflected on the stories of Gogo Shiba and others like her who had personal experience with leprosy and compared them to the documentary evidence I found in archival collections, I recognized that she had helped me identify some central and interrelated truths, each of which figures prominently in this dissertation. Firstly,

² David Hynd to Miss Vera Bond, 27 May 1953, David Hynd Collection, Nazarene Archives, Lenexa, Kansas.
despite the fact that leprosy stigmatization has been a relatively common feature of many societies (and not just Western ones), it cannot be said with any accuracy that Swazi society demonstrated any systematic stigmatization of people with leprosy. Thus, people like Gogo Shiba rarely had any experience with social rejection as a result of their illness that might have disposed them to think of it as something they should especially fear. Secondly, Swazis with leprosy often recognized that their medical condition brought them an unusual amount of attention from Western governments and missionaries. In response, they deployed a range of strategies that helped them turn that attention to their own advantage, particularly in pursuit of material resources. This gap in the cultural meanings of leprosy and the space thereby created for otherwise disempowered Swazis to secure benefits for themselves is at the core of this project.

This dissertation examines the major phases in the evolution of leprosy care in Swaziland throughout the twentieth century with an eye to the tensions and clashes created by differing cultural expectations. In so doing, it illustrates how Swaziland became one nexus, among many others, in the operation of a global network of people invested in leprosy for a variety of reasons, not just as a mechanical process but as a means by which people transferred significant social and cultural ideas (beyond stigmatized ideas alone) across many kinds of boundaries. Because the story itself is so multifaceted, it reveals a number of large themes that tend to ebb and flow across time:

**Stigma**

The story of leprosy in Western societies is closely bound up in the idea of leprosy sufferers as the victims of social stigmas, which Peter Burke describes as “the associative
condition that predisposes people towards set attitudes, which, rather than being biologically driven, reflect the continuation of socialising (or perhaps un-socialising) experiences and then feature as a form of discrimination against certain identifiable groups of people.”

Commonly associated in Western states today with people living with mental illness or physical disabilities, but also associated with racial difference, leprosy sufferers from the medieval period to the twentieth centuries endured some of the very harshest social stigmas in Western culture. The physical ravages of the disease at its worst, disfiguring nodules on the face, lost fingers or toes as a consequence of nerve desensitization, made leprosy readily identifiable and nearly impossible to mask. But leprosy also bore associations with biblical texts and mandates, which further dramatized the condition of leprosy sufferers. As a consequence, many people with leprosy have experienced social rejection in a variety of forms.

Erving Goffman notes that the origins of the word “stigma” come from Greek and that it originally referred to “bodily signs designed to expose something unusual and bad about the moral status of the signifier. The signs were cut or burnt into the body and advertised that the bearer was a slave, a criminal, or a traitor - a blemished person, ritually polluted, to be avoided, especially in public places.” This image is well suited to

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the case of leprosy, for although the signs were not placed upon the signifier by human action, a person suffering from leprosy was clearly identifiable as unusual; the imposition of a negative moral framework upon the medical victim, although not a necessary development, followed readily enough. Goffman and other scholars do, however, emphasize the idea of leprosy as a two-way condition; the person being stigmatized must necessarily feel shame and rejection as a consequence of others’ attitudes. However, this was not necessarily the case in Swaziland. Although many Westerners especially saw leprosy sufferers as objects of pity at best, the Swazis who lived with the disease often found ways to make their lives more bearable and even to seize upon the advantages that came with being seen as the object of another’s pity.

Although Swazis did not habitually stigmatize leprosy sufferers in their midst, this does not mean that stigmatizing ideas cannot be transferred across cultural boundaries, a phenomenon I have attempted to pay careful attention to in this dissertation. Burke notes that stigma can also sometimes rub off, from the stigmatized party to those who voluntarily associate with them. With regard to leprosy workers, this does not appear to generally be the case, especially for those with religious connections. Quite the opposite, they were largely heroized; think, for example, of people like Father Damien, the nineteenth century Belgian priest canonized in 2009 for his work with the leprosy sufferers of Hawaii. Though nowhere near as famous, the people who voluntarily

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6 Wim van Brakel, “Measuring Stigma and Social Participation Among Persons Affected by Leprosy in the SARI Project, Cirebon District, Indonesia,” paper given at the 18th International Leprosy Congress, Brussels, Belgium, Sept. 17, 2013. This session of the ILC, featuring papers on the theme of stigma, was probably the best attended breakout session I witnessed at the entire Congress, an indication of just how high a priority leprosy workers still place on the issue of stigma.
associated themselves with the leprosy work in Swaziland, particularly those connected to the mission of the Church of the Nazarene, received wide ranging admiration for their work. Leprosy workers stood in the place of Jesus, fulfilling his command to cleanse the lepers, and, just as Jesus associated with leprosy victims, so the people who chose to work among leprosy sufferers received a type of indirect holiness by means of their association with Christ. While there is plenty of evidence that Swazis who volunteered for leprosy work could also receive this imparted holiness by association, there is also evidence that some Swazis learned to stigmatize leprosy sufferers by way of their exposure to Western thinking about the illness, thereby introducing stigma into contexts where it had been previously unknown.

**Scientific Optimism & Disease Control**

The core tenet of the “civilizing mission” as an impetus for European empire was the idea that the world’s peoples, both individually and as societies, would be improved by exposure to the benefits of Western civilization. In pursuit of this vision, no tool was more important than Western confidence in science. This confidence stemmed not exclusively, or perhaps even particularly, from the work of laboratory scientists, but extended to a wide ranging system of knowledge that Helen Tilley has described as the product of an array of “institutions and activities, including professional networks and systems of patronage, learned societies and research institutions, field sites and laboratories, and cognitive frameworks and disciplinary structures.”

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the works of medical doctors and anthropologists existed alongside the projects of chemists and botanists in contributing to a spirit that treated knowledge as somehow certain, bounded, and nearly universally beneficent. Especially in the twentieth century, one of the chief expressions of this idea was in the area of medicine, as the introduction of antibiotics and other treatment options produced dramatic improvements in Western efforts to combat disease. With this success came an increased optimism that the next logical step in the process was to gain “control” of disease by attacking its root causes; if this could be done, it was only a small step to aspire towards eradication of particular ailments from certain populations.8 In doing so, as Michael Worboys has argued, “doctors and scientists promised to help governments control tropical colonies and their peoples.”9 This happened first by making these colonies safe for European habitation and then by giving attention to improving the health of indigenous populations.

This led to a steady stream of scientists, doctors, and public health workers entering Africa to carry out surveys, vaccination campaigns, pest control, and more. The hope that these processes would lead quickly to the eradication of leprosy, malaria, sleeping sickness, and other ailments from African populations often proved unfounded, as lessons learned in labs or even in field experiences proved difficult to apply in all contexts. In the case of malaria, for example, Alilio, Bygbjerg, and Breman have argued that early successes reached in mostly temperate climates during the post-World War II era produced an unwarranted optimism that the same results could be reproduced

8 Ibid, 186.

throughout the African continent. This, in turn, led to a downturn in investment in malaria research such that, when the initial optimism proved unfounded, there were few resources available to meet new challenges.10

In the case of the story of leprosy in Swaziland, this narrative of disease control and the aspiration to eradicate the ailment was the de rigueur language of officers at all levels of the British administration and their successors in post-independence Swaziland. In part because Swaziland had relatively low levels of leprosy infection, many individuals viewed leprosy as an ideal candidate for demonstrating the power of Western science and its benefits for humanity. However, as especially demonstrated in the story of the Swaziland Leprosy Survey (a core element of chapter three), such optimism often proved misplaced, not only because leprosy itself proved more resilient in the face of advancing medical knowledge than people expected, but also because scientific knowledge applied without appropriate regard for the cultural context often proved to be an unwelcome intrusion into Swazi lives.

**Clashing Cultural Expectations**

It is virtually a truism among Africanists that the colonial period produced an enormous variety of cultural clashes between African populations and their European rulers. For example, Keletso Atkins has illustrated the conflicts created when nineteenth century European employers in Natal found themselves at odds with their laborers over the very concept of time and such basic questions as how long the work day should last

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or when laborers should be paid their monthly wages. As in the situation Atkins describes, the story of leprosy in Swaziland found African and Western views about the disease approaching the illness from fundamentally different perspectives. I explore this theme most thoroughly in the first chapter, yet it remains pertinent throughout, as this failure of alignment frequently led to failures of communication regarding priorities. But these clashes of culture were in no way limited to interactions between Africans and Westerners. There were also many cases in which debates over leprosy control brought to light the different cultural expectations among Westerners as well, along lines of nationality, religion, and more. These differences are especially prominent in chapter three, in the discussion of how the Mbuluzi Leprosy Hospital became a joint endeavor between Swaziland’s British administration and the missionaries of the Church of the Nazarene.

**Dependency & Posturing/Positioning**

No insight has been more influential in my work than James Ferguson’s recent ideas about moral dependency. Ferguson contrasts the early nineteenth century period of Ngoni expansion and the later growth of an industrial capitalist complex in southern Africa with contemporary state welfare initiatives in this region. What linked the two older systems, according to Ferguson, is that both of them engaged in a struggle over people whom they wished to incorporate as a means of enrichment. While the power dynamics in these struggles were clearly unequal, Ferguson highlights the ways in which

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the relationships formed with incorporated persons provided a recognizable form of social membership and implied the existence of moral bonds between persons of differing social rank. This, Ferguson argues, may have been preferable to current thinking about state welfare programs that, in their attempts to promote autonomy and protect people from humiliating experiences of unequal power relationships, may instead offer only “a cold and impersonal relation with a technocratic state.”¹² The widowed mother in rural Eastern Cape who withdraws her state welfare grant from an ATM experiences a kind of “asocial assistance” that offers, at best, a very shallow kind of moral bond between herself and the nation.

In the Swaziland situation, the experience of leprosy in the middle portion of the twentieth century clearly offered people the opportunity to enter into a form of membership that was inherently unequal and yet fully social, as we will see in the discussions of the Ncabaneni Leprosy Settlement and the Mbuluzi Leprosy Hospital, outlined in chapters two and four. The Swazi men and women who submitted themselves to the treatment regime and peculiar patterns of life at these places did so largely voluntarily, and I argue that they did so at least in part in order to position themselves within an identifiable hierarchy in which both superior and subordinate had specific obligations. Historians and other social scientists have understood hierarchy as an important feature of Swazi social organization since Hilda Kuper’s pioneering anthropological work in the 1930s and 1940s, in which she described a system of rank

within which Swazis lived and defined their relationships to one another.\(^{13}\) Therefore, these relations of dependence did not necessarily appear to Swazis as oppressive to their individual liberty but as helping define their personhood and that of their superiors, creating a moral bond of mutual benefit to all parties.

Although these dynamics of dependency are rather distinctly related to the Swazi situation with regard to leprosy, the act of positioning oneself relative to changing realities was certainly not limited solely to Swazi men and women affected by leprosy. One of the defining realities of the story recounted in this dissertation is that people invested in leprosy work had to constantly reposition themselves in light of changing realities and/or priorities. In no context was this more evident than it was in the decision-making of the British government in Swaziland, which constantly had to submit to the difficulties of financial shortfalls and altered foreign policy, especially in the era of World War II. But this active positioning extended also to the British efforts to maintain a positive face about the transformative power of science. Especially in the years before the 1948 introduction of dapsone, the first effective drug for leprosy treatment, this public commitment to scientific optimism was somewhat regularly maintained in the face of scanty evidence, that provided little certainty regarding the effectiveness of available treatment regimes. This facet of the leprosy experience very much demonstrates the limits of the colonial state and of Western efforts to “civilize” African peoples more generally.

**Why Swaziland?**

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My own position relative to the subject of this dissertation can hardly be described as that of an outsider. In 1985, my father accepted a missionary assignment with the Church of the Nazarene as a medical doctor at the Raleigh Fitkin Memorial Hospital in Manzini, Swaziland. Although the Leprosy Hospital itself had been shuttered three years earlier, the church building on the grounds was still in use as the Mbuluzi Church of the Nazarene. Within months of our arrival, Claudia Stevenson, Mbuluzi’s last nurse matron and at that time part of the Leprosy Control Programme staff that emerged out of the decision to close down the Mbuluzi Leprosy Hospital, invited my father to take on the responsibilities of preaching to the small congregation that gathered there on Sundays. That my father agreed to do so was, in no small part, a consequence of the general sentiment that being solely a medical doctor was, in some fashion, an inadequate expression of the missionary’s calling, as it did not contribute overtly to the work of evangelization. So, for a period of about 18 months, my family made the weekly 35-mile journey from Manzini to Mbuluzi for Sunday services. In chapter four, I will discuss that journey as an informal pilgrimage for many who had completed it during earlier decades, but I admit that I do not remember the journey as a particularly sacred one in my own life. My father’s sermons, delivered in English and then translated into siSwati, were about the only portion of the Sunday services that I could understand. The people there were, I am sure, warm enough, but I felt acutely alien in that context and was never able (chiefly for lack of trying) to bridge that gap in any significant way.

I don’t recall at what point in our time I learned that Mbuluzi had formerly been a leprosy hospital. I do, however, remember that knowledge having a striking impact on
my seven or eight year old self. I suppose that, at that stage of my life, I had had just
enough exposure to biblical narratives to know that leprosy was something truly
terrifying, and I transferred those feelings to my surroundings. This was not so much true
of the people at the Mbuluzi Church, from whom I already felt quite alienated, but of the
buildings themselves, especially the old hospital building which stood a mere stone’s
throw from the church. Unused at the time, the building in my memory was showing
signs of decay, which only increased my feeling that it was somehow an ominous and
threatening place. In the vague manner of children, I wondered whether I too might
contract leprosy if I somehow made a wrong step on those grounds. Having experienced,
in some very circumscribed fashion, the powerful anxieties that leprosy evokes within the
context of the Judeo-Christian tradition, I was quite curious to discover the sources of
that potency as I began delving into this research project.

Aside from my family’s time at the Mbuluzi Leprosy Hospital, my father also
served for a period of two years between 1991 and 1993 as the supervising physician for
the Leprosy Control Programme, which had relocated its base of operations to the RFMH
after the closing of Mbuluzi. Under this new arrangement, the leprosy work was chiefly
the responsibility of lay case workers employed and trained by the Southern Africa
branch of the International Leprosy Mission, the most prominent Christian relief agency
focused specifically on leprosy. The tasks of these lay case workers involved a great deal
of home monitoring and social service provision for patients with disabilities, but the
Nazarene mission provided the supervising medical doctor who saw patients when they
visited the offices located in a wing of the RFMH. My father’s role was a relatively
minor one – confirming diagnoses, writing prescriptions, occasionally attending a meeting of the Management Committee of the Leprosy Control Programme. In this capacity, he and his colleagues do make some appearance in my fifth chapter, discussing the features of leprosy care in Swaziland after Mbuluzi’s closure. I was a little older by this time, but I still remember feeling distinctly uneasy on the one or two occasions when I happened to follow my father into the small leprosy unit of the hospital. Consequently, many of the questions that led me into this research project and that I attempt to address in this dissertation took shape in these formative years of my own childhood.

Besides my own personal experiences, however, there are other reasons why Swaziland makes a good choice for this kind of study, chiefly related to its compact size. Only a little over 17,000 square kilometers in size and with a population that even today remains under 1.5 million, Swaziland is one of Africa’s smallest countries. Its immediate proximity to and historically interconnected relationship with its much larger neighbor, South Africa, mean that its story is inextricably caught up in the themes of race and empire, labor migration, and more that dominate the written histories of this region. Therefore, despite the fact that this is, in one sense, a dissertation narrowly focused on telling the story of a single disease in one small corner of the world, much larger concerns emerge with surprising clarity within that story. Philip Bonner’s observation about the nineteenth century history of the Swazi state holds true for my own study as well, in that it “engages more or less continuously with virtually every other chiefdom or state in
south-eastern Africa, and so acts as a kind of prism through which the broader processes and trends in the region can be viewed.”

Making assertions that one small case study offers a lens for understanding wider patterns is a risky endeavor, perhaps nowhere more so than in Africa, where the habits of Westerners drawing conclusions based on assumptions, very limited data, or outright misunderstandings has been far too pronounced both historically and in the contemporary world. One example of this problem will be discussed in chapter three in the story of A.J. Sowden’s Leprosy Survey of the late 1940s, which failed, at least in part, because Sowden assumed that lessons he had learned from previous experiences in Nigeria and the Sudan would readily transfer to the Swaziland context. Despite these dangers, there are still strong reasons to regard Swaziland as a useful focal point of analysis when trying to understand larger patterns.

**Literature & Method**

In pursuit of these aims, I have employed a range of both primary and secondary materials. My primary source material is chiefly drawn from three large archival collections. The earliest seeds of this project were planted in 2005 when I first visited the official archives of the Church of the Nazarene in pursuit of an entirely different project.

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15 As I write, for example, various news outlets are reporting on a teacher at a Kentucky Catholic school who resigned her position rather than submit to a 21-day leave from her job in order to prove that she was not infected by the Ebola virus. The request that she take the leave came from school administrators under pressure from parents concerned about a trip the teacher had taken to Kenya. See, for example, [http://www.reuters.com/article/2014/11/03/us-health-ebola-usa-kentucky-idUSKBN0IN25I20141103?feedType=RSS&feedName=healthNews](http://www.reuters.com/article/2014/11/03/us-health-ebola-usa-kentucky-idUSKBN0IN25I20141103?feedType=RSS&feedName=healthNews).
that never came to fruition. Reading through the papers of Nazarene missionaries to Swaziland, I noted then just how much attention the leprosy work received, despite its relatively small size, and wondered why this might be the case. After I shifted the focus of my research to leprosy, I returned to those archives and dug much more extensively into the papers of David Hynd, Elizabeth Cole, and others who played roles in the Nazarene mission’s engagement with leprosy work in Swaziland. The papers of missionary doctor David Hynd, a prolific letter writer and meticulous record keeper, were especially significant for this project.

The second archive I leaned upon was the collection at the Swaziland National Archives, where I first conducted preliminary research in 2009 and then several weeks worth of research in 2010. The available materials in this collection heavily favor the period prior to independence in 1968, if only because the best available finding aid only covers the material from this era. Nevertheless, this was not a serious impediment to my work because, as I explain in the third chapter, the decision to hand over the operational side of the work at Mbuluzi to the Nazarene missionaries brought a steady decline in the level of government involvement; thus, materials from this collection diminish in significance in the final chapters of this dissertation. An argument from absence of evidence is hardly the most convincing, but this is where the Hynd collection from the Nazarene Archives is particularly helpful in corroborating my argument. Had government involvement remained constant, one can safely assume that Hynd, who meticulously kept copies of all his correspondence, would have had a large collection of government correspondence that reflected their continued involvement. This, however, is simply not
the case; there is a steady diminishing of the volume of Hynd’s correspondence with the government after 1948. Nevertheless, the Swaziland National Archive collection was certainly the most critical in helping me sketch out the events that took place prior to the opening of the Mbuluzi Leprosy Hospital in 1948, and it provided the main reservoir of primary source material for my first three chapters.

The last archival collection that features prominently in this dissertation, and the most unique resource employed here, is the collection of papers at the Raleigh Fitkin Memorial Hospital in Manzini, Swaziland. When I first discovered this collection in 2009, it was simply a pile of correspondence folders and other records shoved into a closet in the administrative wing of the hospital, alongside broken down typewriters and other discarded relics of past hospital administrations. Even in this chaotic state, it did not take long to discover files of value to this project, as well as to the larger history of the hospital and the Nazarene mission work in Swaziland. Without question, it was here that I most directly benefited from my father’s legacy at the hospital, as the hospital administration was quite willing to work with me in turning this collection into something usable by researchers. In 2010 and 2012, I returned to Swaziland with groups of students and other volunteers from Eastern Nazarene College, where we began turning this collection of documents into a functional archive. Although that vision has not yet reached full realization, I was able to make use of the materials in that collection, which proved absolutely vital for understanding the history of leprosy work in Swaziland from the 1960s onwards.
In addition to these large archival collections, I also benefitted from smaller
document collections made available to me by the Swaziland Ministry of Health in
Mbabane, the Leprosy Mission’s Southern Africa office in Johannesburg, and from the
LEPRA (the successor organization to the British Empire Leprosy Relief Association, or
BELRA) archives in the United Kingdom. But the other chief source of corollary
evidence for this project was the interviews I conducted in both the United States and
Swaziland with former missionaries, caseworkers, and patients. In all, I conducted
several dozen of these interviews, some of which were scheduled, semi-structured, and
recorded while many others took place relatively spontaneously during car rides or at
other moments when the introduction of a recorder would have stunted the conversation.

The greatest number of my interviews occurred with former patients and staff
people of the hospital at Mbuluzi. Because Mbuluzi was always a relatively small
operation, because of the length of time that had passed since its closure, and because the
Swaziland Leprosy Control Programme had functionally ceased to exist in 2005, the task
of finding such people was not a particularly simple one. Without the help of Simon
Dube, a longtime employee of the Leprosy Mission during the time when it operated
Swaziland’s Leprosy Control Programme and also one of my key informants in his own
right, I would have had a very difficult time indeed. Simon facilitated my first
introduction to Gogo Shiba in 2009 and helped me identify some of the key areas in the
country where former leprosy patients now lived. In particular, the majority of my
interviews took place in the areas of Dlangeni, in north-central Swaziland, and
Mankayane, in the western portion of the country, mostly with the aid of translation done by my research assistant, Mxolisi Dlamini.

As is typical in a research process like this one, identifying one informant would usually lead to suggestions about one or two others whom we might contact, sometimes nearby, often not so near. In rural areas, Swazi settlement patterns remain widely dispersed, rather than clustered in village communities, so Mxolisi and I spent many hours driving or walking from one household to another following up on contacts. Because of this pattern of dispersal, it was generally impossible to make more than one visit to the homestead of a particular informant, though there were several that I made a point of visiting more than once, such as Gogo Shiba. In another case, I arranged for three informants who had spent a number of years in the 1950s and 1960s as children together at Mbuluzi to return to the hospital grounds with me for an afternoon so that I could listen to their stories in the context of the place where their memories had taken shape. I never paid any of my informants a prearranged cash figure, though I was always careful to leave with them maize meal, cooking oil, soap, and other small household staples as a gesture of my appreciation for their assistance. In a very few instances, when interviewing a local *indvuna* (headman) or other person in a recognized position of political authority, I would leave a small cash gift rather than household goods, but never more than a figure equivalent to about $25. Such expressions of gratitude are a very normal part of Swazi culture, an expression that acknowledged my position of dependency in a fashion not altogether unrelated to the same relationships of dependence that I describe in this dissertation.
These interviews stand in back of most sections of this dissertation and emphatically shaped my thinking about the subject of leprosy in Swaziland. They do not, however, appear as fully in my footnotes as they perhaps should in order to represent their impact on my thinking. There are two reasons for this. The first is practical; I did not want to privilege my English language interviews (whether with Swazis or with expatriates who lived in Swaziland) over those conducted in siSwati with the help of a translator. Although during my fieldwork I reached a place where I felt confident that I was following the general direction of a siSwati language interview even before translation, I did not acquire an adequate mastery of the language to feel confident rendering translations of those comments into English. For this reason, I have tried to highlight in the text the key insights that emerged as common themes in multiple interviews, rather than quoting particular informants on specific points. The other reason is more directly related to the central claims of this dissertation: for most Swazis, the experience of leprosy was in and of itself a relatively unremarkable event, a reality that was reflected in much of their commentary to me, which contrasted rather starkly with the energetic commentary of the Westerners who were so deeply invested in the various facets of leprosy work. I have tried to make this contrast clear and to provide appropriate analysis explaining the significance of that difference throughout.

With regard to secondary literature, it has only been in the midst of the writing process that I have realized just how profoundly my own historical methodologies and approach to written narrative have been shaped by the field of microhistory. It should come as no surprise, then, that no individual work has had a more significant influence on
me than Carlo Ginzburg’s *The Cheese and the Worms* (1992). An intimate and often surprising reconstruction of the world of a sixteenth-century miller from northern Italy who finds himself facing down heresy charges before the Inquisition, the book has virtually no overlap with my own areas of historical research, yet I find myself deeply persuaded by Ginzburg’s undergirding argument about the fruitfulness of investigating the “reciprocal movement” of cultural influences between a dominant and subordinate class of people.\(^{16}\) Furthermore, the model Ginzburg offers for understanding “big” historical concepts via the most ordinary of stories has helped me immeasurably in thinking about the kind of story I want to tell. Similarly, and much closer to my own field of historical research, Timothy Couzens’s *Murder at Morija* (2003) applies these sorts of methodologies to the Paris Evangelical Mission in Lesotho to create a thoroughly engaging narrative of a small event that still manages to illuminate much wider historical realities. I would be a fool to claim that my own work has accomplished anything on the scale of these two in their adept movement from small stories to big ideas, but I hope that I have offered a reasonable approximation of their approach.

The great promise, as I see it, of the microhistory approach is that it makes possible a distinctly human sort of narrative that can be readily understood and appreciated by a wide range of readers. During my graduate training, there were no bigger buzzwords in the field of African Studies than the concepts of “agency” and “resistance.” In my memory, it would have been a rare seminar indeed in which no one

made reference to the idea that Africans were in some way demonstrating their agency by their resistance to the hegemony of the colonial state. These were, and remain, concepts that contributed significantly to our general understanding of the African past, but they also can distort our ability to see it in all of its complexity. In this dissertation, I do not seek in any way to subvert these concepts, but I do think that we gain something significant when we allow these and other theoretical frameworks to take a backseat to textured narrative. In some sense, I suppose that I have taken for granted the idea that Africans demonstrated agency in making the world around them, and I have tried to focus instead on bringing together the multitude of voices from many parts of the world that connected with one another in Swaziland around issues regarding leprosy. In this way, I hope that my work makes a meaningful contribution to a number of other bodies of research, from which I have drawn important concepts.

The first of these is the emerging field of medical history and specifically those works which look at leprosy in its global context. There are numerous recent works examining the history of leprosy in a variety of contexts from medieval Europe (Demaitre, 2007) to India (Barrett, 2008) to the United States (Moran, 2007). Tony Gould’s recent work on leprosy purports to tell the story of “leprosy in the modern world,” but it is generally focused on the story of leprosy in Europe and the United States and has significantly less to say about the disease elsewhere in the world (Gould, 2005). Rod Edmond’s analysis of the position of leprosy sufferers within the British Empire is focused on the period before 1928, but it provides an important point of departure for my own analysis in the first chapter. (Edmond, 2007).
There is also a significant body of research into the social understanding of health and debility in Africa, which underpins my own research. Julie Livingston’s work on debility in Botswana (2005), Diana Wylie’s book on cultural racism in apartheid South Africa (2001), Feierman and Janzen’s edited volume on health and healing (1992), and Megan Vaughan’s work on power relations expressed in the treatment of African illnesses (1991) all provide theoretical support for research into the character, social consequences, and treatment of disease in Africa. Other works by Bryant (1966), Callaway (1970), Ngubane (1977), Vilakazi (1962), Berglund(1989), and Kuper (1965) have helped me situate my discussion of leprosy within the specific cosmology of the Swazis and their Nguni neighbors.

The history of leprosy in Africa remains relatively understudied, but significant progress in closing the gaps has been made in recent years. Some of the first historical work in the field was done by John Iliffe (1987) and Megan Vaughan (1991) who each devoted a chapter to the topic in their respective books. Iliffe describes briefly, and in necessarily sweeping terms, the scope of the disease across Africa while viewing it as a distinct expression of poverty in Africa. Vaughan focuses exclusively upon the question of how European medical officials and missionaries forged a particular identity as “lepers” for victims of the disease, while saying almost nothing about how Africans themselves thought about the disease or treated its victims in their communities. Eric Silla’s 1998 book on leprosy in Mali remains the leading book-length treatment of the disease in the African context and has been, in many ways, a model for the most recent generation of scholarship on leprosy in Africa, particularly in his efforts to treat leprosy
patients as human agents, actively working to maintain control of their own lives. In addition to my own work, Silla’s approach has clearly had an influence on recent scholarship by Manton (2003), Shankar (2007), and Vongsathorn (2012).

Because of the prominence of missionaries in my research, my work also aims to provide an intimate and complex portrait of the intentions and motivations of an evangelical mission in Africa. In addition to Couzens’s work referenced above, Barbara Cooper’s work on the Sudan Interior Mission in Niger (2006) has been particularly influential in my efforts to reconstruct this perspective, in part because leprosy work also featured prominently in the story of SIM’s work. Along with Shobana Shankar’s very recent work on SIM work in northern Nigeria (2014), these projects illustrate how important leprosy work was for Christian missionaries seeking a point of entry into Islamic societies. Other works from Carpenter (1990), Hardiman (2006), and Robert (1997) have also helped provide critical contextual elements. Older works of memoir and biography from missionaries in other parts of Africa (McCord, 1951; Duncan, 1958) also helped me early in my research to situate the language of the Nazarene missionaries in a broader context, providing useful points of comparison that illustrated the exceptional nature of leprosy work even within the broader framework of medical missions more generally.

The Vocabulary of Leprosy

Few diseases have been the cause of as much fear and stigmatization of other human beings as leprosy has been, and for this reason one has to choose carefully the vocabulary employed to describe both the illness and those who experience it. The word
“leper” is especially problematic in this sense, because it effectively denies the personhood of the individual living with the illness and equates their personhood with their illness. For this reason, the word has been more or less universally rejected by people working in any field of research related to leprosy. In this dissertation, I have scrupulously avoided the use of the term in my own language, preferring instead to talk about “leprosy patients” or other kinds of formulations that attempt to separate the realities of personhood and illness. However, as is customary in recent historical writing about leprosy, I have not made any attempt to expunge the term from the vocabulary of my sources; as such, it appears frequently in quotes found throughout this work.

Even the use of the term “leprosy” can be somewhat problematic, because of the multiple layers of meaning associated with the term. However, there are a number of specific reasons why I have chosen to use this term rather than alternatives such as “Hansen’s Disease” or “hanseniasis.” First of all, as I explain in the first chapter, there is no evidence that the disease was the cause of any serious stigmatization among people living in Swaziland for whom the disease seems to have been a relatively new one. There is, therefore, little or no danger of inadvertently perpetuating false stereotypes or other dangerous ideas by continuing to use the term. Secondly, the term “leprosy” is the only one ever used to describe the disease in the Swaziland context, although it is clear that many people working in this field were aware of debates that existed during the twentieth century about what to call the disease. To take just one example, the archival files of the Raleigh Fitkin Memorial Hospital contained a 1970 Brazilian publication that emerged out of the movement that ultimately resulted in that country officially adopting the name
The representatives of the research unit that produced this publication argued strongly for renaming the disease as hanseniasis because using the name leprosy would cause patients a “terrific shock” from which they “could never recover emotionally” while also negating an opportunity of educating that individual about their condition. Despite their knowledge of these concerns in other contexts, to my knowledge, no one even proposed that people involved with Swaziland’s leprosy control programme switch to using an alternate formulation. To make the switch now would seem to unnecessarily obscure the situation.

Lastly, I think that it is important, particularly when attempting to understand the mindset of the missionaries involved in the leprosy work, to be ever mindful that, however rightly or wrongly, they very plainly associated the work they were doing with the biblical texts that, in their English-language Bibles, made reference to “leprosy.” These links will be made more explicit in the chapters to follow, especially chapters two and four; however, a few comments regarding the biblical usage of the word will help set the stage for those discussions.

References to leprosy appear in many parts of the biblical narratives and would have been quite familiar to the missionaries of the Church of the Nazarene serving in Swaziland, as they were to Western missionaries throughout the world. In the book of 2 Kings, for example, one finds the stories of Namaan, the Syrian general who is cured of his leprosy by the Israelite prophet Elisha, and Uzziah, the king of Judah who was struck

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17 A. Rotberg, “Changing Names is a Very Slow Procedure and International Cooperation is Necessary,” Correspondence File #22, Leprosy Hospital (L6), 1965-1973, RFMH Archives.
with leprosy as a consequence of his attempt to perform the priestly duty of burning incense in the temple. Of even more immediate significance to the missionaries were those stories in the Gospels in which Jesus miraculously healed people described as having leprosy. In Luke 17, for example, Jesus healed ten men who had cried out to him from a distance appealing for his help; of the ten, only one returned to Jesus to express his gratitude for healing. That the man who returned was a Samaritan, and therefore doubly subject to rejection from the majority Jewish culture within which Jesus lived, only served to further the sense that leprosy was a disease of the outcast.

This indeed was the central theme in biblical discussions of leprosy. In the thirteenth and fourteenth chapters of Leviticus, a total of ninety-one verses are devoted specifically to establishing a diagnosis of leprosy. The Leviticus texts describe a range of possible means by which leprosy could be identified, but once finalized, the priest (who bore the responsibility of identifying the disease) would pronounce the man or woman unclean. Upon diagnosis, the text transferred the responsibility chiefly to the victim of the illness: “Now the leper on whom the sore is, his clothes shall be torn and his head bare; and he shall cover his mustache and cry, ‘Unclean! Unclean!’ He shall be unclean. All the days he has the sore he shall be unclean. He is unclean, and he shall dwell alone; his dwelling shall be outside the camp.”\(^{18}\) People identified as having leprosy had no option except to remain in isolation from the rest of society unless or until they were able to get a priest to declare them cleansed of their illness and aid them in performing the necessary purification rituals. This, of course, was the reason why the ten men described in the Luke

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\(^{18}\) Leviticus 13:45-6.
The reality is that the illnesses named as leprosy in English-language Bibles are almost certainly not the same illness that today goes by that name. The Hebrew word used in the Leviticus text and elsewhere is *tzara’at*, and the symptoms associated with this illness, as described in the text itself, do not correspond well with modern leprosy. Rather, the word appears to encapsulate a range of skin conditions, particularly psoriasis. Much of this has been known and accepted in leprosy circles since at least the middle of the twentieth century, but the disconnect in medical pathology between the illness they read about in the Bible and the disease they described by the same name in their own context was of virtually no significance to the missionaries of the Church of the Nazarene in Swaziland. Indeed, I do not have an example of this being mentioned in any letter or other document originating from a missionary source at any time during the period of this study, but references to the particular Scriptural texts connected with leprosy continued to recur. Determining to what extent this represented a willful decision to overlook the differences between biblical leprosy and the disease in their own context is ultimately less significant than simply recognizing that this link to the biblical language was of vital importance in motivating missionary efforts.

**Leprosy’s Medical Biology**

It is not always easy to separate leprosy as a medical condition from the sensationalized understandings of the disease that stem in large part from the association of the disease with the conditions described in biblical texts. Furthermore, leprosy
presents in an exceptionally wide variety of ways, which sometimes complicates correct
diagnosis of the illness and makes it hard to generalize about the lived experience of
patients who contract the disease. Some patients experience very few visible effects as a
consequence of contracting leprosy, while others suffer severe nerve damage and
dramatic physical disfiguration, though such cases are increasingly rare in an age of
multi-drug therapy. Nevertheless, understanding the biological causes of the illness and
something of the range of its possible expressions provides crucial context for this
dissertation.

The disease that is today known as leprosy is caused by a microorganism called
Microbacterium leprae. First observed under the microscope in 1873 by a Norwegian
medical doctor by the name of Gerhard A. Hansen, the bacteria is sometimes called
Hansen’s bacillus, and the disease itself is not uncommonly referred to as Hansen’s
Disease, especially in countries like Brazil where there remain heightened concerns about
social stigmas suffered by people affected by the disease. Somewhat curiously, more
than 140 years after Hansen’s discovery of the bacillus, the exact method of transmission


20 When I attended the 18th International Leprosy Congress in Brussels in September, 2013, for example, a speaker from Brazil in the paper session where I presented a piece of my own research apologized to the audience for the fact that her work with the sources required her to use the word “leprosy.”
of leprosy remains unknown. However, as there are only two known viable hosts for the leprosy bacillus, humans and armadillos, and since the bacillus survives only a relatively short period of time once separated from its host, there is little question that proximity to a person affected by leprosy is the primary contributing factor to transmission. The best research on the subject indicates that leprosy most commonly spreads by way of nasal droplets, much like the common cold. However, the disease is much less contagious than the common cold, and in the vast majority of cases, people are infected with leprosy only after a prolonged period of exposure to a carrier, often years.

Diagnosis of leprosy can be accomplished both in a clinical setting by means of observation or by means of a laboratory observation of skins smears collected from possible sites of infection. In the laboratory, a skin smear sample may contain visible rod-shaped bacilli which are a tell-tale sign of leprosy infection; such cases are today classified as multibacillary (MB) leprosy. The trouble, however, is that it is possible for a person to manifest symptoms of leprosy while having so few bacilli in their body that the skin smear may not show a positive result; people in this category are classified as having paucibacillary (PB) leprosy, and the doctors must rely upon clinical observations to confirm a leprosy diagnosis. The distinctive feature of leprosy in a clinical situation is a skin lesion with definite sensory loss in the affected area, often with signs of thickened nerves. In many cases today, thanks to early detection and effective treatments, relatively few patients progress beyond these relatively mild symptoms. Left untreated, however, leprosy may develop a much wider range of symptoms and related physical effects,
including the appearance of nodules, blindness, or the permanent deformation of extremities as a consequence of the nerve damage.

Such symptoms, however, are not certain to develop even in cases where no treatment is administered, as the progress of leprosy is highly uncertain and largely dependent upon the individual’s immune response. Most individuals have an immune response system strong enough to prevent any symptoms of leprosy from developing at all, and only a very small number of people have such a weak immune response that the leprosy bacilli might produce their full range of physical symptoms if the disease is left untreated. This is why it typically requires exposure over a prolonged period of time for a person to develop symptoms of leprosy, and it is also why leprosy is today chiefly a disease found in developing world regions where the effects of poverty more generally (poor nutrition, the presence of other illnesses, etc.) may compromise a person’s immune system adequately to allow the leprosy bacilli to multiply.

Once a doctor or other medical professional has confirmed a diagnosis of leprosy, the course of treatment is dependent upon the classification of the particular case. In the early twentieth century, doctors differentiated between two kinds of leprosy: nodular leprosy, which affected chiefly the skin, and maculoanesthetic, commonly called simply “nerve type” because its most visible effects were on the nerves.21 Subsequently, and for much of the time period during which the Mbuluzi Leprosy Hospital operated in Swaziland, doctors categorized leprosy according to a system called the Ridley-Jopling

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Classification, which gave some greater recognition to the different gradations of leprosy presentation. In this system, the severity of a patient’s case was determined based on clinical observations and placed along a spectrum ranging from Tuberculoid (TT) to Lepromatous (LL), with a range of Borderline classifications (BT, BB, BL) lying between them. The determination of how to classify a particular patient came about as the result of a thorough physical examination, which would allow medical personnel to assess the extent of nerve involvement, the numbers of lesions and nodules, and the distribution of these around the body as primary guides to assessing the severity of the case. More recently, leprosy case workers have been encouraged to simply classify the case as MB or PB prior to prescribing a course of treatment. A definitive diagnosis of MB or PB, however, requires laboratory facilities that are not available in many contexts in which leprosy diagnosis may occur; most commonly, so some field workers still use the Ridley-Jopling Classifications which do not require lab tests. In such cases, the default diagnosis is MB leprosy with its more aggressive and prolonged course of treatment.

Depending on the classification of the diagnosis, a patient will receive a course of multi-drug therapy to complete. In the case of PB classification, a patient follows a six-month course of treatment, taking a daily dose of dapsone along with a monthly dose of rifampicin. In the case of MB classification, patients undergo 12 months of treatment using three drugs: dapsone and rifampicin in the same dosages as with PB cases plus an additional dosage of clofazimine, which has a monthly pulse dosage along with a smaller daily dose. Of the three drugs used in multi-drug therapy, it is the rifampicin, a powerful antibiotic, that is responsible for elimination of more than ninety percent of leprosy.
bacilli in the very first dosage; from that point forward, a patient can safely be regarded as non-infectious. However, the remaining course of treatment is necessary in order to eliminate persisting bacilli in the patient, prevent the possible resurgence of the disease in the patient, and reduce the chances of allowing drug-resistant strains of the bacillus to evolve.

A patient that follows a regular course of treatment with multi-drug therapy today can and should have every expectation for a full recovery, as this method has proven to have a very high success rate. This high level of certainty stands starkly in contrast with the prevailing situation during the earliest period of British rule in Swaziland when the development of a vision for remedying leprosy in the state was in its most nascent form.
Chapter 1
Leprosy in Context: Government, Missionary, & Swazi Attitudes Before 1932

On March 25, 1918, the deputy assistant commissioner for the Mankaiana District in western Swaziland, a man by the name of D.H. Harvey, wrote to his superiors in the governing British administration, seated in Mbabane. Harvey addressed his letter to the territory’s highest ranking representative of British rule, Resident Commissioner de Symon Honey:

I feel it incumbent on me to report to you that there are several authenticated cases of Leprosy in this part. Recently, at least five labourers sent from here have been sent to Pretoria Leper Asylum and there are 4 others whom Dr. Jamison reported on: another suffering from incipient Leprosy was sent back from the Mines some time ago, and there are 2 other men who appear to me to be Lepers. 1, at least, certainly looks like a leper. As these different cases are scattered in various parts of the District, I would be glad to know if something cannot be done to alleviate the situation and prevent the disease spreading, as soon as possible. If I may, I would like to point out that, besides the women belonging to these men, there is the question of other inmates of the kraals; whilst those sent to work are, in some cases, disposed off (sic), the danger still remains with those who have come into contact with them and who still remain at their kraals, and, although I have warned their respective Chiefs and relations to leave them isolated and not to have any intercourse with them, we cannot be sure of this being done when there is no one, officially, in charge of them. There is another feature! The collecting of Tax where the disease is, or has been, there is, I take it, always the danger of spreading the disease at such times, and there are no means of knowing who have actually been in contact with Leprous people or not.¹

Harvey’s letter communicates an intriguing personal urgency with regard to this public health concern, but the follow up to the letter did not match this apparent urgency.

Harvey’s original letter was either never delivered to Mbabane or else was misfiled in the government’s correspondence files, and so it received no response. It was another nine

¹ D.H. Harvey to de Symon Honey, March 25, 1918, File RCS169/19, “Lepers in Mankaiana District,” Swaziland National Archives, Lobamba, Swaziland.
months before Harvey wrote again, inquiring whether any sort of plan had been developed. Only then did he learn that his letter could not be located, and so he forwarded a second copy of the original letter, which sparked a round of internal discussions among the colonial bureaucrats at work in Mbabane.

Dr. Robert Jamison, Swaziland’s Principal Medical Officer and the doctor referenced in Harvey’s letter, took the occasion to opine that “...the natives have no idea of the serious nature of the disease and so no fear of it;” therefore, he concluded, “The only efficient method of dealing with this matter is to send all the Lepers to Pretoria Leper Asylum.” This, in turn, resulted in letters of inquiry to government offices in the Transvaal and Natal, the neighboring provinces in the Union of South Africa, regarding space available for Swazi leprosy patients as well as seeking advice about cost effective measures that might be employed to deal with leprosy internally. But in the end, no specific actions resulted from this flurry of activity, and Harvey never received any satisfaction in his appeal for assistance.

The mostly innocuous story of Harvey’s letter and the response of the government to that letter nevertheless sheds light on the position of leprosy during the early years of British governance in Swaziland, following their assumption of power at the conclusion of the Boer War in 1902. The same pattern of discussion and action, or inaction, that played out in 1918-1919 would repeat itself a number of times in the years prior to 1932, as the Swaziland government sought the proper course regarding leprosy yet often found

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2 Robert Jamison, internal memo to Government Secretary, February 22, 1919, File RCS 169/19, SNA. All the correspondence referenced in the preceding paragraph may be found in this same file at the Swaziland National Archives.
itself struck with indecisiveness. This chapter contextualizes the problem of leprosy during the first three decades of British rule by exploring Swaziland’s leprosy problem relative to leprosy incidence in other African contexts as well as in relationship to other medical challenges of the time, such as syphilis and malaria. It will then outline the perspectives of the major parties influencing the treatment of leprosy in Swaziland, those being the colonial government, the local Swazis, and the missionaries from American and other Anglo missions.

Reliable statistics about the prevalence of leprosy in the African context in the early twentieth century are, unsurprisingly, more or less impossible to come by. It was found in virtually every context, and case studies of leprosy work in many of them have proliferated in recent years. Although the hard numbers are difficult to come by, the anecdotal evidence does suggest that the prevalence of the disease in Swaziland was generally lower than in many other parts of Africa. For example, Eric Silla has estimated that before 1950, Mali’s rate of infection was about forty cases per 10,000; even at its peak, it is unlikely that Swaziland’s rate was even a quarter of that. And numbers similar to those in Swaziland would have pertained to the wider context in South Africa. Still, medical personnel working in the region at the time often expected leprosy to be one of the major scourges of the people they treated. Take, for example, the case of Dr. Frank Drewe, a medical missionary sponsored by the Society for the Propagation of the Gospel

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3 See, for example, Eric Silla on Mali, Barbara Cooper on Niger, Manton and Shankar on Nigeria, Vongsathorn on Uganda, and Horwitz and Deacon on South Africa. Other well known sites for leprosy work included Sudan, Ethiopia, and Congo.

and founder of Holy Cross Hospital in eastern Pondoland. Before his arrival in South
Africa in 1920, Drewe had been led to expect that, along with syphilis and tuberculosis,
leprosy would be one of the foremost diseases he encountered, yet the local leprosy
institution housed only 42 leprosy cases in a population of over 70 thousand.\(^5\)

Similar interest in a disease that had relatively low prevalence can be found in the
records of the South African government. For example, in the two decades of the 1920s
and 1930s, the *Official Year Book of the Union of South Africa* published a brief synopsis
of the history of leprosy care in South Africa as part of its general review of the history
and prevalence figures for particular diseases. The summary noted, among other things,
that the so-called “Hottentots” of the Cape had leprosy prior to the arrival of Europeans
and that the first case among Europeans was detected in 1756. It went on to point out that
the first institution for the segregation of leprosy patients, founded in 1818, was at
Hemel-en-Aarde, some sixty miles east of Cape Town, where roughly 100 leprosy
patients lived until 1845, when the government transferred those patients to Robben
Island. The Year Book reports also give some hint as to the intersections of social ideas
with medical practice. For example, in its comments about a leprosy institution in the
Transkei, the report noted, “At first the inmates were accommodated in huts of the
ordinary kaffir type, and the sexes mixed freely. In 1896 the huts were demolished and
separate compounds, about a mile apart, were established for male and female patients.”\(^6\)

\(^5\) Diana Wylie, *Starving on a Full Stomach: Hunger and the Triumph of Cultural Racism in Modern South

\(^6\) Union Office of Census and Statistics, *Official Year Book of the Union and of Basutoland, Bechuanaland
This language assured its largely white readership that the government was taking a firm hand in maintaining social and moral norms with regard to sexuality and gender in its efforts to care for these leprosy patients.

The details of the report, however, are hardly as interesting as the simple fact that such a thorough report existed at all. Despite the relatively low rates of infection, leprosy received the largest amount of space dedicated to any one disease, followed by smallpox. This disproportionate allocation of space suggests that leprosy had a special place in the consciousness of the medical personnel in the South African government or at least that they recognized that the disease was most likely to be of interest to their readership.

This situation stands in contrast to the one described by Barbara Cooper in her discussion of colonial-era Niger, in which she finds colonial officials notably lacking in concern for leprosy, especially as compared to the preoccupation of missionaries from the Sudan Interior Mission with the disease. Although likely greater than that of South Africa, Niger’s leprosy case load did not compare in the minds of French colonial administrators with the challenges of yellow fever, smallpox, and other ailments that might constitute an immediate threat to life. Leprosy fit into a lower priority category of illnesses characterized by their slowly debilitating effects, but one suspects that the greatersecularity of the French administration also contributed to its relative lack of interest in

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7 These Year Book reports were compiled under the authority of the Ministry of the Interior, and they used identical language to discuss leprosy from at least 1923 to 1937, the years I was able to review. As noted in their title, the books do purport to give some attention to Swaziland and the other High Commission territories, but the amount of information provided is relatively miniscule. On the subject of health, the reports merely indicate that malaria and dysentery were common problems in the lowveld portion of Swaziland.
leprosy. Interest in leprosy increased, Cooper suggests, when one viewed the illness through a Christian lens, as a consequence of sin and an ailment whose long treatment process provided ample opportunity for exposure to Christian teaching. Southern African governments under British influence, whether in the Union of South Africa, Basutoland, or Swaziland, were more likely to be sympathetic to missionary preoccupations with leprosy, but the attention of the Year Book report to leprosy is also indicative of the cumulative impact of nearly a century of carefully crafted government policy aimed at dealing with leprosy.

This public fixation with leprosy, the emphasis on maintaining order, and the unique access to financial resources that characterized the South African state of the late nineteenth and early twentieth century combined to produce a distinctive trajectory for leprosy care in that country. In 1891, the British administration in the Cape had made segregation of leprosy patients in a colony compulsory, a policy that would eventually be extended over the rest of the country until the 1920s. South Africa and Basutoland were among the few states in Africa that attempted compulsory segregation, but in Basutoland, the effort was, in practice, short-lived. The costs of such unpopular policies were simply too great for most colonial states to bear. The South African state, buoyed by the advent

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of the diamond and gold mining economy and committed to a view of the world that emphasized racial difference, had both the resources and the determination to try to enact its vision of public health by social control. Yet, although it had better developed economic resources than many others, the South African state’s vision was not its own invention.

Rod Edmond’s recent work on the place of leprosy in Western empires explores at length the shifting ideas reflected in the uses of the word colony at the end of the nineteenth and the beginning of the twentieth century. Building upon the work of Michel Foucault, Ann Laura Stoler, Paul Gilroy, and others, Edmond points out that, in this era, the uses of the word “colony” proliferated. Unmoored from its original Latin roots, which suggested the linkage between a parent state and a new, agrarian settlement, the term was regularly applied “to any group or concentration of people living in some way separate from the rest of society.”\textsuperscript{11} For some, as in the artistic, socialist, or utopian communities that took on the name, the separation was a voluntary one as individuals sought to remove themselves from a dominant culture. But, in other places, such as penal colonies and institutions for leprosy care, the separation was generally one orchestrated by authorities “for the purposes of containment and segregation.”\textsuperscript{12} Beyond these expanded uses, the term also found application in the natural sciences, most importantly from Edmond’s perspective, in reference to the collections of micro-organisms being

\textsuperscript{11} Rod Edmond, \textit{Leprosy and Empire: A Medical and Cultural History} (Cambridge: Cambridge University Press, 2006), 179. My discussion concentrates particularly on Edmond’s fifth chapter, entitled, “Concentrating and isolating racialised others, the diseased and the deviant: the idea of the colony in the later nineteenth and early twentieth century.”

\textsuperscript{12} Ibid
observed for the first time under microscopes at the end of the nineteenth century. For Edmond, the laboratory preoccupation with the prevention of contamination that led to the development of plate culture techniques for the isolation of colonies of microorganisms offered a telling parallel with the attitudes of empire builders. “Isolation is essential if the purity of the culture or colony is to be secured. Contamination is the worry. Bacterial and imperial colonies are homologous.”

Edmond argues that the idea of the colony, therefore, reflects “a cultural preoccupation with drawing lines, establishing boundaries, and constructing enclosures to separate different kinds of people from each other.” Difference could be construed in various ways, but was usually encapsulated in the idea of isolating “the primitive, the diseased, and the backward.” In Edmond’s analysis, the concentration camps of the South African War and Nazi Germany, the Native American and Australian Aboriginal reservations, and tuberculosis sanatoria are all representative of the same kind of thinking that lay behind the efforts to isolate people afflicted with leprosy. It was, in one sense, a reversal of the mandate found within the Levitical law which kept those with leprosy “without the camp.” Instead of pushing those with leprosy outside the boundaries

13 Ibid, 183.
14 Ibid, 187.
15 Ibid, 217.
16 The phrase “without the camp” comes from the translation of Leviticus 13:46 found in the King James Authorized Version of the Bible and is one of the most common phrases used in the study of leprosy when discussing the stigmatization of the disease and its sufferers. See, for example, Megan Vaughan’s chapter on leprosy in Curing their Ills: Colonial Power and African Illness (Stanford: Stanford University Press, 1991).
within which people free of the disease lived, the representatives of Western empires in the nineteenth and twentieth centuries pursued solutions based on the “construction of camps within which lepers could be concentrated.”\textsuperscript{17} Prescribing isolation for leprosy patients was not the invention of this time period, but the idea of creating institutions for the purpose of strictly enforcing that isolation was notably intensified. The institution that best represented the full flowering of the South African state’s vision, as well as the one that intersected most directly with developments in Swaziland, was the Westfort Leper Institution, opened in 1898 in the latter years of Paul Kruger’s Boer Republic of the Transvaal.

Simonne Horwitz has argued convincingly that Westfort was a logical manifestation of the South African state’s policies, both in its prioritizing of public health in sequestering patients afflicted with leprosy and in its own internal racial segregation. As the largest of South Africa’s leprosy institutions and the only one serving a multi-racial population after the closure of Robben Island as an asylum in 1931, Westfort embodied racial segregation “...not only in physical terms, but also in the way patients were cared for, their access to facilities, clothing allowance and even their rations, as well as how food was prepared and where it was eaten.”\textsuperscript{18} Constructed 10 miles outside the city of Pretoria, with a 12-foot barbed wire fence around its perimeter, Westfort was an institution focused on exercising control over the people who entered and exited. Long before Bantustans entered the South African lexicon via apartheid, patients were

\textsuperscript{17} Ibid, 187.

\textsuperscript{18} Horwitz, “Leprosy in South Africa,” p. 20.
separated along the lines defined by the state. Africans and Coloured patients from Pondoland, Zululand, or Transkei were sent to other state-run facilities in their respective areas, while those from Western Cape, the Orange Free State, and the Transvaal were kept at Westfort in facilities physically separated from units that housed South Africa’s Europeans and Indians afflicted with the disease.

The evolution of South African policy towards leprosy was of direct relevance to Swaziland, whose political and economic fortunes were closely tied to developments in South Africa from the mid-nineteenth century forward. On the economic front, Swazi labor was regularly drawn into the migratory patterns that drew Africans from all across the region to the gold mines of the Witwatersrand and the diamond mines at Kimberly. The report from deputy assistant commissioner Harvey with which this chapter opened hinted at this reality; Harvey’s language leaves room for interpretation, but his reference to “five labourers sent from here” almost certainly refers to Swazi men who had gone to work on the gold mines, from which they had subsequently been sent to Westfort for leprosy treatment. It is not possible to know, unfortunately, whether those men had contracted leprosy in Swaziland or upon arrival at the mines, as Harvey provides inadequate information with reference to the timing of their diagnosis or departure from Swaziland. But their story was not an entirely irregular one for Swazi men. Salakwanda Zulu, an unusually prominent case of leprosy in Swaziland, whose story is a focal point of chapter 4, also first received a leprosy diagnosis while living and working on the Witwatersrand. The cramped spaces of mining compound quarters may well have facilitated the spread of leprosy among workers, but the ability of the mining supervisors
to routinely monitor workers’ health and thereby select out those showing signs of weakness or contagion certainly played a role in directing Swazi laborers towards treatment regimes at Westfort.\textsuperscript{19}

The presence of Swazi men among the laborers at South Africa’s mines was not, of course, merely a result of the economic pull of wage labor. It was also tied directly to the political evolution of the Swazi state and intentional efforts by its European rulers to direct Swazi labor into their preferred channels. Swaziland was one of many pawns in the late nineteenth century struggle between the British and the Boers that climaxed in the South African War of 1899-1902. At the end of that conflict, Swaziland, along with Basotholand and Bechuanaland, became a British possession under the supervision of the British High Commission, seated in Pretoria and Cape Town. In the first decades of their rule, British authorities commonly assumed that the High Commission territories, particularly Swaziland, would eventually be united with the South African state, and the structures they implemented reflected that assumption. In the most dramatic example of the extension of South Africa’s racialized politics to the Swazi context, Lord Selborne, the High Commissioner, issued the 1907 Partition Proclamation, which by 1914 had

\textsuperscript{19} On the routines for monitoring the health of mine workers, see Randall Packard, \textit{White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa} (Berkeley: University of California Press, 1989), esp. ch. 3.
allocated two-thirds of the land in Swaziland to white settlers of both British and Boer
descent.²⁰

Beyond this, the legal code in effect in the Transvaal was transferred more or less
wholesale to the Swazi context, meaning that laws regarding the isolation and
compulsory segregation of leprosy patients were in effect in Swaziland.²¹ Ordinance no.
23 of 1904 granted the government wide ranging powers in the establishment of asylums
for the “treatment or detention of persons affected with leprosy” and required the internal
segregation of patients along both racial and gender lines, though the law did make
provision for “…married persons over the age of fifty years both of whom are persons
affected by leprosy to live together in any asylum.”²² Presumably, this exception existed
only because such patients would be beyond the years of procreation, and as long as they
remained confined within the institution, there was no danger of them spreading their
contagion. This exception aside, the law essentially transformed leprosy institutions into
prisons, and a confirmed diagnosis of leprosy was effectively the same as a criminal

²⁰The 1907 Partition and its impact on the movement of Swazi labor is undoubtedly the single most
thoroughly discussed component of Swaziland’s historiography. For a brief but clear summary, see Alan R.
Booth, Swaziland: Tradition and Change in a Southern African Kingdom (Boulder, CO: Westview Press,
1983), especially pages 15-31. But see also various works by Jonathan Crush, J.S.M. Matsebula, Hilda
Kuper, and Philip Bonner.

²¹Hilda Kuper offers some more general insights into the problems created by the transfer of the Transvaal
legal code to the Swaziland context in The Uniform of Colour: A Study of White-Black Relationships in
Swaziland (Johannesburg: Witwatersrand University Press, 1947), pp. 81-84. Although the onset of World
War II meant that Kuper’s work would not be published until 1947, her field work was done during the
years 1934-1937, and the book was published in 1947 more or less as Kuper had completed the manuscript
in 1938.

²²Ordinance No. 23 of 1904, “Leprosy.” Laws of the Transvaal in Force in Swaziland on the 1st Day of
January, 1949 by Virtue of Proclamations No. 3 or 1904, No. 11 of 1905, and No. 4 of 1907. Compiled by
H.C. Juta. London: C.F. Roworth Ltd., 1951. The first selection of quoted text comes from section 2 of the
ordinance; the second portion from section 16, paragraph 2.
conviction in that refusal of detention and isolation was not an option available to persons receiving the diagnosis. Ordinance no. 23 remained on the books in Swaziland until at least 1959, meaning that in theory the High Commission government there had the power to pursue an approach to leprosy control that would have rated among the world’s most coercive at the time, but in reality, with one notable exception discussed in chapter three, no such policy was even seriously discussed, primarily as a function of Swaziland’s small size and limited colonial infrastructure.

By any measure, Swaziland was a tiny outpost of the British Empire, with an estimated population still under 150,000 as late as 1934. In any British colony, one could expect to find a strikingly spare colonial bureaucracy, a manifestation of Britain’s preference for indirect rule.23 Swaziland’s small size, its inclusion under the umbrella of the High Commission, and the assumption that it would eventually be transferred to the South African state helped insure that no more than the minimally required staff received assignments to Swaziland. As a consequence, the limitations of its resources became the overarching narrative in discourse about the provision of medical care in general, a narrative that persisted well into the 1940s. Outside observers and colonial officials alike had little difficulty identifying the vast range of public health needs that existed in Swaziland, a roster of ailments that went far beyond leprosy. In the decades of British rule leading up to 1930, malaria, syphilis, epilepsy, and measles feature most

prominently, while tuberculosis emerged slowly into view. The problem was not in identifying threats to public health; the trouble was whether anything could be done about them. The language of government medical officers commonly sounded the theme of government inability:

- From 1913, regarding a serious outbreak of malaria: “It seems almost impossible to get the natives to believe in the preventive and curative properties of Quinine, even those who have been in contact with civilization for a long time prefer to the (sic) treated with native remedies by native doctors.”
- From 1928, highlighting the incidence of epilepsy: “Epilepsy is most extraordinarily prevalent all through the country. It is not possible to get at any figures, but the large number of out-patients who come to be treated for this complaint, the number of cases one finds in the gaols and the number of offences directly traceable to the effects of this disease dealt with in the courts of the Assistant Commissioners point to a very high incidence of the malady. No feasible explanation of this has been put forward.”
- From 1930, regarding a significantly delayed annual medical report for 1929: “… the Medical Department, in common with others in this country, lacks vision and its activities have been confined to the daily treatment of illness rather than an attempt to control the incidence of disease. Lack of staff and funds have been responsible largely for this inertia and I hope that the increase sanctioned for 1930/1931 will result in a marked change in Government Medical activity before the next annual report is written.”

Each of these different examples points to the varying contributing factors that signaled the inability of the British administration to attain its public health goals. Whether because of the refusal of local peoples to cooperate, the lack of reliable data, the absence of visionary leadership, or more simply because of their small numbers and

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24 On the emergence of tuberculosis in the Swaziland context and throughout the region, see Packard, *White Plague, Black Labor*, esp. ch. 4. Packard notes that tuberculosis did emerge more slowly in Swaziland than in other parts of the region, perhaps as a result of lesser participation in migrant labor and the dispersed nature of Swazi homesteads, but in his assessment, the 1930s were the crucial decade for its emergence.

25 Robert Jamison, 1913 Annual Medical Report, File RCS 391/23, SNA.

26 Robert Jamison, 1928 Annual Medical Report, File RCS 35/30, SNA.

27 T.A. Dickson to the High Commissioner, the Earl of Athlone, September 4, 1930, File RCS 35/30, SNA.
scanty budgets, the agents of British rule in Swaziland, as elsewhere in the world, regularly found themselves, as Jane Burbank and Frederick Cooper have recently declared, forced “... to be more realistic about the limits of their own power.” What they wished to attain, as suggested by the language of the final quote, was not just to treat illnesses but to “control” them, a somewhat ambiguous term that referred to any and all efforts to identify and eliminate the sources of diseases. But, as Randall Packard has illustrated in the case of malaria, administrators often misdiagnosed the situation quite significantly, blaming malaria outbreaks on heavy rainfall, for example, even in years when rainfall was below average, while overlooking entirely the contributions of their own economic policies to creation of famine that likely had a much more direct influence on the malaria outbreaks. Whatever their motives, the British could not simply will Swaziland or any other place in their global empire into fitting their prefabricated vision of a world living under British order. These limitations were felt acutely at times by agents of British colonial rule, because, as Helen Tilley has argued, the early twentieth century was a period of optimism about the possibilities of besting various infectious diseases, and many “metropolitan scholars and critics ... viewed health conditions as a litmus test for how well or badly specific colonies were being managed.”


Despite their frustrations over these limitations, the infrastructure for the delivery of health services in Swaziland grew slowly but steadily during these decades. The Annual Medical Report for the financial year that ended March 31, 1911 recorded that only 65 patients had been admitted to Swaziland’s lone hospital, a government institution located at Mbabane. According to the Government Medical Officer, many of those had been admitted as a result of “wounding at beer drinks by either knob sticks or spears.”

By the 1930s, Swaziland had two government hospitals, two more hospitals run by missionaries, and 5 additional dispensaries. And, perhaps most importantly from the perspective of the government, tens of thousands of Swazis were visiting these institutions for outpatient and inpatient medical care. The 1930 Annual Medical Report estimated attendances at hospitals and dispensaries at 25,000, an indication to the report’s author that “…European doctors and scientific methods of treatment are increasing their hold on the natives every year.”

If, in fact, Swazis were making increased use of Western medical facilities during these decades, then it was due in some considerable measure to the efforts of its “extremely capable and sympathetic Principal Medical Officer,” Dr. Robert Jamison.

Originally from Belfast, Jamison completed his medical training in 1910 as a Fellow of the Royal College of Surgeons of England and received an appointment as the Medical Officer for Swaziland’s Hlatikulu district in June of that same year. Within just a few

31 R. Clark Perkins, 1911 Annual Medical Report, File D09/114, SNA.
32 Robert Jamison, 1930 Annual Medical Report, File RCS 35/31, SNA.
33 Kuper, The Uniform of Colour, p. 78.
short years, Jamison had moved to Mbabane and become the government’s Principal Medical Officer, a position he held continuously until his retirement from government service in 1937. Even after his retirement, he remained in Swaziland, taking on private employment as the Medical Officer for the Havelock Mine, where he and his wife Isabel remained until his death in 1945. With nearly three decades of government work that stretched across the administrations of five different Resident Commissioners, Jamison was an unusually steady voice in matters related to the provision of medical care in Swaziland. Clearly well-liked by members of the expatriate community in Swaziland, Jamison’s correspondence and annual reports also reveal him to be, on the whole, an empathetic voice for concerns about the well being of the Swazi people. In the end, his retirement from government service came about in no small part because of chronic conditions contracted while paying frequent home visits to patients at all hours of the night or in inclement weather. Whatever the shortcomings of Swaziland’s medical services, they were not the consequence of a failure to invest on the part of Jamison.

While all observers of the situation agreed that increased Swazi access of Western medical care signaled their appreciation for its benefits, careful observers recognized that this did not necessarily imply a corresponding decrease in Swazi reliance upon their own traditional medical practitioners. In the mid-1930s, for example, the anthropologist Hilda Kuper observed repeated instances in which Swazis sought out dual diagnoses for their

34 File HS 9/2/1911 and File RCS 379/37, SNA, contain documents related to Jamison’s assignment to Swaziland and his retirement in 1937.

35 Hilda Kuper’s assessment of Jamison was confirmed independently by Dr. Samuel Hynd, a life long missionary resident of Swaziland, in a personal conversation in July, 2010.
conditions, relying upon both the Western expertise of Dr. Jamison and an *inyanga* (traditional healer) for counsel on how to treat their illnesses.\(^{36}\) As illustrated by Kuper’s observations and in the above quote from the 1913 Annual Medical Report, Swazis were clearly not anxious to abandon indigenous ideas about illness and wellbeing in favor of Western ones, a situation that frustrated the practitioners of Western medicine, who would have much preferred that Swazis develop exclusive reliance upon their techniques.

The annual medical reports from Swaziland’s principal medical officers during the years prior to 1932 communicate similar themes with regard to the perceived leprosy problem. And the notion of leprosy as a “perceived problem” was significant, because although leprosy was commonly referenced in annual medical reports, no one had any firm numbers about the prevalence of the condition. According to R. Clark Perkins, the Government Medical Officer who filed the 1911 Annual Report, it was “impossible to estimate the number of lepers, the very few cases seen are discovered by accident, but I have no doubt many exist.”\(^ {37}\) Why exactly was Perkins so certain that “many” cases of leprosy could be found in Swaziland, even in the absence of any firm numbers? Probably because, like Dr. Drewe on his way to Pondoland nearly a decade later, he had been led to expect that leprosy would be a serious problem in the African context, and the fact that Swaziland’s health infrastructure remained in its infancy excused him from needing to amend his prior assumptions based on his own experience. But the hospital records for the years after 1911 show that it was a rare year indeed when Swaziland’s doctors

\(^{36}\) Kuper, *Uniform of Colour*, p. 79.

\(^{37}\) Perkins, 1911 Annual Medical Report, File D09/114, SNA.
diagnosed more than one or two cases of leprosy. Nevertheless, leprosy continued to
interject itself into government discussions about health concerns in Swaziland, although
the correspondence from these years suggests the rather drifting approach of the medical
services.

The first recorded instance of serious government conversation about how to deal
with leprosy in Swaziland came in September, 1916. Dr. Jamison and Allen G. Marwick,
a future Resident Commissioner of Swaziland but at this time the Assistant
Commissioner for Mbabane, visited the kraal of Chief Dinabantu in the Dlangeni area to
the east of the administrative center. Here, Jamison examined six men and women,
ranging in age from 16 to perhaps 70, each of whom he confirmed had contracted leprosy.
Two other cases were also described to Dr. Jamison but not examined because they were
unable to travel to the previously established meeting spot; at least one of those cases had
previously been diagnosed with leprosy by a Dr. Anderson three years earlier. The report
Marwick filed the day after making this visit to Dlangeni centered around isolation of the
patients as the only reasonable measure to take. Marwick had communicated to
Dinabantu before his arrival the instructions of the Resident Commissioner, Sir Robert
Coryndon, that an area be set aside for these patients where they could be safely
segregated but “... with sufficient ground to cultivate and yet sufficiently near their
relatives for the latter to come to the boundary of the area to see the patients.”

Dinabantu had cooperated by identifying a kraal on land along the northern bank of the
Black Mbuluzi River, which had belonged to the late husband of one of the patients, who

38 Allen G. Marwick to the Government Secretary, September 5, 1916, File RCS 437/16, SNA.
was now under the care of a household from which three of the other patients had come. Since this household already had four patients in it and an extra kraal already constructed, this seemed a logical solution to Marwick, particularly if clear boundaries, both physical and social, could be delineated to ensure adequate food resources and adequate isolation from uninfected neighbors.

However, other problems had quickly emerged. Dinabantu informed Marwick that, although the families of the leprosy patients were prepared to cooperate with the authorities, each of them had some special pleading to offer, particularly regarding the patients whose families believed them too old or too weakened by their condition to effectively care for themselves. Marwick himself quickly arrived at the conclusion that, if all the patients were moved to one location, there was little chance that they could be self-sufficient in basic matters of food and shelter and that, unless some sort of regular provisioning could be arranged, many of the patients would soon abandon the settlement in favor of returning to their kraals. Given that government attendance to such a settlement was not an option anyone was prepared to seriously discuss, he concluded that the best course of action would be to leave the patients essentially where they were along with instructions from Jamison on how to avoid spreading their illness. In Marwick’s judgment, “I think that they are likely to obey such instructions because they do realize the awful nature of the disease.”

39 Ibid. See also Robert Jamison’s internal memo to the Government Secretary, February 22, 1919, File RCS 169/19, in which Jamison, in referring back to this discussion, notes that “segregating (leprosy patients) in a body inside the territory .... (was) rejected as impracticable, as there was no means of dealing with those who were unable to look after themselves.”
In 1916, Jamison may or may not have shared Marwick’s optimism about the likelihood of his instructions being followed; perhaps he simply felt it better to defer to the judgment of his more senior colleague. In either case, there certainly appeared to be little choice in the matter. An internal memo scrawled across the front of the folder containing Marwick’s correspondence about the Dlangeni patients declared in no uncertain terms that the government was “…not in a position at present to remove these people & others out of the country or to a local asylum but it is desirable that such measures of segregation (illegible) be adopted in the meantime as can be carried out without undue hardship or considerable expenditure.” Financial considerations always exercised a shaping influence on the decision making about provision of care. The archival records confirm that Jamison made at least two additional visits to Dlangeni to check on these patients in 1917, during which time he diagnosed one additional case in the area and two of the original eight patients died, but beyond that, there is little to indicate whether or not any of the patients received any benefits from his attentions.

Having made its first halting steps towards engaging the leprosy issue in Swaziland, the following decade in Swaziland produced a shifting set of strategies framed by both a cautious yet persistent optimism about the possibility of doing something medically effective for people living with leprosy and, more prominently, the perpetual search for the most financially expedient method of addressing leprosy. In Jamison’s case, he apparently lost faith in Marwick’s solution relatively quickly, dependent as it was on the willingness of the Swazis to impose isolation upon the

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40 Government Secretary internal memo to Allen G. Marwick, September 11, 1916, File RCS 437/16, SNA.
members of their own homesteads. It was less than three years after Marwick’s original report, in response to D.H. Harvey’s letter about leprosy patients in Mankaiana and in direct contravention of the opinion of his senior colleague, that Jamison expressed his view that the Swazis “have no idea of the serious nature of the disease and so no fear of it.” In Jamison’s assessment, effective measures required a more tangible intervention.

By 1919, Jamison was increasingly an advocate for responding to Swaziland’s leprosy problem by sending patients to institutions in the Union of South Africa, a strategy also employed for dealing with “lunatics.” By the time Harvey’s long-delayed letter about known leprosy cases in the Mankaiana District came under discussion in Mbabane, Jamison was aware of a total of forty-two cases of leprosy in Swaziland, more than half of them located in the Mbabane and Mankaiana Districts. He encountered some resistance to the idea, as sending these patients to Westfort would be no small matter from the financial perspective. The Union government charged 3 shillings/day or £54.15.0/year for the maintenance of Swaziland’s leprosy patients at Westfort, a sizable expense for a department whose annual budget only reached £14,000 in 1938. Despite the expense involved, Jamison was convinced that this was the only available option, and he pressed his case at every opportunity. In the first draft of his 1923 annual report for the League of Nations, for example, Jamison wrote:

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41 It is unclear precisely when the Swaziland government began sending mental health patients to South African institutions, and they received relatively little attention in the Annual Medical Reports. But see, for example, Robert Jamison, 1925 Annual Medical Report, File RCS 314/26, SNA.

42 Robert Jamison, internal memo to Government Secretary, March 13, 1919, File RCS 169/19, SNA.

43 Kuper, Uniform of Colour, p. 77.
Now that Leprosy has at last become amenable to treatment more provision should be made for dealing with it. The cost of building, equipping and maintaining a Leper Asylum would be so great it could not be considered, consequently the Lepers must be sent away for treatment. Arrangements have been made under which not more than five Lepers at a time will be maintained in the Union Leper Asylum. This number is much too low, and if it could be increased to twenty the Leper problem in the territory would soon be solved.\textsuperscript{44}

Jamison’s confident, albeit mistaken, assertion that leprosy was, in 1923, amenable to treatment reflects the optimistic spirit of the times in terms of the ability of medical science to deal with infectious disease, as does his contention that all it would take to solve leprosy was the provision of adequate care for twenty leprosy patients. This latter claim, which can also be seen in retrospect to have been too optimistic, was likely based on Jamison’s growing confidence that most cases of leprosy in Swaziland would eventually self-arrest, a relatively common phenomenon in tuberculoid leprosy patients, or what Jamison referred to as “nerve type.”\textsuperscript{45} But Jamison’s misplaced optimism in the report about the possibilities of resolving Swaziland’s leprosy problem was not in the least troubling to his superiors, who likely appreciated an optimistic tone in the report. What concerned them was the relatively mild criticism of their policies when Jamison opined that five was far too small a number of patients to effect any remedy. Jamison received a confidential, firmly-worded reproof from the High Commissioner’s office, cautioning that these reports to the League of Nations should be of a sufficiently innocuous and inoffensive nature as to be “…suitable for communication to the

\textsuperscript{44} Robert Jamison, Annual Medical Report for League of Nations, draft copy, 1923, File RCS 391/23, SNA.

\textsuperscript{45} For example, see Robert Jamison, 1931 Annual Medical Report, File RCS 34/32, SNA.
League.” As a consequence, Jamison had to amend his final report to expunge several statements criticizing the inadequacy of Swaziland’s health care provision. Regarding leprosy, Jamison’s final statement in the amended report noted vaguely that, “Arrangements have been made under which a limited number of lepers will be sent for treatment to the Leper Asylum in the Union of South Africa.”

It is unclear from the surviving records precisely when the first Swazi leprosy patients arrived at Westfort or how they came to be there. As noted above, Harvey’s 1918 letter suggested that some Swazis were already at Westfort, but likely had come there via their employment in the mines of the Witwatersrand. In 1920, Government Secretary B. Nicholson responded to an inquiry about Swazi leprosy patients by claiming that, “Lepers from this Territory are usually isolated in Asylums in the Union and there is no intention of erecting an Asylum at present.” This, however, reads like an attempt by the Government Secretary to put the best possible face on the situation, since there is no evidence that the Government had actively pursued sending any cases of leprosy to Union institutions before 1920, and the language Jamison used in his 1923 report for the League of Nations strongly suggests that the arrangements for sending leprosy patients from Swaziland to Westfort was a new one. That Nicholson was aware of Swazi patients at Westfort is undoubtedly true, but mostly a reminder of the relatively blurry boundaries that existed between Swaziland and the Union during this time period.

46 File RCS 391/23, SNA.

47 Jamison, Annual Medical Report 1923 for League of Nations, 1923, File RCS 391/23, SNA.

48 See the correspondence between L.W. Ritch, a solicitor in Johannesburg writing on behalf of Rev. William Mquqo, and Government Secretary B. Nicholson in File RCS 169/19, SNA.
A turning point of sorts came in April of 1925 when Dr. Jamison oversaw the transportation of five Swazi leprosy patients to Westfort, including a woman named Madolwane Maziya whose story makes up the heart of chapter two. By Jamison’s own account, the effort barely amounted to even a token effort. Writing in January of 1926 to Dr. David Hynd, the Scottish-trained medical doctor who had arrived in Bremersdorp the previous year as a missionary for the Church of the Nazarene, Jamison noted that upon receiving funding to send five patients and in the absence of any more systematic plan for prioritizing leprosy care, he simply “had a whip round this area and collected five in fairly early stages, filled in all their papers, explained to them that they had to undergo special treatment, to which they agreed & sent them off last April.”

The relatively benign tone of Jamison’s wording to Hynd is belied to some degree by other correspondence from the period that indicated the government was prepared to consider coercive measures in the event that patients did not agree to be sent to Westfort. On January 6, 1925, Government Secretary Nicholson wrote to the Assistant Commissioner in the Mankaiana District, most likely still D.H. Harvey, with instructions regarding a certain Madhlebe Nzima, suspected of having leprosy:

Please find out whether Madhlebe is prepared to submit himself voluntarily for treatment. There is no danger in the treatment, I understand and a cure may be effected within six months. There will be other Swazi lepers going up with him. Madhlebe would have to be sent here (to Mbabane) for examination by two medical officers.

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49 Jamison to David Hynd, January 21, 1926, David Hynd Collection, Nazarene Archives, Lenexa, Kansas.

50 B. Nicholson to Assistant Commissioner, Mankaiana, January 6, 1925, File RCS 437/16, SNA.
The examination by two medical officers was a requirement of Ordinance no. 23 of 1904, adopted from the Transvaal, and Nicholson makes it plain in his letter that he intends to employ the coercive “alternative procedure” contained within the ordinance “(i)f Madhlebe is not prepared to submit himself voluntarily for treatment.” This could ultimately mean police detention and removal for uncooperative men or women diagnosed with leprosy. Perhaps Nicholson handled the situation in this fashion because he knew that Harvey had some personal interest in proper leprosy control, but the approach in this case is notably more assertive than had been the case in previous years. Ultimately, however, these sorts of instances stand as outliers to a more general pattern of government equivocation and compromise; even after two complete decades of British oversight in Swaziland, the administration’s efforts to assert its authority still came in fits and starts at best.

The level of concern for enforcing leprosy control was certainly unevenly felt throughout the layers of government bureaucracy. In his 1926 letter to Hynd, Jamison described himself as “in a deuce of a Quandary at present about Lepers.” On the one hand, Jamison wrote, “The Medical Advisory Council of the Colonial office has been after us about Lepers...” while at the same time the Swaziland Advisory Council had, just the week prior to his writing to Hynd, recommended that money designated by the administration for sending twenty additional patients to Westfort out of the proposed financial estimates for 1926 instead be used for more actively pursuing and treating cases

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51 Ibid. In his letter, Nicholson indicates that the AC should review sections 4 through 8 of Ordinance no. 23 for guidance on how to proceed.
of syphilis. Jamison was not happy with this recommended course of action, feeling that “The end of the whole thing will be that we shall have only the five lepers treated, and only a few more syphilitics,” but, by his own estimate, syphilis was a greater public health threat in Swaziland “…to the individual both white & native and a greater danger to the race than is Leprosy.” Presumably because he assumed that Hynd would understand the reasons for his assessment, Jamison offered no elaboration on the reasons why syphilis constituted such a serious “danger to the race” (nor did his language even make it precisely clear to which race he was referring), though the fears of infertility and the degeneration of British ideals of manhood and racial superiority loomed large in such discussions. Karen Jochelson has argued convincingly that such sentiments were not at all uncommon among whites living in this region at the time, for many of whom the spread of ailments such as syphilis was simply an expression of “wider anxieties about the instability of the social, political, and moral order.”

Aside from his conclusion that syphilis constituted the more serious issue, by the time Jamison wrote to Hynd, the Westfort experiment had begun to go awry. Just eight months after sending the patients to Westfort, Jamison noted that he had word from Pretoria that although they were doing well, the Swazi patients were refusing treatment for reasons unknown to him, and he planned to go to Pretoria as soon as he could “to go

52 Jamison to Hynd, January 21, 1926, NA.

into the matter.” The situation of the leprosy patients at Westfort is a central element of chapter two; for now, it will suffice to say that by 1929, Jamison was of the opinion that the arrangements with Westfort had “proved very unsatisfactory,” stressing that “Some time ago the Administration decided to cease sending Lepers there.” It’s not clear how much the administration knew about these unsatisfactory arrangements with Westfort, though they would soon know a great deal about them thanks to the extended letter writing campaign of the patients there, but for once, this opinion seems to have been generally shared among government officers, because not only was it relatively expensive to maintain the Swazi patients at Westfort, there seemed to be little point in doing so if they were not receiving beneficial medical treatment. Two years earlier, in 1927, the Swaziland government had investigated the possibility of having the Westfort patients transferred to the Amatikulu Leprosy Institution in Natal, a move that J.W. de Vos, the Medical Superintendent at Westfort, thought the Swazi patients would find “more congenial.” This move, however, was apparently meant mostly as a cost saving measure, because when the government of Swaziland learned that the cost of patient maintenance at Amatikulu were being raised to the same rate of 3 shillings/day as at Westfort, they let this proposal, as so many others before it, drop.

54 Ibid.
55 Jamison, internal memo to Government Secretary, October 5, 1929, File RCS 633/29, SNA.
56 J.W. de Vos to the Secretary for Public Health, Pretoria, August 22, 1927, File RCS 633/29, SNA.
57 E.N. Thornton to Government Secretary, Swaziland, October 15, 1927, File RCS 633/29, SNA.
Having witnessed the failure of his previous recommendation and just as convinced as ever that local quarantine within communities would never be effective, Jamison concluded that the best and most cost-effective measure in the long run would be to construct a leprosy colony inside Swaziland, but not an elaborate one with a Medical Officer or large buildings. Rather, they should aim to find a piece of land where the patients could “live under conditions approximating as closely as possible to those they have been accustomed to.”\textsuperscript{58} Despite this recommendation, three more years of inactivity followed, inertia finally broken by the unexpected interventions of Madolwane Maziya and her fellow patients at Westfort.

In summary, the first three decades of British rule in Swaziland produced a set of shifting policies and strategies for handling leprosy, shaped primarily by their optimism about the power of science as a transformative force and also by the realities of their finite sociopolitical power and financial wherewithal. Like their counterparts in other outposts of the British Empire, Swaziland’s colonial officials on the whole wanted to “treat leprosy as a dangerous epidemic;” think again of the words of Deputy Assistant Commissioner Harvey, with which this chapter opened.\textsuperscript{59} But the management of leprosy patients had to be kept in balance with other concerns about malaria, measles, syphilis, epilepsy, and tuberculosis, none of which was receiving all the attention that the Swaziland administration might have liked.\textsuperscript{60} The administration’s financial calculations

\textsuperscript{58} Jamison, internal memo to Government Secretary, October 5, 1929, File RCS 633/29, SNA.

\textsuperscript{59} Cooper, \textit{Evangelical Christians}, p. 298.

\textsuperscript{60} Kuper, \textit{Uniform of Colour}, p. 77. Kuper was aware of failed proposals by Jamison for tackling tuberculosis, veneral disease, malaria, and nutrition.
were generally a zero-sum game, and additional expenditures in one area were likely to mean cuts in another.

The frustrations of balancing their vision of healthcare with the constraints of finances led the British to turn to partners outside the colonial administration; in Swaziland, as elsewhere, this meant missionaries. In contrast to the French in Niger, the sympathies of the British to a certain kind of spiritual outlook were evident:

While the crusading spirit is absent from government officials, who do not force Christianity on the Swazi nor strive directly at conversion, they indirectly exercise a proselytising influence. The administration which they serve is the organ of a “Christian” country, and a number of its laws ... regulate behaviour in accordance with “Christian” ethics. The officials inevitably have an egocentric evaluation of their own religious beliefs and practices.61

The generically Christian ethos that Hilda Kuper detected in Swaziland’s colonial hierarchy rarely broke through in their internal discussions, but in Kuper’s assessment, the administration’s decision to subsidize missionary schools and health institutions “...helps maintain towards them a religious rather than a scientific attitude.”62 And if any condition lent itself particularly to this religious attitude, it was surely leprosy.

Although missionaries of more than a dozen denominations were working in Swaziland by the 1930s, only one of them had developed a substantial medical work: the Church of the Nazarene, a denomination organized in the United States in 1908 and therefore a relative newcomer to missionary work in Africa. In one sense, the birth of Nazarene missions was part of a larger wave of new Protestant missions that appeared out

61 Kuper, Uniform of Colour, p. 108.
62 Ibid.
of the West at the end of the nineteenth and beginning of the twentieth century, animated especially by the growth of premillennial dispensationalism, which held that the return of Jesus Christ to earth was an imminent event and the only sure hope of improving the world or humanity’s condition. Most of these new missions fit the category of “faith missions,” enterprises driven by individuals who could not gain employment with mainline denominational missions but who entered the mission field on the strength of pledged support from individuals and churches in their home country. Because of their premillenialist views, they were generally very focused on matters of evangelization, rather than on building institutions or engaging in humanitarian work. The Nazarenes, however, did not fit neatly within that model.

The Church of the Nazarene represented a new and relatively conservative branch of denominational missions and was not necessarily strongly premillennial, although some influential leaders in the church subscribed to that particular view. However, because the Nazarene Church itself had developed out of a union of several different church bodies with their own particular cultures and points of emphasis, it had developed a noteworthy emphasis on unity in essential matters and freedom in non-essentials, and the question of premillennialism fell into the latter category.


64 For more on this, see particularly chapter 9, “Nazarenes and Society” in Floyd Cunningham, ed., Our Watchword & Song: The Centennial History of the Church of the Nazarene (Kansas City: Beacon Hill Press, 2009).
the imminent return of Jesus Christ as the driving force behind missionary work, Nazarenes emphasized the one essential doctrine that formed the basis of their denominational unity and distinctiveness, the idea of holiness and the need for the spiritual transformation of entire sanctification which followed conversion and transformed a person’s life on this earth. It was a sort of modified version of the Christian civilizing vision passed down from the Nazarenes’ mostly-Methodist roots.  

The theological language of the Church of the Nazarene regarding entire sanctification was relatively unchanged throughout the twentieth century. The Articles of Faith explained that entire sanctification was an “act of God, subsequent to regeneration, by which believers are made free from original sin ... and brought into a state of entire devotion to God ...” Entire sanctification was something distinct from the decision to convert to Christian faith (described as regeneration) and an event that Nazarenes and others in the Holiness tradition expected to occur at some later point in a person’s life. The purpose of this event, particularly noteworthy in considering the missionary work of the church, was to “(empower) the believer for life and service.”  

The change in one’s life, in other words, was not an abstract or purely spiritual concept; it should be clearly evident in the way a person lived. Indeed, the church had quite a specific list of evidences in mind, especially with regard to things that its members should not do. The church’s General Rules for membership clearly stated that those who desired membership in the

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65 Dana Robert, American Women in Mission: A Social History of Their Thought and Practice (Macon, GA: Mercer University Press, 1997), pp. 139-140.

66 The Manual of the Church of the Nazarene (Kansas City: Nazarene Publishing House). The language quoted here was used without amendment between 1928 and 2009.
Nazarene church should avoid “evil of every kind,” which included things such as taking the Lord’s name in vain, profaning the Sabbath, quarreling, and dishonesty but also included specific prohibitions on the consumption or trafficking of alcohol and tobacco, the indulgence of outward pride in dress or behavior, and any participation in the theater, dancing, lotteries, or any oathbound secret societies. Missionaries for the church were, and still are, expected to give clear testimony to this experience of deepened spiritual life by way of entire sanctification and to endorse the church’s universal prohibitions against “evil.” The fact that they did so, as we will see especially in chapters three and four, often created tension between the missionaries and both the people they hoped to win as converts and, at least in Swaziland, the British administration under which they operated.

Swaziland was one of the very first mission fields where the Church of the Nazarene opened work. In fact, the 3 missionaries who founded the work in Swaziland traveled to South Africa in 1907, as representatives of churches that subsequently joined the Church of the Nazarene at its establishment in 1908. In 1910, Harmon Schmelzenbach, his wife Lula, and their co-worker Etta Innis opened the work of the Church of the Nazarene at Ndzingini in northern Swaziland. Like the faith missions of the same era, the Church of the Nazarene officially eschewed humanitarian or

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67 Ibid. The summary here is based on a review of Section V, Paragraph 1 in the 1948 edition of the Manual, but the language was subject to only minor revision from the time of the church’s founding until 1976 when some of the more specific prohibitions (such as those regarding tobacco and alcohol) were replaced with more general prohibitions against “Habits or practices known to be destructive of physical and mental well-being” (Section V, Paragraph 26).

civilizational mission work in favor of preaching a message of repentance, conversion, and sanctification. Consider, for example the position expounded in the 1928 Report of the Department of Foreign Missions:

> Your Department of Foreign Missions has never undertaken, in its work among the heathen people, to spread Western civilization as such, nor to preach through its missionaries the modern gospel of sanitation, soap and water, and other modern reforms. It has consistently insisted on spreading regeneration and entire sanctification at its mission stations, where they have been planted. ‘Tis true, that where the real gospel goes, there also go all its by-products, of enlightenment, sanitation, and civilization, but your Department has faithfully devoted itself to the main current of personal salvation, and the generation of the experience of holiness, as a second definite work of grace, and allowed the by-products to enter in as they would.⁶⁹

Such language may have articulated official priorities, but the reality on the ground in Swaziland and in the subsequent work in the Union of South Africa and Portuguese East Africa that developed out of it was starkly different. Any careful examination of the activities of the missionaries in these areas demonstrates that endeavors in health care and education, which would undoubtedly have fit under the banner of “Western civilization” described above, could hardly be described as “by-products” following the “real gospel.” In fact, seven years before the declaration above, the Nazarene missionaries in Swaziland had already identified education as a critical need:

> While we are convinced that the education of the native is not his greatest need, yet we realize that our educational work is of very great importance. We have passed the days of pioneer work ... today we are entering into the second stage,
the building must be erected and as to what kind of structure it will be, will be
largely dependent upon our educational work.\textsuperscript{70}

Preaching, education, and eventually health care became interchangeable pulpits for the
same goal - conversion and sanctification of Swazis, with the concomitant
transformations of their social life, the necessity of which was a point of agreement
among all Nazarene missionaries whatever their proposed methods.

The surest evidence of the Nazarene’s impulse towards mission as civilization
came in August of 1925 with the arrival of a Scottish medical doctor named David Hynd,
who would live out the remaining 65 years of his life in Swaziland exercising
unparalleled influence over the development of the Church of the Nazarene in Swaziland.
Today, Hynd’s gravestone lists among his accomplishments his role as the “pioneer and
founder” of the Manzini Nazarene Mission, Raleigh Fitkin Memorial Hospital, Clinics,
the Nazarene Nursing College, the Swaziland Leprosy Programme, Schools and Teacher
Training College, the Swaziland Conference of Churches, the Bible Society of
Swaziland, Baphalali Swaziland, and the Red Cross Society. Hynd’s work, more than
that of any other Nazarene missionary in Swaziland (and perhaps anywhere in the world),
pushed the construction of institutions that sometimes concerned other missionaries.
From his very earliest days in Swaziland organizing the construction of the Raleigh
Fitkin Memorial Hospital, Hynd had to pay careful attention to the attitudes of other
missionaries and to what exactly got reported back to mission leadership back in the

\textsuperscript{70} Report of the Committee on Education in the Official Proceedings of the Second Annual Assembly of the
South African District of the Church of the Nazarene, microfilm reel 34:037, Nazarene Archives, Lenexa,
Kansas.

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Conflict certainly existed, but it was rare that other missionaries expressed outright disapproval of medical work; in fact, there had been an earlier attempt to get such work started under an American medical missionary stationed at Pigg’s Peak. But when the failure of the doctor to obtain British recognition of his medical credentials led to his reassignment, the door opened for Hynd to come to Swaziland. As a British citizen and a man of extraordinary vision and energy, Hynd was well positioned to exercise considerable influence over the direction of the work.

For Hynd, there was no distinction between the medical work and the evangelistic work of the church; in fact, he was convinced that the hospital itself constituted perhaps the most effective tool available for the mission:

Perhaps the greatest single factor that God has used to help on the work has been the influence of the hospital and medical work. One has to realise what witchcraft means to appreciate what a hold it has upon the native mind. The greatest wedge for prying into the stronghold of witchcraft is medical missionary work. I wish I did not have a host of medical duties awaiting me now, so that I could tell you of how in places scattered throughout the country the contact with the hospital has made its definite contribution to the salvation of the people, and to the propping up of the faith of our native christians when during their sicknesses they were assailed by the old dread of witchcraft. Apart from these results, of course, there is the great contribution which the hospital has made towards the relief of the great sea of suffering amongst the people.72

71 See, for example, David Hynd to “Papa” [George Sharpe], February 7, 1926, File 1364-8, and David Hynd to “Papa,” May 24, 1931, File 1364-13, David Hynd Collection, Nazarene Archives, Lenexa, Kansas. In the 1931 letter especially, Hynd makes an impassioned defense of the need for institution building and offered some very harsh criticisms of some of his missionary colleagues and their narrow views, alleging that they scarcely read anything other than the Bible, the Herald of Holiness, and The Other Sheep, both of which were denominational periodicals.

72 David Hynd to Mrs. Bert Smith, December 15, 1929, File 1364-8, David Hynd Collection, Nazarene Archives, Lenexa, Kansas.
Hynd understood the curing of physical ailments to be a secondary benefit of medical missionary work, following the primary commitment of evangelical work aimed at conversion. But because Hynd understood the worldview of the Swazis to be one shaped primarily by witchcraft, it was necessary to use medical work to break the strength of that older set of cultural norms. In holding to such ideas, Hynd was following in the established footsteps of other medical missionaries at work throughout the African continent. One could also suggest that Hynd is merely using the language he knows is necessary when communicating to missions supporters abroad, but there is a consistency about his articulation of this idea over time that suggests he truly embraced it as his personal philosophy.

Hynd’s views on leprosy stemmed from this same wellspring of concern for overcoming the influence of witchcraft on the Swazis and turning them towards Christian faith. Barbara Cooper has argued that Hynd’s contemporaries in the Sudan Interior Mission at work in Niger believed that leprosy was an incurable illness except by means of spiritual intervention, and that its cause was likewise rooted in the spiritual rather than the biological. There is little evidence to suggest that Hynd believed that leprosy’s cause was somehow spiritual in nature, but he, much like Dr. Drewe in Pondoland, was interested in the leprosy situation right from the beginning. The letter from Dr. Jamison referenced above was almost certainly a reply to a specific inquiry from Hynd about the

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74 Cooper, *Evangelical Christians*, p. 299-304.
leprosy situation and came just five months after the first face to face meeting between the two men and more than a full year before Hynd had finished building the Raleigh Fitkin Memorial Hospital, which opened in Bremersdorp in July of 1927. Hynd may well have regarded leprosy as a kind of low-hanging fruit that might give the medical work of the mission a relatively easy but particularly resonant victory. By 1930, Hynd was confident that leprosy was not “a very prevalent disease” in the area, but rather than seeing this as a reason for neglect, he saw this as an incentive to action as it opened the possibility “that with proper measures the Territory might ultimately be rid of the disease after a number of years.” In making such declarations, Hynd imbibed the same optimistic spirit that Jamison and his successors would articulate in steadily increasing ways during the years that followed, but beyond his scientific confidence, Hynd also drew motivation from leprosy’s spiritual significance. With its biblical connections, Hynd likely understood caring for leprosy patients as an important intersection of interests, for his overseas church supporters and the Resident Commissioner’s government that wanted to bolster the evidence of its modern medical services.

Hynd’s vision for leprosy work coalesced conveniently with the position that Jamison had assumed in light of the failed Westfort experiment. In his report for the year ending December 31, 1929, Hynd reported having seen a few cases of leprosy, and even the arrest of the disease in one case under treatment, though it is unclear what sort of

75 My thanks to Thomas Noble, currently working on Hynd’s official biography, who provided valuable information about the timeline of events in Hynd’s life, based on his review of Hynd’s daily diary.

76 David Hynd to Deputy Assistant Commissioner, Bremersdorp, 12 February, 1930, David Hynd Collection, NA.
treatment Hynd might have offered. He did also note that he and the Deputy Assistant Commissioner for Bremersdorp, Mr. S.B. Williams had successfully germinated seeds of the hydnocarpus tree that produced chaulmoogra oil. The seeds had been provided by the nascent British Empire Leprosy Relief Association (BELRA) out of Siam, and as far as Hynd knew, it was the first time anyone had attempted to grow the tree in South Africa. Hynd clearly envisioned leprosy care as a long term project, which brought him to his core recommendation:

> Attempts have been made to isolate these cases at their kraals but this is, at best, an unsatisfactory method of control. A well-regulated leper colony in which all lepers could be segregated would seem at once to remove a menace to public health and provide comfort, treatment and spiritual solace to those much in need of such ministrations.\(^77\)

Hynd’s words seem carefully calibrated to align with the thinking of Dr. Jamison, with whom Hynd had been building a relationship for nearly five years by the time he wrote this report. The only thing that separates Hynd’s recommendation from Jamison’s own views at this time is his inclusion of “spiritual solace” among the needs of the leprosy patients.

Hynd used similar language regarding leprosy in his annual reports for the years 1930 and 1932, as he worked steadily to position the Church of the Nazarene as the natural partner for the government of Swaziland in relationship to leprosy care. However, likely understanding the inevitable slow movement of the government, Hynd also took steps to seize the initiative with regard to leprosy. On the one hand, he was not

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\(^{77}\) David Hynd, Raleigh Fitkin Memorial Hospital Report for the year ending 31 December, 1929, File 1367-1, NA.
above subtly increasing pressure on the government by suggesting that their efforts compared poorly to other colonies, as he wrote in his 1932 report: “From both a public-health and humanitarian point of view an early attempt should be made to stamp out this disease as is being done in other parts of the Empire.”

Hynd was also actively reaching out to other organizations concerned about leprosy work, such as BELRA and the Mission to Lepers, which would eventually come to play a very significant role in Swaziland’s leprosy program. In March of 1930, Hynd received word that £100 had been donated by the American Mission to Lepers, meant to serve as seed money to aid the Church of the Nazarene in starting a colony for leprosy patients. With money in hand, Hynd even began actively investigating a site just two miles from the RFMH, going so far as to informally discuss the matter with Sobhuza II, the Swazi Paramount Chief, who had responded favorably. Hynd’s proposal got as far as being endorsed by Jamison in his financial estimates for 1931/32, as well as site inspections by Mr. Williams, the D.A.C., Bremersdorp, a representative of Sobhuza, and the Resident Commissioner, but no further.

The existing correspondence does not make entirely clear why the proposal died. The most likely explanation is that the item was cut out of the estimates at a higher level of the colonial bureaucracy, particularly considering the onset of the Great Depression.

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78 David Hynd, Raleigh Fitkin Memorial Hospital Report for the year ending 31 December, 1932, File 1367-1, NA. Emphasis added.

79 William C. Terril to David Hynd, March 3, 1930, David Hynd Collection, NA.

80 See David Hynd to the Deputy Assistant Commissioner, Bremersdorp, 28 July, 1930, and S.B. Williams to the Paramount Chief, 8 September, 1930 in the David Hynd Collection, NA. Also see Walter Johnson to the Resident Commissioner, 3 August, 1938, File RCS 577/38, SNA.
But other local factors may have intervened as well. Hynd himself departed the country in 1931 for a year long furlough, and although he dedicated some of that furlough time to contacting BELRA, the Mission to Lepers, and other interested parties about supporting leprosy work in Swaziland, his absence may have contributed to a loss of momentum for the project on the ground. It is also possible that Sobhuza never gave his final approval to the proposal. The land Hynd wanted to use had no kraals on it, though it did have some cultivated fields, so he saw it as relatively convenient for his purposes. But the plot in question was Native Area land under the terms of the 1907 Land Partition Proclamation, and Sobhuza was in no mood to cooperate with any proposal that might result in further reductions of land under Swazi control.81

By 1932, the missionaries of the Church of the Nazarene, led by Dr. Hynd, had done their best to position themselves as the natural partners for the Commissioner’s government in the project of leprosy care for Swaziland, but despite their efforts, they also had failed to overcome the logistical obstacles involved in starting a work that would adequately fulfill their vision of what should be done. The initiative then was left in the hands of Swazi people, whose voice and agency were noticeably lacking in the developments outlined so far. It is, of course, difficult to surmise the views of Swazis about leprosy from a period beyond the recovery of individual memory and in a largely

81 There is some evidence that Hynd himself believed Sobhuza’s lack of cooperation to be the chief obstacle. In a letter written five years later to the General Secretary of the Mission to Lepers, Hynd explained, “When I got back here after furlough I endeavoured to get the Paramount Chief through the Government to grant a piece of land for the purpose of a leper colony but I did not get very far.” However, the letter contained no further elaboration, so it remains unclear even why Hynd believed that he had been unable to get very far with his proposal. See David Hynd to W.H.P. Anderson, 28 November, 1937, David Hynd Collection, NA.
non-literate culture. But drawing on the observations of parties both within Swaziland and in neighboring contexts, we can sketch out a reasonably clear picture.

The crucial point is that there is little evidence to suggest that Swazis had any long-standing prejudices against people suffering from leprosy. In fact, they may have had relatively little experience of the disease prior to the twentieth century. In 1938, Sobhuza told Walter Johnson, the Medical Superintendent of Basutoland’s Botsabelo Leprosy Hospital that he believed the disease to be a recent introduction into Swaziland, because there was “no native name for it.”

My own research in Swaziland largely supports this assertion, as the only commonly used word for the condition was *bulephelo*, clearly a derivative from English. I asked missionaries, local leprosy workers, traditional healers, and many of my interview subjects about other names for the condition, and none were offered. In the Swaziland National Archives, the file that contained correspondence about the Dlangeni leprosy cases had a note scribbled on the front suggesting that, in isiZulu, the word for leprosy was *ucoko* and that, in siSwati, the word used was *mdilikana*. A number of people with whom I spoke had encountered the isiZulu word, and it can commonly be found in isiZulu Bible translations, but it was not commonly used in Swaziland, nor had anyone I spoke to ever used the word *mdilikana*.

According to the note on the file, the word *mdilikana* was used because it referred to a practice of leaving the body of a leprosy patient unburied inside a hut, which was then allowed to decay until it collapsed upon that body. But again, no one in Swaziland

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82 Walter Johnson to the Resident Commissioner, 3 August, 1938, File RCS 577/38, SNA.

83 File RCS 437/16, SNA.
recalled any such custom, nor have I found any other references to it. The only close parallel to this practice I have uncovered was Henri Junod’s description of Tsonga burial practices for people who died of leprosy. In the first volume of his ethnography, Junod asserts that the Tsonga would bury a leprosy sufferer in a hut, but no one else. In the second volume, he elaborates on this practice by explaining that a grave would be dug right outside the hut, a hole made in the wall, and the body dragged through that hole and deposited into the grave without further ritual. All of this work would be done by people who were not blood relatives of the deceased, for people related by blood were particularly vulnerable to the contagion associated with the condition. After the burial, Junod continues:

> All the implements are broken in the depth of the forest, at a great distance, for fear that a relative may touch one of them and die. Or they are left in the hut, and the whole village at once removes. Leprosy is called *nhlulabadahi*, the disease which is stronger than the doctors. It is very much dreaded; however lepers are not segregated; they live in the village with other people and even attend beer-parties, but they bring their own mug, whilst every other guest receives a drinking utensil from the master of the village.

All in all, Junod perceived significant social stigma surrounding leprosy in Tsonga communities, and given that he published his two volumes just three to four years before Allen Marwick and Robert Jamison visited the Swazi leprosy patients in Dlangeni, it is conceivable that his work influenced their thinking, particularly that of Marwick, who

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seemed convinced that the Swazis understood the nature of leprosy in similarly awful terms to those of Europeans.

Despite Junod’s assertion of Tsonga fears of leprosy, he did not believe that the Tsonga regarded the illness as one that required recourse to explanations dependent upon the actions of unhappy ancestors or evil spirits. On this point, there was much wider agreement around the region. A.T. Bryant, for example, had a similar assessment of leprosy among the Zulu, claiming that “Leprosy and venereal diseases were absolutely unknown among the Zulus...” until sometime after the arrival of Europeans in the region. In both cases, some traditional healers could offer specialized herbal remedies, but these were not necessarily dependent on spiritual interventions. A similar pattern appeared to be at work in Swaziland.

When Allen Marwick’s nephew, Brian A. Marwick who would himself give nearly 40 years of service to the Swaziland colonial administration, published his University of Cape Town Master’s thesis as an ethnography of the Swazi in 1940 (after 15 years in Swaziland), he declared that leprosy, along with epilepsy, venereal diseases, and a few other ailments such as a toothache or a boil, was not believed to result from witchcraft. Indeed, he argued, “Natives do not even take the trouble to send these people to the doctors.” In this case, Marwick’s use of the term “doctors” refers to both practitioners of Western medicine and the Swazi’s own traditional healers; unfortunately,

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86 A.T. Bryant, *The Zulu People as they were before the white man came* (Pietermaritzburg: Shuter and Shooter, 1949), p. 121. Publication of the book was seriously delayed, as Bryant had finished the manuscript by 1935.

Marwick offered little further elaboration, except to state that leprosy belonged to a class of “ordinary diseases” that “are known to everyone and are regarded as having natural causes.”\textsuperscript{88} Marwick’s views are also generally in agreement with the explanations given to me by multiple Swazi traditional healers, although they were all in agreement that in the past, Swazis had regularly consulted certain traditional healers who specialized in the treatment of leprosy, who employed a variety of herbal remedies to assist those with the disease.\textsuperscript{89}

In total, the evidence suggests that Jamison and Hynd were quite correct in their conclusion that isolation of leprosy patients within their own kraals was a strategy unlikely to be followed with the strenuous rigor they felt was necessary. Swazis simply were not inclined to treat people affected by the illness as social outcasts or imminent dangers to their own well being. Megan Vaughan has asserted that missionaries who encountered this absence of stigma surrounding the disease elsewhere in Africa responded with “deep horror,” as it affirmed their convictions about the “‘primitiveness’ of such societies.”\textsuperscript{90} Horror is probably too strong a word to use in describing the reaction of Hynd or Jamison, but they did seem to see it as a sign of Swazi backwardness that they could not recognize the dangers of the illness. The irony is that, in retrospect, it is now clear that the views of the Swazi people were much more in line with the realities of leprosy and its potential dangers than were the inflated fears of the Europeans who

\textsuperscript{88} Ibid, p. 252-253.

\textsuperscript{89} Mr. Ndzingane, interview by author, Dlangeni, Swaziland, November 13, 2010. Group Interview by author, Traditional Healers Association, Siteki, Swaziland, October 20, 2010.

\textsuperscript{90} Vaughan, Curing their Ills, p. 80.
criticized them. The extent to which some Swazis really did understand both the illness itself and the nature of the state under which they lived would become clear in the years following 1932, as a consequence of the extraordinary actions of Madolwane Maziya and her fellow Swazis at Westfort in Pretoria.
Chapter 2
“We are thrown away”: Swazi and Missionary Views on Disability at the Ncabaneni Leprosy Settlement, Swaziland, 1932-1948

Leprosy as an illness may not have been, on the whole, a major concern of Swazi society in its own right, but this did not mean that those select few people who suffered from the disease consequently became passive objects upon which Westerners could simply enact their visions of disease control and/or spiritual transformation. In fact, the opposite was true. In this chapter, I argue that Swazis in various contexts managed to decode Western language about leprosy and then repurpose it for their own ends. I do this chiefly by examining closely the lives of two women, Madolwane Maziya, a female Swazi leprosy patient whose letter writing campaign to the Swaziland colonial government led directly to the founding of the Ncabaneni Leprosy Settlement, and Elizabeth Cole, an American missionary nurse for the Church of the Nazarene who arrived in Swaziland in 1935, pursuing what she understood as a divine calling to work with people suffering from leprosy.

Although the existing documentation is inadequate to demonstrate this conclusively, there is a reasonably strong chance that these two women met each other at least once in late 1935 or 1936 at the recently established Ncabaneni settlement. It is an apt illustration of the power dynamic at work on that day that we must imagine the presence of Maziya; although she, more than any other individual, was responsible for the existence of this settlement, we do not know if or when she ever left that place. In contrast, Elizabeth Cole, a newly arrived American missionary, left multiple written
accounts of her first visit to Ncabaneni, and for her, we know that the day was a crucial
one. In 1937, she published an article in her denomination’s missions periodical, The
Other Sheep, pleading for support to start work among leprosy sufferers in Swaziland.
Under the headline, “Swazi Lepers. Nobody Cares!!” Cole summoned the dramatic
language and pathetic imagery commonly associated with leprosy to frame her appeal:

‘We are thrown away and nobody cares.’ There was hopelessness in the speaker’s
voice. He was a leper; just a leper in Swaziland and nobody cared.

For fifty years the gospel of Jesus Christ has been preached in
Swaziland... Still there are many, very many, who have never had the opportunity
of hearing the Good Tidings of salvation. Among those who have never been
reached are the lepers.

A number of lepers are locked in a small enclosure near the center part of
Swaziland. Here they pass through a living death – no hope, no Christ, no
anything. Others are left to spread their sickness. They are left to wander about
the country as diseased and loathsome beggars; left alone in their sufferings – left
alone outside the camp, left alone without Christ; downtrodden and outcast and
Jesus still saying, ‘Heal the sick, cleanse the lepers... freely ye have received,
freely give.’1

Cole’s words and the image accompanying the article illustrate the mission
mentality towards leprosy work, demonstrating what Vaughan has called a “powerful
Christian disease symbolism,” in which leprosy patients were “simultaneously ‘damned’
and ‘saved,’” while the disease itself was to be heroically “combated with Christian
compassion.”2 For Cole and her supporters, the work with leprosy patients was a sacred
duty, an explicit act of obedience to Christ’s command to “cleanse the lepers.” Given the
pervasiveness of such pathos-laden imagery in Western Christian discourse about leprosy,

Italics found in the original.

2 Megan Vaughan, Curing Their Ills: Colonial Power and African Illness (Stanford: Stanford University
few of her readers would have thought twice about Cole’s implication that these leprosy patients endured profound isolation as a consequence of having been “thrown away.” They expected leprosy sufferers to endure social rejection from all but the most heroic of Christian workers. Though it is absent in this case, Cole and her fellow missionaries often asserted that the settlement’s name, Ncabaneni, should be translated as “the place of suffering/quarreling,” a name that confirmed a particular image of the suffering of “lepers.”

Evocative as they are, Cole’s words disguise almost as much as they reveal about the position of the men and women of the Ncabaneni Leprosy Settlement and the means by which they came to be in that place. The name, for example, had no specific association with the leprosy settlement; in fact, the word “incaba,” the siSwati word at the root of the name, means something more like “fortress, stronghold, refuge.” My interview subjects who lived in the area confirmed that the name predated the settlement and referred to nearby caves where Swazis had historically fled during times of war. In other words, the name could be reasonably understood to imply “the place where people went during times of suffering/quarreling,” which bore some relationship to the idea that missionaries communicated but which put the idea of protection or refuge at the center,


4 She does not specifically mention Ncabaneni, but in Hilda Kuper’s survey of the early history of the Swazi state, she refers to the 1828 orders of Sobhuza I that his subjects not “engage in pitched battles, but, if necessary, to take refuge in the mountain caves” when faced with invading impis acting on the order of Dingane, the neighboring Zulu ruler. See An African Aristocracy: Rank Among the Swazi, reprint with new preface (London: Oxford University Press, 1961), 14. For an account of the kinds of conflict that existed in this region prior to the onset of colonial rule, Philip Bonner’s Kings, Commoners, and Concessionaires: The evolution and dissolution of the nineteenth-century Swazi state (Johannesburg: Ravan Press, 1983) remains the best source.
rather than the ideas of suffering and quarreling that the missionaries made central.

Furthermore, both written records and oral accounts make it far less clear that those “hopeless” and apparently uncared for leprosy patients would have readily accepted Cole’s characterization of their condition. This chapter attempts to recast the story of the Ncabaneni settlement in light of both Swazi and missionary language about leprosy in the years between 1932 and 1948 when the Mbuluzi settlement’s opening led to the closure of Ncabaneni, highlighting the connections and the discrepancies between the missionary narratives and those derived from other sources. In so doing, I aim to uncover the pattern of Swazis who cannily repurposed Western language and ideas to negotiate a more favorable position for themselves.

From the perspective of the British colonial state in Swaziland, the very existence of the Ncabaneni Leprosy Settlement was something of an historical accident to begin with. As explained in chapter one, the British had pursued a series of shifting strategies with regard to leprosy, all of which they had largely come to regard as failures. The reasons for this were twofold. First, the limited financial resources of the state perpetually stymied their efforts to invest in the medical infrastructure necessary to fulfill their vision of a modern system of healthcare. Secondly, Swazis had generally proven quite unwilling to adopt the pathological fears and social stigmas of Westerners with regard to leprosy and so had proven unwilling to impose upon their own family members and neighbors the kinds of solutions that colonial agents and missionaries recommended.

The combined result of these two factors was that, although Principal Medical Officer Robert Jamison had settled on a vision of establishing a settlement where the patients
could “live under conditions approximating as closely as possible to those they have been accustomed to,” very little had been done in bringing this vision to fruition.\textsuperscript{5}

The inertia of the British colonial government was finally broken in surprising fashion in April of 1932 when a man named Mpetsa Dlamini, the brother of a Swazi leprosy patient at the Westfort Leprosy Institution, handed a letter to Brian A. Marwick, at this time a deputy assistant commissioner in the colonial administration. Madolwane Maziya, one of the female Swazi patients originally sent to Westfort in 1925, had composed the letter addressed to Swaziland’s Resident Commissioner, writing on behalf of herself, Mpetsa’s brother, and two other Swazis at Westfort. It was to be the first in a long series of ten letters written over the course of two years, the ultimate result of which was the repatriation of the Swazis at Westfort and the establishment of the Ncabaneni Leprosy Settlement. The letters reveal a portrait of an intelligent and forceful woman who possessed an extremely sophisticated understanding of Western patterns of thought and styles of governance. Their combined effect is a resounding affirmation of William Beinart and Colin Bundy’s assertion, derived from their Eastern Cape case studies, that “...local struggles constantly threw up intellectuals: individuals capable of expressing the economic, social and political interests of a social group.”\textsuperscript{6} But it was not just the interests of a group that Maziya represented; she was undeniably a capable, compelling advocate for herself, determined to bring about changes in her circumstances that aligned

\textsuperscript{5} Robert Jamison, internal memo to Government Secretary, October 5, 1929, File RCS 633/29, SNA.

with her own sense of her needs. Aligned with the more indirect sources discussed in the first chapter, the letters give us an exceptional window into Swazi thinking about leprosy and also about the lived experience of leprosy patients. For all these reasons, the letters warrant considerable unpacking.

Writing on March 27, 1932, Madolwane Maziya and her fellow patients stated their case in brief but direct fashion:

We report ourselves to you so that you may lift up your eyes to see where we are. We Swazis here are oppressed because the Union people say, when we complain, that they have no concern with us, that we should complain to you to build a hospital for this disease (which causes spots), further they exemplify the Xosas who are sent to their homes and Moshesh’s Basuto who are sent to theirs and the Zulus who are also sent to theirs. So that when we complain they refer us to you and the doctor at Mbabane, and say it is your concern. We close, Sir, Sympathize with us.  

Intentionally or not, this first appeal from the patients reminded the administration of their comparative failure to do anything about the leprosy issue in Swaziland. They certainly recognized the truth of the Maziya’s claim that areas populated primarily by Xhosa, Zulu, or Sotho speakers had their own leprosy hospitals. Jamison, the “doctor at Mbabane” to whom the letter refers, was sympathetic to an extent, and his comments on the letter indicated both his frustrations with the inadequacy of the approaches attempted in Swaziland, as well as the larger reality that there was little that anyone could do to effectively aid patients like Maziya. The Swazis at Westfort had, in his assessment, never been happy, even after he had personally visited them some years prior in an effort to

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7 Madolwane Maziya to the Resident Commissioner, March 27, 1932, File RCS 338/32, Swaziland National Archives. Letter originally composed in siSwati; quoted text taken from the 1932 translation of the letter found in the same file.
ameliorate their unhappiness. In light of this, Jamison concluded that the benefits of their course of treatment at Westfort were inadequate to justify the expense; the logical next step was for government to pursue repatriation. Interestingly, Jamison did not take this opportunity to press again for his desired leprosy settlement, rather suggesting simply that there be some “attempt made to have them isolated at their kraals.” Jamison likely knew that trying to secure additional funding for such an endeavor outside the annual budgeting process was a fool’s errand.

But Jamison’s sympathetic response was not enough to bring about a change of course by the administration. When the Swaziland administration received a negative response to their inquiry about whether the patients could be safely repatriated to Swaziland, they dropped the matter. The word from the Medical Superintendent at the Westfort Hospital was that 3 of the 4 patients responsible for the letter, including Maziya, were too contagious to be safely released from the hospital, and the other was nearing the end stages of his treatments and could expect release, on the hospital’s terms, within the year. Even Dr. Jamison apparently agreed that this scientific judgment of the Medical Superintendent trumped the plea of native patients for a change of circumstance, and no response of any kind was sent to the Swazi patients.

8 Jamison, internal memo to Government Secretary, April 25, 1932, File RCS 338/32, SNA.

9 Westfort Medical Superintendent, Report at Request of the Swaziland Government on Native Patients at Pretoria Leper Institution, undated, File RCS 338/32, SNA. This report was forwarded to the Swaziland administration alongside a letter from the Union Secretary for Public Health dated June 10, 1932 in response to a letter from Swaziland’s Government Secretary dated May 5, 1932.

10 Robert Jamison to Government Secretary, July 6, 1933, File RCS 338/32. In this letter, written a little over year later, Jamison says that he favored the status quo in 1932 because of the Medical Superintendent’s report and also because of logistical difficulties related to repatriation.
Maziya, however, was not prepared to accept the lack of response. On February 13, 1933, she wrote again:

We are again appealing to you this year to ask you to raise your eyes and look to where the Swazis are who have been appropriated by the Union people. We are the food of the Union people, and their sheep from which they get their Wool every month, and yet there are some whitemen in Swaziland who should support themselves with the Wool and the lands that are reaped (sic) every month. We say that if our Government is not able to put up a Hospital for people who are suffering from these marks, so that they could be injected there, the Government should fetch us back to our homes. We do not think it is necessary for the Government to look after us. The Government should look after orphans and people who are not able to look after themselves, by reason of not having any stock. We request the Government to send our Doctor up from Mbabane so that we can speak to him, and so that he could see the medicine with which they inject us. We say that we could live at our kraals, and the authorities could tell us when to go in for injections. That is our request to our Chief the Commissioner for the Swazis. Answer please Sir.\textsuperscript{11}

This second letter repeats many of the same requests heard in the first letter, but with some notable elaborations. The petition for attention from “our Doctor” is more specific; he should come in order to assume responsibility for their treatments, which the patients do not accept require their continued presence at Westfort. The language suggests that the patients believed Dr. Jamison could be a significant ally for them, if they could successfully appeal to his sense of responsibility for them. The fact that Jamison himself had directly overseen the process of sending Maziya and one other of these patients to Westfort in 1925 and that he had visited them there at least once in the intervening years probably gave these patients enough personal interaction with him to increase their confidence in the strategy of appealing to him for help.\textsuperscript{12} One does not

\textsuperscript{11} Maziya to the Resident Commissioner, February 13, 1933, File RCS 338/32.

\textsuperscript{12} There is a very high probability that Jamison was in some way involved in the processes that brought the other two members of this group to Westfort as well, but there is no specific evidence to support this.
have to read much into Dr. Jamison’s correspondence to think that this was a strategy with a high probability of success, given Jamison’s generally conscientious manner.

The letter also articulates more clearly the nature of the oppression the patients have experienced at Westfort through the vivid metaphors of themselves as the food and sheep of the Union people. Maziya’s choices in imagery, particularly in regard to her reference to sheep, are intriguing and suggestive of the patterns of thinking that framed her letters of appeal, drawing upon elements of both Swazi and Western culture. On the one hand, Swazi praise poems (tibongo) and clan praises (sinanatelo) frequently draw upon references to animals as metaphors for human behavior and experience. Vail and White, for example, discuss the imagery of the elephant, the mamba, and the black bull as symbols of the “uncomplicated celebration of military ferocity” in the praise poem of the nineteenth century Swazi Ngwenyama Mswati II.13 Sheep, however, do not often appear in these kinds of sources, nor were they a significant a part of the traditional Swazi economy, especially by comparison to cattle.14 Why then did Maziya reach for the metaphor of wool sheared from a sheep rather than the readily available image of milk drawn from a cow? I would argue that it may well have been because sheep were more naturally associated in her mind with the behaviors of white South Africans exploiting the


14 I could not find a single reference to sheep in any of the recorded tibongo or sinanatelo in the sources contained in note 13. Hilda Kuper reported that the Swazis owned 125,000 sheep in 1932, as compared to 311,420 cattle; see The Uniform of Colour: A Study of White-Black Relationships in Swaziland (Johannesburg: Witwatersrand University Press, 1947), 4.
resources of Swazis. Sheep were a sizable part of the larger South African economy, and every year, approximately 250,000 sheep owned by South African farmers of European descent would enter Swaziland for winter grazing, with negligible economic benefits to the local economy.\textsuperscript{15} Given the severe land shortages characteristic of the Swazi experience since the 1907 Partition, the metaphor of herself and her fellow patients as sheep to be sheared evoked a rich image of oppression and exploitation.

To this point, the mechanisms of this oppression are as yet unnamed, but it is clear that the patients felt that they were experiencing economic exploitation. The agents of the colonial state, with the possible exception of Dr. Jamison, likely had little idea what that looked like, but subsequent correspondence revealed that Maziya and the other patients were routinely assigned work for “white people” at Westfort, such as laundry. We will return to the nature of that work in greater detail below, but in this letter, the interesting thing to note is the way that the imagery employed by Maziya turns her exploitation into a disadvantage for the colonial state in Swaziland. This was clearly another intentional part of their strategy of appeal, as the closing of their first letter had contained a similar brief comment: “We hope that you will take heed, also the doctor at Mbabane who is deprived of his bread by the people here.”\textsuperscript{16} Jamison may have felt that the patients at Westfort were always unhappy, but they have ingeniously inverted the situation by

\textsuperscript{15} Union Office of Census and Statistics, \textit{Official Year Book of the Union and of Basutoland, Bechuanaland Protectorate and Swaziland} (Pretoria: The Government Printer, 1933), 1086. The \textit{Year Book} lists South Africa as the world’s fourth-largest sheep-owning state during this time, with more than 46 million sheep in the country as a whole (p. 385). Kuper also notes that the best sheep in Swaziland were those owned by Europeans who brought them into the country solely for winter pasturing; see \textit{The Uniform of Colour}, 59.

\textsuperscript{16} Maziya to the RC, March 27, 1932, File RCS 338/32.
suggesting that the people who should be most unhappy about this situation are the agents of Swaziland’s colonial government.

But the assertion that might have attracted the most attention and that sets up the most obvious contradiction with Western conceptions of leprosy is Maziya’s claim, “We do not think it is necessary for the Government to look after us.” The statement adamantly denied the disability that Westerners tended to automatically assign to those who suffered from leprosy and forcefully challenged the paternalistic tendencies of a colonial administration steeped in the ideology of a civilizing mission. The Swazi patients at Westfort clearly did not perceive their condition as a cause for hopelessness, nor did they concede that it relegated them to dependency upon the state. Such status belonged to orphans or people who had no access to cattle, the most basic unit of the Swazi traditional economy, particularly with regard to perpetuating the household by way of marriage exchange.17 Significantly, Maziya and her fellow patients also did not express any uncertainty about the willingness of their communities to allow their return. Their confidence apparently confirms what Jamison and other Western observers had believed about Swazi attitudes towards leprosy for some time, that they did not regard the disease as particularly contagious or dangerous. If one of the patients at Ncabaneni did report to Elizabeth Cole in 1937 that the people at the camp were “thrown away,” it was apparently not the Swazi people who bore that responsibility.

17 For the best overview of the role of cattle in the pre-colonial Swazi economy, see Philip Bonner, Kings, Commoners, and Concessionaires.
It was not entirely inconceivable that this second letter might have produced a different reaction from the administration than the first. In the intervening months between Maziya’s two letters, Dr. David Hynd of the Nazarene mission had returned to Swaziland from his furlough with promised support from interested parties overseas and had approached the government to revisit his plan for a site near the Raleigh Fitkin Memorial Hospital in Bremersdorp. The government also was apparently pursuing some plans of its own, as Allen Marwick had written to Sobhuza II around the same time that Maziya had composed the second letter with reference to a possible leprosy site opening on mission land in another region of the country. And when Maziya’s second letter arrived on his desk, J.R. Armstrong, the new Government Secretary, inquired with Jamison about whether it would be worthwhile to see if anything had changed in the year since the last report. If Jamison did make any further inquiry, there is no record of it. In the end, Armstrong wrote to the Union’s Secretary for Public Health and asked that a reply be relayed to the Westfort patients totally in line with the prior year’s recommendations of the Westfort Medical Superintendent.

Armstrong was undoubtedly following standard diplomatic protocol in relaying the administration’s response through Union channels, but doing so only caused the intensity and breadth of this clash of perspectives to grow. The patients at Westfort were disinclined to place their faith in the Medical Superintendent’s report, and their

18 David Hynd to S.B. Williams, November 9, 1932, File RCS 898/32, SNA.
19 Allen G. Marwick to Sobhuza II, February 15, 1933, File RCS 898/32, SNA.
20 J.R. Armstrong to Robert Jamison, undated internal memo, File RCS 338/32, SNA.
subsequent response introduced a new theme into the dialogue between themselves and
the commissioner’s government in Swaziland:

We are pleased to hear that you received our letter, but we are disappointed
because you did not reply to us direct, but you sent your reply to the person from
whom we asked to be released. We feel sorry about you not informing us that we
now belong to this place. The gentleman here informs us that you say we must
remain here with him, as you have no place there for sick people. We would have
understood better if you sent us a letter written in the Native language. We think
that this gentleman is not telling us what you say but what he says himself.\textsuperscript{21}

The Swaziland administration was not prepared to violate diplomatic procedure
by writing directly to Maziya, but they did show some limited responsiveness to this new
criticism. J.R. Armstrong relayed a letter, translated into siSwati and addressed to
Maziya, via the Union’s Secretary for Public Health and the Westfort Medical
Superintendent. The message, however, was unchanged, as Armstrong informed the
patients that since most of them had leprosy in a “highly infectious stage,” it was in their
own best interests, as well as the best interests of the territory that they remain where they
were.\textsuperscript{22} The apparent alignment of the commissioner’s government in Swaziland with the
medical staff at Westfort provoked a forceful reply from Maziya:

I thank your kindness to reply to me. You state that the Government is looking
after me but I say not at all, I am looking after the Government because since I
came to Pretoria I am working hard doing washing for white people. I am really
tired as I have been doing this for the last nine years. You have never seen a
person working so many years without rest like me. Though you say I am still
sick I think that should not debar me from returning home. It seems our
Government does not wish me to look after my children but instead that I should
look after the white people... I can assure you that this disease is not infectious at
all because we mix together with people who have not got the disease but they do

\textsuperscript{21} Maziya to the Resident Commissioner, April 5, 1933, File RCS 338/32, SNA.

\textsuperscript{22} J.R. Armstrong to Madolwane Maziya, May 2, 1933, File RCS 338/32, SNA.
not get it besides that many of the Native Police have wives who have the disease but they do not get it, and how then is the disease infectious.\textsuperscript{23}

Maziya’s distrust of the authorities at Westfort was further highlighted later in her letter, when she noted that the letter from the Swaziland government had come to her without an envelope, leading her to petition again for a direct reply from the government. Furthermore, she expressed doubt regarding the news found in the government’s letter that one of her fellow Swazis at Westfort was soon to be released, noting, “I doubt if he will be released soon because he is also working like us.”\textsuperscript{24} In this assertion, she would prove mistaken, as the man in question received his discharge during the following month, but even this did little to reduce Maziya’s distrust. She credited his discharge to the action of visiting doctors “from Cape Town” rather than to Westfort’s own staff, her exploiters.\textsuperscript{25}

This fourth letter is the most impassioned and intensely personal of the ten letters that come from Maziya’s hand; it is telling that this is the only time that she speaks in first person singular rather than plural. The letter finally makes plain the nature of the oppression Maziya had referenced since her first letter, and at the center of that complaint is the notion of work done for white people. This is telling because in all likelihood, those “white people” believed that this work would be crucial in effecting a cure for Maziya’s leprosy. For despite Jamison’s confident claim back in 1923 that leprosy had “at last become amenable to a cure,” the reality was that no effective treatment for

\textsuperscript{23} Maziya to Armstrong, May 13, 1933, File RCS 338/32, SNA.

\textsuperscript{24} Ibid.

\textsuperscript{25} Maziya to the Resident Commissioner, June 12, 1933, File RCS 338/32, SNA.
leprosy existed until the advent of sulphone therapies in 1948. The only treatments regularly used at Westfort or any other leprosy hospital in the world were injections of chaulmoogra oil, and these treatments were often painful and of questionable efficacy. Maziya herself, went on to comment in her letter that “...ever since I arrived here I have not had a drop of medicine in my mouth and besides this we are fed up with these injections.” There is no evidence that the practice of traditional medicine would have inclined Maziya or the other patients at Westfort to prefer oral remedies over the available injections; both Hilda Kuper and Brian Marwick describe Swazis taking medicines by a variety of means, including oral ingestion, inhalation, and scarification/tattooing. It seems reasonable to conclude then that Maziya’s frustration with the injections and the refusal of many Swazis at Westfort to cooperate with the treatment regime are linked solely to the discomfort associated with them and their ambiguous effectiveness.

In the absence of truly effective medical remedies, Western doctors often stressed that the key to curing leprosy was found in improvements in diet and in carrying on significant physical labor. For example, at the same time as Maziyia’s correspondence with the Swaziland administration, R.G. Cochrane, the Medical Secretary for the British

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26 Measuring the effects of chaulmoogra oil was made more difficult by the tendency of the body to eventually arrest the progression of leprosy on its own, making it almost impossible to know who had benefitted from the oil and whose leprosy had naturally been arrested.

27 Maziya to Armstrong, May 13, 1933, File RCS 338/32, SNA.

Empire Leprosy Relief Association (BELRA) wrote to David Hynd, advising him to remember in his plans for a leprosy settlement that “... the average case is not an ill man and that he can do quite active work;” therefore, Cochrane suggested, Hynd “... should choose a place where there is plenty of land for cultivation, so that you would ensure that the patients get enough exercise and have sufficient ground so that they may grow their own produce and become as near self-supporting in that line as possible.”

It was guidance that Hynd fully embraced, and his concern for providing leprosy sufferers with suitable employment as therapeutic remedy persisted even after the advent of sulphone therapy in Swaziland. Even in 1957, Hynd still felt that although Diaminodiphenylsulphone (usually shortened as D.D.S. or “dapsone”) was the main chemotherapy employed in leprosy treatment, “... of great importance in the rehabilitation of the patients is the improved and good hygienic conditions under which they live, together with the occupational and recreational activities in which they are encouraged to engage.”

Jamison was of much the same mind in this regard. Having obviously soured on the remedies employed at Westfort, he wrote in his annual report for 1933 that the “essential factors” in bringing about a cure for leprosy were, “cleanliness, good feeding, a moderate amount of work and a contented frame of mind.” The productive labor of leprosy sufferers served as both an economic efficiency and a mode of therapy that sought to improve the overall condition of the afflicted. In this sense, the idea was

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29 R.G. Cochrane to David Hynd, July 29, 1932, David Hynd Collection, NA.

30 David Hynd, Annual Report of Mbuluzi Leprosy Hospital for the year ending 31st December, 1957, File 3021D, SNA.

31 Robert Jamison, Annual Medical Report for 1933, File RCS 31/34, SNA.
undoubtedly a holdover of what Peter Gay calls the Victorian bourgeoisie’s “problematic gospel of work,” in which “work was a prophylactic against sin.”32

Far from being a path to moral rightness or physical wellbeing, Maziya clearly experienced her work assignments at Westfort as exploitation, a feeling not unique to her. In the context of hardening lines of racial segregation that characterized 1930s South Africa, Maziya and other patients like her could readily interpret the expectation that African leprosy patients perform labor in compliance with the orders of white doctors as an extension of the racial inequality of the wider society.33 Simonne Horwitz’s work further reveals that African patients at Westfort were assigned to work as the domestic servants of white patients as early as 1916, and she also recounts a 1939 sit-down strike, led by four African female patients in protest of the poor living conditions and the abuses of African patients at the institution. What makes the picture even more complicated, however, is Horwitz’s assertion that all patients were paid for their work, albeit at a lower wage than would have been given to someone from outside the institution.34 Did Maziya feel exploited because she knew that her wages were lower than those of “clean” persons performing the same tasks? Her insistent denial of physical disability certainly makes this a viable explanation for her dissatisfaction. Or is it possible that, because the Swazi


patients were being supported by an outside government, that no wages were paid to Maziya and her associates? Was their labor an expected contribution to the maintenance of the Westfort Institution on top of the money paid by the government of Swaziland for their care? This possibility cannot be dismissed outright, as Maziya never references receiving any pay, but it seems unlikely, as this fourth letter and subsequent correspondence revealed that Maziya and her fellow patients had accumulated some personal cash savings. In this letter, Maziya offers Jamison £1 for petrol if he will come and visit them; future letters would offer even larger sums as the Swazi patients worked to secure their return home.

Maziya’s forceful arguments and continued insistence that her condition posed no threat of contagion were still inadequate to change the views of the Swazi government. On May 30, 1933, Armstrong wrote again noting summarily that the Resident Commissioner “...wishes me to say that in view of the medical opinion which has been given to him, he is unable to alter the decision which was conveyed to you on the 2nd May, nor does he consider that it would do any good to send a Medical Officer to Pretoria to see you.” Armstrong’s letter, like all previous communication with the Swazis at Westfort, passed through the offices of the Secretary for Public Health and the Medical Superintendent at Westfort before delivery, and the language he used communicated an air of finality about the subject. The government clearly did not intend to alter either its practices or its attitudes in light of arguments made by its subjects.

35 Armstrong to Maziya, May 30, 1933, File RCS 338/32, SNA.
But even prior to receiving Armstrong’s reply, Maziya and her fellow patients at Westfort had written again.\textsuperscript{36} Perhaps suspecting that their May 13 letter would not receive a sympathetic response from Armstrong, they appealed once again directly to the Resident Commissioner, introducing yet another new argument in favor of their repatriation:

Father of the Swazi Nation, we appeal to you as a father. We understand that you love us but that you have no money with which you can build a suitable Shelter for us. We therefore beg to request the authorities to build a place for us at our own expense of £15, each of us to contribute £5. Susipisi will arrive there, as he has been discharged by the Doctors from Cape Town. We are sorry because our Government is paying money to this whiteman here, for keeping us, and yet we are made to work. If you agree to have a place built for us we would be glad if it could be made now in the winter so that we could commence our ploughing with the other Swazis, at the place where our Shelter is going to be built.\textsuperscript{37}

At this point, it seems plain that these Swazis at Westfort had a thoroughly sophisticated understanding of Western views of leprosy and the nature of the colonial state, an understanding they had used to gain the upper hand in the conversation by effectively anticipating and/or nullifying every argument that could possibly have been made against their appeal for repatriation. The patients clearly recognize that in terms of relative power, the government holds all the cards, but even so, they understand how to make that same hegemonic power work in their favor. Having anticipated that their common sense arguments about the contagiousness of leprosy would not succeed and doubting whether their pleas on humanitarian grounds for relief from oppression would

\textsuperscript{36} Maziya’s June 20, 1933 letter to the Resident Commissioner clarifies that Armstrong’s May 30 letter had reached the Swazis at Westfort on June 13, the day after the patients had written. All correspondence found in File RCS 338/32, SNA.

\textsuperscript{37} Maziya to the Resident Commissioner, June 12, 1933, File RCS 338/32, SNA.
lead to a change of circumstance, the patients now turn directly to money. Since Armstrong had insisted in his May 2 letter that the government could not afford to construct an institution for leprosy sufferers, the Westfort patients offer to use their own resources for the construction of a shelter. More subtly, the patients also point out the inconsistency they perceive in the way the government’s own money is being used. Why, they wonder, should they be made to work at Westfort when the Swazi government was paying the institution for “keeping” them?

This fifth letter finally began to tip the scales in favor of repatriation for the Westfort Swazis. Whether from exhaustion, embarrassment, or simply because they recognized the strength of the arguments Maziya and her fellow patients made, the internal correspondence of the government officials began to shift. The patients’ key ally within the administration was the Principal Medical Officer Jamison, whose voice had been noticeably absent in the correspondence since his comments on the original letter in April, 1932. When asked to comment on this most recent of Maziya’s letters, Jamison pointed to the injustice created by the original decision to send such a small number of patients to Westfort. Conceding that an institution may be the best place for infectious cases, Jamison pointed out that, “While a number of lepers at least as infectious as these are going about free in Swaziland it is unfair that these few should be segregated so far from their homes.”

38 R. Jamison to J.R. Armstrong, June 23, 1933, File RCS 338/32, SNA. Barbara Cooper notes that British medical officers in colonial Nigeria were also reaching the conclusion that continued isolation of patients was no longer justifiable in the absence of effective medical remedies. See Evangelical Christians in the Muslim Sahel (Bloomington: Indiana University Press, 2006), p. 303.
Commissioner expressed in the previous month, that it might be beneficial for him to visit
the patients personally, given that the logistical arrangements for their repatriation were
likely to require that they remain at Westfort for at least an additional year, and that
verbal assurances would probably be more helpful than further written communication.

Jamison’s proposed personal visit never came about, and it is unclear what
decision might have been reached solely on the basis of the last letter and Jamison’s
renewed call for repatriation. The wheels of government bureaucracy were turning too
slowly for Maziya, who wrote yet again after she realized that the government’s last letter
of May 30 and hers of June 12 had crossed in the mail. This sixth appeal sounded
familiar themes:

We beg to request that our Chief should have mercy on us. We bring our humble
request to you because there is no one else that can take us out of the fire besides
our Government; even those in charge of this Institution state that they can do
nothing for us because it is at the request of our Government that they detain us
here; but we wish you to know that our detention here is worrying us very much.
We ask that the Government should not look at the expense of feeding us if we
have to return to Swaziland as we think we can feed ourselves until next autumn
when what we would plant during the next plough season would then be ripe. We
ask for direct reply to us. We are your children.39

A postscript to the letter reiterated the offer of using the patients’ own financial resources
for the creation of a place where they could live. That the letter contains no new
arguments or information is interesting in its own right. This letter was addressed
directly to J.R. Armstrong, the Government Secretary whose signature had appeared on
the government’s May 30 letter, rather than to the Resident Commissioner. The letter
seems to have been written primarily as an expression of protocol, a way of

39 Madolwane Maziya to J.R. Armstrong, June 20, 1932, File RCS 338/32, SNA.
acknowledging received correspondence, but it was also a way of ensuring that the patients had the last word on the subject. They wanted there to be no confusion about their refusal to accept the government’s logic.

Because of the overlapping timetable of correspondence at this moment in the story, it is impossible to say how much impact this sixth letter had, but by July 12, T.A. Dickson, the Resident Commissioner, had signaled that he was ready to go ahead with plans for repatriation.\textsuperscript{40} Dickson credited his decision to the change of views expressed by Jamison, but it can safely be said that none of this would have come about were it not for the persistence of Madolwane Maziya and the others at Westfort. Even so, the government still responded without any particular urgency waiting until August 8 to compose a letter to the Westfort Swazis, expressing their consent to the idea of repatriation but indicating only that they would send word when the Resident Commissioner had “determined upon a plan.”\textsuperscript{41}

The problem was that the various schemes for an institution devoted to the care of leprosy patients had gained no traction whatsoever. As a consequence, the preparations took another 15 months to carry out, during which time Maziya wrote at least four more letters in which she continued to stress the ability of the leprosy patients to care for themselves and to strenuously object to every minor obstacle that the government in Swaziland mentioned as an impediment to progress towards the founding of the settlement. Although the correspondence generated during that time period focuses on

\textsuperscript{40} Internal memo by T.A. Dickson, July 12, 1933, File RCS 338/32, SNA.

\textsuperscript{41} J.R. Armstrong to Madolwane Maziya, August 8, 1933, File RCS 338/32, SNA.
logistical matters, there are fascinating pieces that continue to emerge and illuminate further the interactions of Swazis and the colonial state.

For one, the decision to repatriate meant that the administration needed to consult with Sobhuza’s parallel Swazi government, as they did on all questions that had any bearing on the question of land use. Even before he wrote to the Westfort patients, Armstrong had written to Sobhuza inquiring whether he would favor an option in which the patients were each sent back to their own homes or one in which “some small portion of Native Area” would be set aside for this purpose.42 Notably, there is no mention of possibly acquiring land under European ownership, by far the larger portion of the country. Doing so, however, would most likely have required the colonial administration to purchase land with money that it did not have, and one suspects that most Europeans would have been hesitant to have any portion of land adjacent to their own used for housing people with leprosy, a disease they feared.

Sobhuza’s response on July 31 has the feel of a masterful piece of political foot-dragging:

I have consulted my councillors on the proposals laid down in your letter under reply and their opinion is that whilst they highly appreciate His Honour the Resident Commissioner’s sympathy for our people who unfortunately have fallen victims to this disease, a much wider survey of the position from a critical point of view should be taken into consideration, namely, that before a proper establishment which should satisfy both the Government and the people (Europeans not excepted) no step should be taken to return the lepers already in the Union Asylum, and that those who may be infected while the matter is under consideration should be detained where they are until a solution is arrived at.43

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42 J.R. Armstrong to Sobhuza II, July 19, 1933, File RCS 338/32, SNA.

43 Sobhuza II to Government Secretary, July 31, 1933, File RCS 338/32, SNA.
What exactly is going on in this evasive reply? Christopher Lowe has argued that by the 1930s, Sobhuza had adopted a strategy in which he “temporized endlessly about taking practical actions to implement British desires.” The point in doing so, according to Lowe, was to exploit the weakness of the colonial state in order to gradually shift the terms of political debate to suit Sobhuza’s own agenda. And while the discussion of how to deal with a few leprosy patients living in the Union may not have been a top priority for Sobhuza, the question of land use was. In 1933, Sobhuza and his council were merely seven years removed from the final defeat of their legal petitions to have the 1907 Land Partition Proclamation reversed and the concessions upon which it was based declared illegitimate. In all likelihood, Sobhuza’s hesitation to support immediate repatriation of the Westfort patients had more to do with his desire to protect Swazi land from further encroachment by Europeans than it did with his professed desire to ensure a “proper establishment.” In this particular instance, Sobhuza did not get his way, as the Ncabaneni site was a piece of Native Area land, but Sobhuza’s intervention is a good reminder that Maziya’s ability to employ effective argumentation in pursuit of aims that did not align with the colonial agenda was not unique to her.

It was only after agreeing to repatriation that the administration finally began an inquiry into the identity of Maziya (and to a lesser extent, the other Swazis at Westfort).

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45 The site selected for the settlement was a portion of Native Area 16, a fact verified in the correspondence contained in File 100, “Leper Settlement General,” at the Swaziland National Archives.
In early September, Armstrong instructed the Deputy Assistant Commissioner for Swaziland’s Central District (so-called even though it was headquartered at Siteki, along Swaziland’s eastern frontier) to investigate Maziya’s age, marital status, and whether there might be anyone among her relatives who would come to the leprosy settlement and care for her, if necessary. The brief reply, sent a month later, sheds the only sliver of light still perceptible to us regarding Maziya’s family background. The D.A.C. estimated her age to be between 35 and 40 years of age and reported that she had been married to the late Chief Sibhamu Matenjwa of Zululand but had left him when her sister (an Mbulawa Maziya) had died of leprosy. It was the D.A.C.’s opinion that both Mbulawa and Madolwane must have contracted leprosy in Zululand, and he reported that there was “nobody suitable or prepared to go into the leper settlement to look after her.”

This brief summation is the only known record of the life of Madolwane Maziya, and it is a frustratingly slim written record when one considers the persuasive force of her letter writing campaign on behalf of the Swazi patients at Westfort.47 We can deduce from her literacy that she likely had some previous exposure to Christian missionary education, given that Swaziland’s first government school did not open until 1908 and was located at Zombodze, relatively far from the Maziya home area along the Lubombo

46 Deputy Assistant Commissioner, Central District to Government Secretary, October 6, 1933, File RCS 338/32, SNA.

47 I tried unsuccessfully to use the available information about Madolwane Maziya to track down surviving descendants or other relatives. Maziya is a very common sibongo (surname) in eastern Swaziland, and the information available was inadequate to narrow down the search in the time I had available.
Mountains. William Beinart, in a Transkei case study, has argued that women from the Christian community were among those most adversely affected by things like the rising commodity prices in the 1920s, which in turn led them to very active political engagement in the form of strikes and boycotts. Perhaps a similar dynamic is at work in the case of Madolwane Maziya; unfortunately, there is inadequate evidence to answer the question decisively. However slim the biographical record of these patients may be, we do know that on the night of October 30, 1934, three Swazis from Westfort finally arrived at their new settlement site at Ncabaneni. Of the four patients represented in Maziya’s first letter, written more than two and a half years earlier, only two arrived at Ncabaneni. One had been discharged in early June of 1933, and another had died on March 17, 1934 as a consequence of a sickness that had spread among many patients at Westfort. The third patient to arrive at Ncabaneni had joined with the other Swazis in their efforts to gain repatriation in September, 1933.

The settlement site itself consisted of four acres of ground, fenced in, and containing a few homes constructed in the traditional Swazi style and a small allocation of land for the raising of food crops. The government had arranged to have the farming

48 Hilda Kuper, *Sobhuza II: Ngwenyama and King of Swaziland, The story of an hereditary ruler and his country* (New York: Africana Publishing Co., 1978), 44-47. The first government school was specifically opened to provide an education to Sobhuza II that would not place him under the direct influence of one particular mission.


50 On the patient who received his discharge, refer back to Maziya’s letter to the Resident Commissioner, June 12, 1933. On the death of the other, see Madolwane Maziya to the Government Secretary, April 21, 1934, File RCS 338/32, SNA.

51 Madolwane Maziya to J.R. Armstrong, September 18, 1933, File RCS 338/32, SNA.
acreage plowed and fertilized before the patients arrived and had hired a man to serve as
custodian of the property; beyond that, they were reluctant to invest much more. The
provision was hardly lavish, but it in most ways fulfilled Jamison’s 1929 vision of a
facility where the patients could, “... live under conditions approximating as closely as
possible to those they have been accustomed to.” Jamison had chosen those words
carefully; they reflected the most common discourse in Western medical circles of the
time. It is interesting, then, to acknowledge that it took only a few short years before
missionaries and government medical staff alike had taken to describing Ncabaneni as a
completely inadequate situation, a theme that will be more thoroughly explored later in
this chapter and in chapter three.

It is unfortunate that we have only indirect testimony about the responses of the
leprosy patients who arrived at Ncabaneni on that Tuesday night in October of 1934. But
what we do have provides some telling, and more than a little amusing, insights. The
deputy assistant commissioner for Mankaiana district who oversaw their arrival reported
to his superiors the next day that the patients, upon arrival, had made three requests.
Their first was for a daily meat ration and tea twice each day, the same ration they had
received at Pretoria. The D.A.C. advised them that this would not be possible, because in
this new situation, they were intended to “...live as they would at their own kraals. One
of the patients stated that he had always had tea even at his own kraal.” The second
request from two of the patients was to continue receiving the same injections about
which Maziya had been so fed up while at Westfort. And, finally, the patients requested
that they be provided with “writing material for writing letters, and for posting facilities.”

In short, the patients’ requests reinforce the heart of their original complaints and demonstrate how acutely they felt their alienation from home and the oppression of work done for white people. Freed from those complaints, the Westfort Swazis could readily identify key components of their life at Westfort which were beneficial to them. One can imagine Armstrong and Jamison shaking their heads somewhat ruefully upon reading of these requests. Jamison managed to be reasonably conciliatory in his reply, conceding that some quantity of tea might be possible and that it might also be possible to increase the quantity, if not the frequency, of an already planned twice weekly meat ration. The request for injections was more complicated, though it might be possible to administer them once a week; more often would simply not be practical, “…especially as the benefit she (and it seems evident that he must be thinking of Maziya here) derived from the injections is problematical.” Regarding the request for writing material and postal facilities, Jamison simply noted that he saw no reason to object, though it must surely have crossed his mind that granting such a request meant running the risk of continuing to receive still more strongly worded letters of complaint!

If Madolwane Maziya ever wrote further letters to the government in Mbabane, they have either not survived or simply eluded my searching in the archive. But for the most part, it is clear that she had attained her primary objectives, and so it seems most

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52 Deputy Assistant Commissioner, Mankaiana to J.R. Armstrong, October 31, 1934, SNA.

53 Robert Jamison to Government Secretary, November 6, 1934, File RCS 338/32, SNA.
likely that she found no further reason to write. Her story is an extraordinary one in many ways, one that requires us to reach well outside of her gender and socioeconomic circles to find parallels. One notes in Maziya’s letters hints not just of Sobhuza’s strategy for dealing with the Swazi colonial administration, but also of the strategic maneuvering of Sebele, Khama, and Bathoen, the three Tswana chiefs who journeyed to the United Kingdom in 1895, seeking protection from the aggression of Cecil Rhodes’s British South Africa Company. But these parallel cases of Africans maneuvering effectively in a political context center around the lives of men. Other links might be made to the work of Jonathan Crush who found evidence of Swazi labor migrants whose “aversion to wage labour” found expression in sporadic work performed as near to their home state as possible and who tended to desert quickly when conditions were not to their liking. Though still centered on the experience of men, this link is interesting, yet the situation described by Crush pertained chiefly to the era prior to the 1907 Land Partition Proclamation; perhaps Maziya’s situation hints at the persistence of these cultural attitudes beyond the period of capitalist penetration that followed after 1907.

One can also find parallels for Maziya’s situation in stories that reflect deeply on the resourcefulness of women in this region during the twentieth century. In this genre, Mpho ‘M’atsepo Nthunya’s autobiography of her life in Benoni Location and rural Lesotho stands out, as does Belinda Bozzoli’s work, aided by Mmantho Nkotsoe,

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exploring the lives of migrant Tswana women from Phokeng. These works amply demonstrate that women were active agents in shaping their social environments, but they are also dependent on the reconstruction of memory and the necessary process of self-representation that it entails. Maziya’s case is extraordinary precisely because it allows us to hear her voice in that moment in time so clearly. This is not to argue that Maziya’s voice is, therefore, preferable to those found in other works; there are, of course, plenty of interpretive pitfalls in this method of historical reconstruction, as with any other. I simply want to stress the unique nature of her voice and the remarkable clarity with which we hear her.

The most direct parallel to Maziya’s situation and a source from which she likely drew some sort of inspiration was that of the former Ndlovukazi (Queen Mother) Labotsibeni Mdluli (c.1858-1925). In the Swazi system of monarchy, the Ndlovukazi wields significant ritual power, especially in connection with her rain making powers, and political influence, and Labotsibeni was, without any question, the most influential Ndlovukazi in Swazi history. Some of this was the consequence of simple endurance; her time in office lasted more than thirty years between 1890 and 1921. Some was also circumstantial; because her son, Bhunu, died in 1899, Labotsibeni was the chief political power in Swazi society through the long regency of her grandson, Sobhuza II. But the chief reason why Labotsibeni is regarded as having had so much influence was because of her impressive record of standing up against the encroachment of both Boer and

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British settlers, a reputation reflected in her more popular name, Gwamile, which connotes the idea of standing firm or unshakeable. Her resolute defense of the institution of the Swazi monarchy and skillful political negotiations to protect the integrity of the Swazi kingdom played a pivotal role in shaping the modern state of Swaziland. But, beyond being a strong defender of traditional Swazi culture and authority, Labotsibeni was also an advocate of spreading European style education in order that Swazis, who could no longer hope to win their security and independence by military means, could effectively negotiate with Britain and other European powers.57 A young woman like Madolwane Maziya, who grew up in the household of a chief during the years when Labotsibeni’s struggle with the British administration of Swaziland was at its peak, might very well draw upon the Ndlovukazi’s example in her own struggles to make her voice heard.

As we listen to Maziya speak, we hear a great deal about Swazi conceptions of wellbeing, as related to leprosy as well as other illnesses. But what we do not hear is any sentiment that might parallel the key emotions and images of Elizabeth Cole’s 1937 account of her visit to Ncabaneni, with which this chapter opened. How can we reconcile this discrepancy in language about leprosy? In order to do so, we need to balance our understanding of Maziya’s claims with deeper knowledge of the perspective from which Cole viewed the encounter. Getting to this perspective requires us to first understand

something of the life story of Elizabeth Cole, particularly the ways in which she herself constructed a narrative about her own life. In reconstructing this narrative, I am leaning heavily on the application she submitted to the Church of the Nazarene in 1934 for appointment to missionary service, as well as later narratives to which she contributed directly as either author or interview subject.\textsuperscript{58} Doing so helps us understand Cole’s perspective and manner of representing the leprosy work, but the views she expresses in these texts are very much in harmony with the oral testimonies of people I interviewed, both Swazis and Westerners, and represent a larger narrative about leprosy work, most particularly propagated by missionaries.

Born January 15, 1911, Cole lived most of her early life on a ranch in eastern Montana, the eighth of eleven children in her Methodist family. Cole grew up as a self-described cowgirl who loved horses and the relative isolation of the Montana range where she herded cattle, two relatively innocuous passions that would later become linchpins in the narrative of her life leading towards leprosy work in Swaziland. Cole’s conversion to Christianity came at 13 years of age, though her religious fervor cooled considerably during her high school years. But after graduation from high school in 1929, Cole felt led by God and her mother’s encouragements to enroll in nurse’s training at Deaconess Hospital in Billings, Montana. There, under the influence of a Dr. A.J. Movius and his wife, Marion Murray Movius, Cole joined the local Church of the Nazarene in 1931. In this context, Cole began to contemplate for the first time the idea of

\textsuperscript{58} The relevant materials for this section are housed at Nazarene Archives in Lenexa, Kansas. See especially, File 1195-1(C), File 211-54, File 1312-24, and Cole’s own book, \textit{Give Me This Mountain} (Kansas City, Nazarene Publishing House, 1959).
work with people affected by leprosy: “A short time after (joining the Church of the 
Nazarene) the Lord let me see that poor patients with foul diseases and diseases that 
could not be cured had very receptive hearts. I thought of the leper people and wondered 
if Jesus would ever let me go to them.”59 Feeling the need to prepare for a life of 
Christian service among leprosy sufferers, Cole enrolled in a Bible Training School in 
neighboring Washington state where, in April 1934, she experienced what she would later 
identify as her definitive call to missions and specifically to work with leprosy patients:

I was having my quiet time when suddenly the room seemed light and light went 
clear through my whole body. I knew that Jesus was beside me - that I was His 
child - that he wanted me to go to the lepers - that He would go on before - and 
that I need never doubt again.

This was not a dream, imagination, or fanaticism. I know even plainer 
than I know I’m writing that Jesus called. Again and again since that evening 
tests have come. people have said that it would be impossible for me to go and 
have begged me not to even think about it. They have offered me permanent 
positions with high wadges (sic); but always when I look through and behind 
these things to Jesus they are small.60

Within a year of having received this vision, Cole had applied for missionary 
service and been assigned to the work in Swaziland, with the clear understanding that she 
would be set apart for work with leprosy patients just as soon as possible. The visionary 
experience of April 1934 was neither the first nor the last time she would report 
experiencing supernatural intervention in her own life. But this particular experience 
remained central to her identity and serves as a powerful indicator of the ways in which 
Cole felt that her own call to work among people affected by leprosy was more than just a

59 Elizabeth Cole to Dr. J.G. Morrison, Foreign Missions Secretary, December 10, 1934, File 211-54, 
Nazarene Archives, Lenexa, Kansas.

60 Ibid
practical or medical endeavor. It was an explicitly spiritual work, motivated by an intense piety, not altogether uncommon for early twentieth century women in American Holiness circles.

Like other holiness missionaries before her and yet still in the notably dramatic and specific fashion of her reported vision, Cole’s sense of a calling to leprosy work became central to her identity and direction in life.\(^6^1\) Although she performed her general nursing duties at the RFMH conscientiously, it was always clear that her singular passion was to develop and expand the Nazarene work among leprosy patients. For example, during her furlough of 1950-1951, less than two years after having assumed full time leprosy work at the Mbuluzi Leprosy Hospital, Cole was already talking to church members and leaders about her conviction that “... it is God’s will that our church have leper colonies (sic) in other places in Africa and in other parts of the world ----- I believe that the God who helped us in the little leper colony in Swaziland is able to help us in other leper colonies.”\(^6^2\) Even after her retirement in 1972, Cole was still emphasizing the leprosy calling. Claudia Stevenson, Mbuluzi’s last nurse matron, told me that her own calling to leprosy work, which climaxed during a furlough bus ride to Kansas City when Jesus came and sat in the empty seat next to her and called her to work with leprosy patients, had come about in part because of the prayers of Elizabeth Cole that someone

\(^6^1\) Regarding the links between holiness piety and the sense of a calling into particular kinds of ministry, see Dana Robert, *American Women in Mission: A Social History of Their Thought and Practice* (Macon, GA: Mercer University Press, 1997), esp. pp. 148-152 & 231-240. A great deal of work focused on the idea of a calling examines the experience of women, probably because there are major disputes within Christian theology about the appropriate place of women in the church.

\(^6^2\) Elizabeth Cole to Dr. and Mrs. Hynd, October 14, 1950, File 1366-17, “Letters to Missionaries, 1950-51, A-G,” NA.
would take up the call to leprosy work in Swaziland. In her zeal, Cole apparently tried a number of times to convince David Hynd and his wife that they should be the ones leaving Swaziland and spearheading the expansion of Nazarene leprosy work around the African continent. But, as discussed in chapter one, Hynd’s burden was for medical missionary work as a whole and not for one individual facet, as was the case for Cole.

This understanding of her work among leprosy sufferers as explicitly spiritual persisted for many years, and indeed the spiritual framework applied by the mission was perhaps the key distinction between it and the colonial government of Swaziland. One gets a clear indication of how significant this issue was for Cole in a letter she wrote to Marjory Burne in 1950, explaining why she felt that she could not participate in a project aimed at telling Cole’s story to missions supporters in the United States:

I can not feel clear about telling to the outside world anything regarding the leper work - myself included - unless we see the lepers turning to God. I mean really turning to God (underlining in the original). I am to the place where I feel that everything else has been in vain and is in vain unless that comes to pass.

Cole represented a larger vein of women missionaries who were filling the ranks of holiness church missions during the early twentieth century. Dana Robert describes the holiness avenue as a parallel to the faith missions of the same time period in terms of their attraction for pietistic women, marked by their specific beliefs in “a process of spiritual development by which they could live on an elevated plane of Christian spiritual

63 Interview with Claudia Stevenson, July 16, 2008.

64 Cole refers to these conversations in her letters to the Hynds of October 14, 1950 and April 28, 1951, File 1366-17, NA.

life, following the direct leading of God through the power of the Holy Spirit. Coming originally from Methodism, holiness thought pervaded denominational missions as well as emboldened women to set out on their own.”

Women, both married and unmarried, played a significant role in the work of the Church of the Nazarene from its beginnings in Swaziland. In this sense, according to Robert, the church departed significantly from the movement within mainline denominational missions in the first half of the twentieth century, as the women’s missionary movement was subsumed within denominational missions and as the rise of fundamentalism created greater emphasis on the subordination of women to men. Although not entirely free from these influences, the holiness theology of the Church of the Nazarene left a distinct sphere of activity and leadership for women in missions.

As explained in the previous chapter, anyone who could attest to the experience of entire sanctification could exercise a measure of leadership within the holiness tradition of the Nazarenes. Indeed, Cole is remembered to this day as an esteemed missionary and a model of Christian compassion, although her testimony about her experience of entire sanctification shifted somewhat over the course of her life. In her application for missionary service with the Church of the Nazarene, Cole indicated that she had experienced both conversion and sanctification in May of 1924, when she was only thirteen years of age and prior to what she described as her “fall from grace,” during her later teen years. In a later account of her life, Cole related that she believed “she was

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sanctified at the time she was definitely called to the lepers.” This comment is somewhat ambiguous; it could mean that Cole thought of herself as “already sanctified” at the time she received the vision calling her to leprosy work, but I would argue that the much more likely reading of the statement is that Cole believed that her call to leprosy work represented the moment when her life truly entered the “state of entire devotion to God” referred to in the Nazarene Manual. The significance of this association between the central religious experience of her life and the call to leprosy work should not be missed.

In light of all this, I want to return at this point to Cole’s story with which I began this chapter. It had been something of a disappointment for Cole that the Nazarene mission was unable to assign her directly to leprosy work upon application; it had been a specific point of inquiry during her interview process whether she would hesitate to accept assignment in general medical work, with only the promise of hoped-for involvement with leprosy work at some future point. Cole, after praying on the matter, had consented to be sent to the Raleigh Fitkin Memorial Hospital in Bremersdorp to work alongside David Hynd, but the chance to interact with leprosy patients at Ncabaneni was of great significance to her. In a later retelling of the same event described earlier, Cole provided an even more elaborate picture of her first encounter at Ncabaneni:

When the service was over, a man whose face showed the scars of deep suffering stood in the midst of his people and made motions that he wished to speak. With the aid of a stick he hobbled forward on his ulcerated feet. “We are thrown-away

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67 This quote appears as part of a handwritten note by Marjory Burne on c.1950 document compiled by Burne relating the details of Cole’s life story, which Burne was collecting for a mission publication. See File 1312-24, NA.
people and nobody cares.” He spoke on and on telling of tragic separations: little children taken away from their parents, husbands from their wives, and wives from their husbands. He then told of sufferings and sorrows unbelievable. Afterwards, he pleaded for help. In closing he repeated his cry, “We are thrown-away people and nobody cares.”68

The notion of Swaziland’s leprosy sufferers as “thrown-away people” became a sort of motif in Nazarene language about leprosy in Swaziland that persisted throughout their work; one of Elizabeth Cole’s successors in leprosy nursing care used the phrase when speaking to me in 2008. But the image barely corresponds with the evidence from this period that Swazis in general did not seriously stigmatize people with leprosy. Certainly, there is nothing about the words of Madolwane Mazyia that suggests victimhood. So what do we make of the apparent discrepancy between the language of the man described by Elizabeth Cole and the letters of Madolwane Maziya?

On the one hand, it would be easy to suggest that Elizabeth Cole simply misunderstood what she was seeing and hearing at the leprosy settlement. We do not know the exact date of this encounter, but we know that Cole was a new missionary in Swaziland, having just arrived in the country in August of 1935.69 She was listening to a man speak a language that she did not understand, and it would not be surprising at all if she merely interpreted what was happening or the words that were being related to her via translation through her own particular lens of leprosy as among the very worst manifestations of both physical and spiritual suffering. The story could easily have been


69 In her 1959 book, Cole dated the event to 1935, which means it would have had to happen sometime after August. The September, 1937, issue of *The Other Sheep* is the first dated record of the event, but it makes no specific reference to the timing of the event.
given an interpretive gloss in order to align it with the expectations of her Western Christian readers. In this vein, of course, one might also suggest that Cole either fabricated the story or at least exaggerated the drama involved in the petition.

However, I would argue that something else may very well have been happening here, a process at work similar to the one that allowed Maziya and her fellow leprosy patients at Westfort to successfully motivate the establishment of the Ncabaneni settlement. Perhaps the man appealing to Cole and the other Nazarene missionaries present understood that his petition to a Western missionary needed to be framed in a particular fashion, just as Maziya clearly understood that her petitions to the Resident Commissioner needed to be framed in a particular fashion. Indeed, there are noticeable parallels between these historical accounts and my own experience in interviewing Gogo Shiba, the former leprosy patient I referenced in the Introduction. Gogo Shiba informed me, in a speech laden with obvious pathos, that “No one cares for leprosy patients anymore,” as she explained to me the consequences she had suffered as a result of the functional ending of the leprosy program in Swaziland in recent years. There is, I think, no question that she understood very well the potential power of her very dramatic story to effect some change in her situation. In the case of the man Cole describes, we must concede, of course, that we know even less about his background than we do about Maziya’s. Yet even if the man in question had never previously encountered missionaries and their teachings, something that seems unlikely, there were clues in the very events of that day that might have helped him understand the language of Christian missionaries surrounding leprosy. According to Cole, Dr. David Hynd had just concluded a message
to the leprosy patients centered around the text in Matthew 8:1-4, in which Jesus immediately follows up his delivery of the Sermon on the Mount with the healing of a man with leprosy who kneels before him petitioning for a cure. Such a sermon would have revealed much to a careful listener.

The man’s petition, however, was not solely a calculated act intended to manipulate Westerners by deploying language they could understand; rather, it clearly bears the imprint of core ideas rooted in Swazi culture. The act of petitioning in Swaziland is a dramatically performative one, and if the man in question desired help from someone in a superior socioeconomic position, he would readily have reverted to a very pathetic physical posture as well as using language that suggested extremity. In this way, he could communicate not just his own need but also his respect (*inhlonipho*) for the superior status of the other, a crucial organizing principle in Swazi society. Although she does not describe it in terms of *inhlonipho*, Hilda Kuper has described the creation of a system of social rank in the formation of the nineteenth century Swazi state, during which time the expanding power of the Dlamini clan during the reigns of Sobhuza I and Mswati II brought large numbers of other clan groups into relationships of dependent subjection. In Kuper’s assessment, as long as they accepted their inferior position with the expected humility, “Loyal subjects could anticipate protection from external foes and a limited security of person and property within a system of law.”

As we shall see below, this

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70 Cole, *Give Me This Mountain*, 21.

pursuit of “limited security” was likely an important consideration for Swazis living at Ncabaneni as members of a nation dealing with severe land shortages during this period.

Political relationships between clan groups are, of course, an inexact parallel to the situation Cole described at Ncabaneni, but Casey Golomski’s recent anthropological work on Swaziland on Swazi cultural responses to the crisis of HIV/AIDS highlights the persistence of this concept of *inhlonipho* or moral subjection, as he has termed it, at a more interpersonal level. In particular, he highlights the ways in which young people, especially in religious institutions such as Sunday schools, are firmly instructed to show deference to both God and their elders within their communities as a means growing towards adulthood and attaining their full social status. In conjunction with Kuper’s work and James Ferguson’s recent work on the concept of dependency throughout the region, we can begin to identify the contours of a Swazi strategy for dealing with the confounding social inequalities instituted by European rule in this region, one firmly rooted in their own cultural habits. In chapter four, we will see this strategy come even more fully into practice at the Mbuluzi Leprosy Hospital.

In saying this, I do not mean to suggest that everything happening at Ncabaneni on the day in question was somehow entirely an artificial construction. Instead, I see what happened on the day Elizabeth Cole first visited Ncabaneni as a demonstration of the dynamic and adaptable nature of human culture. Swazis like Madolwane Maziya and

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the man appealing to Elizabeth Cole remind us that, even as they encountered a new kind of modern/Western existence with its particular expectations and understandings of the world, they quickly mastered those concepts and developed the intellectual and cultural tools necessary to make this new world livable and even beneficial for themselves.

This chapter has focused very narrowly on a few years surrounding the opening of the Ncabaneni settlement, between 1932 and roughly 1936. Two remaining points are necessary regarding the subsequent twelve years of its existence. The first is that the small settlement grew quite rapidly after 1934, reportedly without much encouragement or incentive from the British government. One year after the arrival of the first patients, Jamison reported that, “three further Swazi lepers have at their own request been sent to this settlement and that others have been making enquiries about it.”74 By July of 1936, the number had grown to fifteen total patients at Ncabaneni, not including two of the original patients who had been discharged.75 Two years later, the number was twenty-one, and by October of 1939, almost exactly five years after its opening, the number had reached forty-three.76 All of this growth apparently took place in the absence of any further efforts on the part of the government to identify or isolate Swaziland’s leprosy population, though one suspects that many of the new patients may have heard about the settlement from European doctors.

74 Robert Jamison, “Memorandum by the Principal Medical Officer on the treatment of leprosy and tuberculosis,” October 21, 1935, File RCS 241/35, SNA.

75 Robert Jamison, Principal Medical Officer’s Minute, July 26, 1936, File RCS 241/35, SNA.

If there is little reason to suspect that these men and women were being pushed out of their homesteads because of their illness and if there was no organized strategy for gathering them, why did so many Swazi leprosy patients come to Ncabaneni? One explanation might be perceived optimism about a cure. In 1937, Swaziland’s Government Secretary wrote to the High Commissioner, Sir William Clark, explaining, “Jamison says that the results of treatment at the present small settlement near Mankaiana ... have exceeded his expectations and some cases which made no improvement at the Pretoria Asylum have apparently been cured.”

It was Jamison’s hope that discharging some patients as cured would lead others to come in, and perhaps this was the case for some of those new arrivals. Unfortunately, the government’s minimal investment in Ncabaneni meant that they were keeping no records of case histories which might answer that question definitively.

But 1937 is the last mention in government correspondence about patients being discharged from Ncabaneni, and the optimism about providing cures via treatment seems to have waned quickly, a subject we will return to in a moment. But if optimism about a cure was short lived, why did patients come? The other explanation might be that the quick growth of the Ncabaneni settlement was a sign of land pressure elsewhere in Swaziland. Relatively little land was available to Swazis in their own country as a result of the British Partition, and the pressure on that land seems to have been increasing steadily during this time period. In fact, Hamilton S. Simelane has identified the mid-1930s as a period during which the number of Swazis evicted from European-owned

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77 H.B.A. McCarter to Sir William Clark, June 7, 1937, File RCS 839/36, SNA.
land was growing measurably. It is probable that some of the patients who came to Ncabaneni were individuals with few other alternatives who believed that the settlement represented a kind of social and economic security, even for their dependents. In 1946, there was one known case of an uninfected woman whose husband had leprosy moving into the Ncabaneni settlement along with her husband and their five uninfected children. Even when government offered her a social welfare subvention to support her family outside the settlement, she refused to leave, a decision that regrettably resulted in two of the children contracting leprosy. For a woman such as this, reportedly destitute and lacking other relatives to fall back upon, the settlement at Ncabaneni was not a panacea, but it offered basic security. If the men and women there could not necessarily control the land themselves, they could at least hope for some access to land for gardening and feel confident of receiving a regular ration of meat from the government. The correspondence from this period suggests that only a minority of the patients suffered noticeable physical disability, which suggests that many of these patients were, in fact, seeking some kind of opportunity or security.

The relatively rapid and apparently unexpected growth in patient numbers undoubtedly caused some deterioration of the living conditions at Ncabaneni, though the few oral testimonies I collected from people with memory of Ncabaneni do not suggest anything like the abject squalor that Cole and Hynd depicted in their correspondence.


79 Minutes of Meeting of Acting Government Secretary with Paramount Chief and Council, Lobamba, August 23, 1946, File 100A, SNA.
particularly not at such an early stage in the life of the settlement. But this brings me to my final observation about the Ncabaneni settlement, which will help set the stage for chapter three. Even as Ncabaneni grew, Westerners, both missionary and government, quickly turned on it as an unsatisfactory solution to the leprosy situation in Swaziland, primarily because the infrastructure and staffing in place at Ncabaneni did not permit them to exercise adequate supervision of the patients’ lives and behaviors. In 1939, for example, Dr. D. Drew, who had replaced Jamison as Principal Medical Officer in 1937, and the Resident Commissioner had to ask Sobhuza and his council to intervene at the settlement because of reports about male and female patients living together, which violated both British moral and medical sensibilities. When Sobhuza had his local chief investigate, an even longer list of complaints emerged from the patients and the Swazi supervisor at the site, including complaints that men were asked to bury the bodies of deceased female patients, a task which they felt belonged to members of the same gender as well as to close kin of the deceased.\textsuperscript{80} Drew resolved this issue by having bodies buried by prison labor, but it was clear that Ncabaneni had become a place of clashing cultural expectations.\textsuperscript{81}

Even Jamison himself had passed judgment on Ncabaneni as an inadequate step prior to his retirement. As early as 1935, he had taken to declaring Swaziland as “... one of the few countries in the world where practically no attempts are made to deal with

\textsuperscript{80} This claim aligns well with the findings of Hilda Kuper, who was conducting her field research at this same time. See \textit{An African Aristocracy}, 180-182.

\textsuperscript{81} For details on this incident, see various correspondence between April and October of 1939 in File RCS 839/36, SNA.
Leprosy.” In light of this and other similar declarations, it is apparent that Jamison’s optimistic 1937 assessment of the benefits patients received at Ncabaneni was intended to help persuade his superiors in the government to stay invested in leprosy work in Swaziland and to further the chances of its financing the construction of a larger leprosy colony that could adequately house and treat the sixty to one hundred patients that Jamison had come to believe needed it. Jamison continued to press for this even though he himself recognized that there had been little in the way of medical advancement for treating leprosy. In 1936, he argued that the main reason why it was important to continue providing Swazi leprosy patients with injections was their “great psychological effect on the native. It gives him the belief that practical interest is being taken in his case and without it the chances of prolonged voluntary stay in a settlement are remote.”

This, in the end, represented Jamison’s final assessment of what was necessary to aid leprosy patients. They needed to be removed from the context of their homes in order to improve their access to good food and sanitation, as well as a psychological shift in their thinking about their illness. Ncabaneni could not provide this because it so quickly became overcrowded, but also because the buildings on the site were of the traditional Swazi type, which Jamison and others believed were quite unhealthy because they provided inadequate light and fresh air. The arguments Jamison made were almost enough to accomplish his aims. In the end, two things seem to have prevented the government from proceeding with plans to build a new leprosy settlement. The first was

82 Robert Jamison to J.R. Armstrong, February 6, 1935, File 241/35, SNA. In his Minute of July 26, 1936, cited above and found in this same folder, he repeated this criticism nearly verbatim.

83 Robert Jamison to Government Secretary, November 11, 1936, File RCS 839/36, SNA.
Jamison’s own retirement in 1937, which caused High Commissioner Clark to postpone one proposed version of the settlement, presumably to let Jamison’s successor have a voice in such a significant expenditure. The second, and ultimately much more significant obstacle, was the onset of World War II in September of 1939, which caused money set aside in the budgets for 1940 for the new leprosy settlement to be cut completely. Ultimately, Ncabaneni would remain Swaziland’s only leprosy settlement until 1948. The story of how that new institution finally came into existence and the cultural tensions that it embodied make up the subject of chapters three and four.
Chapter 3
Leprosy and Modernity: Western Visions of Institutional Medicine at the Mbulazi Leprosy Hospital

The Mbulazi Leprosy Hospital’s relatively short life in Swaziland from 1948 to 1982 corresponded closely with the critical transformations in the medical treatment of leprosy. Previously perceived by many as a sinister, disfiguring, easily transmissible, and difficult to treat disease whose victims had to be excluded from the daily activities of their own societies, the year 1948 saw the introduction of sulphone therapies, the first routinely effective treatment for leprosy sufferers. Mbulizi, thus, was largely planned and built as an institution that fulfilled a vision outdated almost as soon as it became a reality. Though the linkage between Mbulizi’s founding and the advent of sulphone therapy was entirely coincidental, the same cannot be said for Mbulizi’s closing in 1982. In 1981, the World Health Organization recommended a course of treatment known as Multi-Drug Therapy, which is now used around the world and has rendered leprosy routinely curable; furthermore, Western medical doctors had finally become convinced that leprosy is relatively difficult to transmit, which made isolation in specialized treatment institutions such as Mbulizi unnecessary.

This chapter analyzes the competing visions of medical care that lay behind the founding of Mbulizi and the way that vision was enacted in light of developments that the founders could not have anticipated, including the dramatic shifts in medical knowledge, the World War II-era adjustments to the British philosophy of imperial rule especially as represented by the Colonial Development & Welfare Acts, and the steadily
growing influence of missionaries for the Church of the Nazarene. Mbuluzi was a community shaped by Western scientific values and norms, but challenges to those ideals inevitably came from both within and without. My argument through this chapter and the next is that, over the course of its life, Mbuluzi became steadily less and less an institution of Western medicine and increasingly a site of Christian pilgrimage, a place defined more by its spiritual resonance than by its medical work. In this chapter, the focus will be on the creation of an institution of medicine; in the subsequent chapter, I will explore more thoroughly the emergence of the spiritual. In both cases, I want to explore the ways in which Swazis responded to the efforts of Westerners to establish their idealized vision, despite the fact that their participation was often consciously excluded from key decision-making processes.

Although the institution established at Mbuluzi formally bore the title of a leprosy hospital, it was rare indeed for the term “hospital” to be applied to the institution anywhere save in the titles of annual reports submitted by the supervising medical officer. Instead, people more commonly referred to the institution as “the settlement” (the preferred word of British administrators) or “the colony” (the word used more commonly among the missionaries). Even within their annual reports, medical supervisors like Dr. David Hynd would use this language to distinguish between the “hospital,” the one building at the site where inpatient treatment could be delivered to particularly acute cases, and the “colony,” which generally referred to the much larger range of buildings, people, and activities connected to the maintenance of community life at Mbuluzi. But,
in most circumstances, words like “colony” simply became a shorthand reference for the entire institution and its medical, social, and spiritual functions.

In this way, Hynd and his contemporaries followed closely the common practice of people throughout the British Empire and the rest of the English-speaking world. As explained in the first chapter, Rod Edmond’s recent work highlights the proliferation of this term in Western society and helps us understand better the particular visions of control and containment that lay behind the use of such a word. Understanding this perspective helps explain why Ncabaneni was not in any way the sort of institution that would fit a Western vision of leprosy care, and why the various people who commented upon the situation at the settlement were so ready to condemn it, even if their narrative of misery and rejection had to be forced. There was little hope that the settlement, with its small size and immediate proximity to the road connecting Mbabane and Mankaiana, two seats of the British administration, could ever provide the kind of isolation envisioned for the prevention of contamination.

In 1938, Sir Walter Johnson, the Superintendent of the Botsabelo Leper Settlement in Basutoland and a future Director of Medical Services for the High Commission Territories, confirmed this judgment of Ncabaneni. Invited to Swaziland to advise the administration with regard to its leprosy situation, Johnson spent four days in mid-July, 1938, visiting the country to survey the needs. In his report back to the

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1 Rod Edmond, Leprosy and Empire: A Medical and Cultural History (Cambridge: Cambridge University Press, 2006), 179. My discussion concentrates particularly on Edmond’s fifth chapter, entitled, “Concentrating and isolating racialised others, the diseased and the deviant: the idea of the colony in the later nineteenth and early twentieth century.”
Resident Commissioner, Johnson characterized Ncabaneni as “very unsatisfactory from every point of view,” particularly as it had “no room for expansion and very limited ground for growing crops.” Johnson’s declaration may have overstated things; he himself conceded that the settlement’s patients, as far as he could judge, “seem to be quite reasonably happy.” The site had virtues from other perspectives as well; as High Commissioner Clark had written the year before, the government’s overall aim was to avoid building an institution that would require a resident doctor or European nurse, rather than just a Swazi supervisor. This was, of course, chiefly in order to address concerns regarding funding.

Johnson’s relatively extensive report on Swaziland’s leprosy situation went on to define the contours of the approach that the government would pursue in the years ahead, though the onset of World War II would lead to significant delays in bringing it to reality. Johnson, concluded from his investigation that leprosy was a relatively rare condition in Swaziland, which suggested there was a unique opportunity to eradicate the illness before it had the opportunity to spread significantly, a conclusion very much in keeping with those reached by others such as Hynd and Jamison. Pursuing this aim of eradication required a two-pronged approach in Johnson’s estimation: first, the gathering of more concrete data about the extent of Swaziland’s leprosy situation, and second, the development of institutional resources for providing care to all identified cases of leprosy in the country. The implementation of each of these strategies warrants careful review.

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3 Clark to McCarter, July 27, 1937
and reveals a great deal about the vision of the British government and others of what a proper institution for dealing with leprosy should be.

Regarding his first recommendation, Johnson acknowledged that the most thorough way of gathering the necessary information would be to conduct a full leprosy survey, which would mean hiring a trained medical officer and a team of trained Swazi assistants to visually inspect as many as possible of Swaziland’s estimated 130,000 inhabitants. This possibility, however, he discounted for several reasons: the considerable expense involved, the inevitable slow progress of the survey given the dispersed nature of Swazi homesteads, and finally, the unnecessary alarm he believed would be caused by carrying out the relatively invasive, full-body inspections that a survey would require.

Instead of a survey, Johnson suggested that the Swaziland administration emulate a model currently in use in Basutoland: the hiring and training of one or two Swazis to serve as leprosy inspectors, charged with the responsibility of identifying additional leprosy cases by examining family members of known patients and other cases reported by chiefs to the authorities. During his visit, Johnson had discussed this proposal with Sobhuza II, who had approved of the idea and indicated that he could help “find a reliable man who would have authority.” The “authority” to which Johnson refers here is a good deal more than just the medical knowledge to identify a leprosy case; the man in question would need to wield sufficient social influence to be able to persuade identified leprosy cases to enter the leprosy institution without compulsion. It is telling that Johnson and the rest of the British administration apparently believed that the best way of investing

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such authority in a person was via the assistance of Sobhuza, a tacit, and perhaps not entirely conscious, recognition of the limits of their own legitimacy in Swazi eyes. Whatever the case, Johnson’s recommendations clearly acknowledged that for any method of information gathering to be an effective tool in leprosy control, it would require the consent and cooperation of local people. Johnson recognized that it could not be assumed that such consent and cooperation would be a foregone conclusion, and as the case turned out, he could scarcely have been more correct.

It was not until 1946 that the Swaziland administration got around to pursuing this information gathering work, and when they did, the wisdom of Johnson’s suggestions was rather heartily affirmed, though chiefly in the breach. By 1944, Swaziland had finally received the large cash infusion that it needed to deal with leprosy, by way of a £27,300 grant out of the Colonial Development and Welfare Fund. As Hamilton Sipho Simelane has pointed out, CD&W money was the “most important innovation in the relationship between the metropolis and the colonies” during the 1940s (and probably before or after), in that it vastly increased monies available for development in Africa. The purpose of the money, first disbursed in 1940, was twofold: to stave off criticism of empire and calls for decolonization, voiced by Americans and others around the world,

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5 Walter Johnson, “Report on the Visit of the Director of Medical Services for the High Commission Territories to Swaziland, 3rd-26th February, 1944,” File 674, SNA.
6 Hamilton Sipho Simelane, Colonialism and Economic Change in Swaziland, 1940-1960 (Kampala: JANyeko Publishing Centre, 2003), 9.
by fostering a more philanthropic image of the British Empire and to mobilize colonial resources both for wartime and for the postwar recovery process.\(^7\)

Although Simelane argues convincingly in favor of the latter purpose as the primary motive overall, the philanthropic purpose seems more apropos in the case of Swaziland’s grant for leprosy work, which could hardly be expected to have a significant economic effect. The primary purpose of the CD&W money was for construction of a leprosy hospital, but it also prompted the hiring of Albert John Sowden, a leprosy field worker for BELRA. Sowden brought with him 7 years of prior experience in leprosy work, having worked for BELRA in both Nigeria and Sudan before coming to Swaziland in November of 1944. The transition to Swaziland was not an entirely smooth one for Sowden: he had agreed to the transfer in large part because an illness to his wife had prompted the decision to leave Sudan, and then word had come less than six months after arrival in Swaziland that his mother in the U.K. had only a few months left to live, which caused him to depart suddenly for six months of leave in March of 1945. In the meantime, there had been significant delays in getting the road to the site of the new Mbuluzi settlement built, as well as a seemingly endless round of negotiations related to

\(^7\) Ibid, 47-48.
Sowden’s compensation, as a result of his secondment from BELRA to the Swaziland administration.\(^8\)

It was out of those protracted negotiations that the decision to have Sowden carry out a full leprosy survey emerged, contrary to Walter Johnson’s earlier cautions. Johnson and the Swaziland administration still seemed to intend to follow the basic outline of information gathering by means of Swazi leprosy inspectors and saw Sowden as a welcome addition because he had experience in supervising construction work and would play a long term role in the development of the work at Mbuluzi. But Sowden’s superiors at BELRA felt that “it would not be the most profitable use of an experienced and efficient worker ... if Mr Sowden’s activities were confined to looking after a home for a small number of lepers while nothing was done regarding those, possibly many more, who were outside it.”\(^9\) Such demands for a broader range of activity were part and parcel of BELRA’s approach to leprosy at this time; John Manton, for example, has identified the implementation of a leprosy survey as one of the conditions of assistance associated

\(^8\) More information on the transition of Sowden from Sudan to Swaziland can be found in File 678 and File PF205, SNA. The negotiations over Sowden’s salary and compensation package centered around the fact that BELRA workers in places such as Sudan received particular benefits with regard to extra leave time and such because of the perceptions that work in Sudan involved extraordinary hardship. Government employees in Swaziland received few hardship benefits of this type, but BELRA argued that Sowden should receive special consideration because of “the trying nature of leprosy work and the often depressing circumstances in which it necessarily has to be conducted...” (J.R. Martin to H.N. Tait, April 24, 1944, File 678, SNA).

\(^9\) J.R. Martin to the Office of the Secretary of State, Sept.19, 1944, File 678, SNA.
with a grant it was considering for the Ogoja Province in Nigeria, although in that case, that particular condition was eventually withdrawn.\textsuperscript{10}

BELRA further pressed the point by soliciting the opinion of Dr. Ernest Muir, BELRA’s Medical Secretary and at the time perhaps the world’s most influential voice on matters of leprosy care. Muir, while admitting that he had no direct knowledge of the Swaziland situation, offered his assessment that it was Swaziland’s remarkable good fortune to be receiving a man as experienced as Sowden and that he ought to be put to the greatest use possible:

It has been accepted generally in our Colonies that leprosy can never be controlled by segregation of known lepers alone. Leprosy becomes infectious long before it becomes conspicuous and easily recognisable. So the infection is spread before the leper is recognised and segregated. Hence the need for following up contacts, examining school children, educating the public, etc. These are all things that Sowden is able and willing to do. Of course if the Swaziland authorities wish only to provide a refuge for advanced cases, and have no desire to control the disease, that is a different matter.\textsuperscript{11}

Caroline Elkins has argued that the singular credo guiding the administration of the British Empire was “always to ‘trust the man on the spot,’” but this case illustrates the limits of that trust and the ways in which local officials could be influenced by expertise devoid of context.\textsuperscript{12} Muir undoubtedly knew that his statement on the matter combined with the desire of British colonial officers everywhere to ensure their efforts compared


\textsuperscript{11} Ernest Muir, June 19, 1944, letter excerpted in J.R. Martin to the Office of the Secretary of State, Sept. 19, 1944, File 678, SNA.

favorsably with those in other places meant that there was little chance Swaziland would explicitly commit itself only to constructing a hospital refuge for severe leprosy cases. Indeed, no one in the Swaziland administration offered any prolonged resistance to BELRA’s arguments, and by August of 1945, even Walter Johnson was referring to the “real need” for a leprosy survey in Swaziland.\textsuperscript{13} The start of the survey work, however, had to wait until after Sowden’s six month leave, which commenced in March, 1945, just four months after his first arrival in Swaziland. In the end, the project did not begin in earnest until midway through the year 1946.\textsuperscript{14} It would not be long before Sowden began to encounter difficulties.

The first recorded step in initiating the survey was to have Mr. Sowden, backed by Swaziland’s new Director of Medical Services, J.C. Callanan, appear before a meeting of the Government Secretary with the Paramount Chief and his Councilors at Lobamba on August 23, 1946. There, Sowden laid out his case for conducting the survey and the critical need for assistance from the chiefs in getting people to turn up for examination. Sowden couched the survey as part of a wider “system of control,” which would, if

\textsuperscript{13} Johnson had visited Swaziland again in July or August of 1945; his words about the need for a survey came in a letter from August of that year, which was excerpted in J.C. Callanan to J.R. Armstrong, April 30, 1946, File 100A, SNA.

\textsuperscript{14} Among other reasons, the start of the survey was delayed for a time because no one seemed to be able to find a way to provide Sowden with the camping equipment necessary for the travel associated with the survey. In fact, it took an exasperated letter from the High Commissioner’s Administrative Secretary in Cape Town, criticizing the lack of creativity and initiative shown by the administration under Resident Commissioner E.K. Featherstone, to motivate anyone to free up the £100 needed to provision Sowden for the survey (see the letter of H.E. Priestman to E.K. Featherstone, May 22, 1946, File 100A, SNA). Perhaps unsurprisingly, Featherstone was transferred back to Nigeria later that same year, having left a relatively poor legacy of problematic relations with Sobhuza and the rest of the Swaziland government (see the entry on Featherstone in Alan R. Booth’s \textit{Historical Dictionary of Swaziland}, 2nd ed.).
properly carried out, “mean that at the end of 50 years there will be no leprosy in Swaziland.” Sowden understood the survey as an essential component of that system of control, but he recognized also that it was quite invasive, as examinations required that he do more than examine hands and faces. As he explained to the councilors, “It is no good just looking at hands because leprosy is not often first developed in the hands. I want to see the whole body.” In effect, Sowden’s request to the council was that he be given their permission and support to visually inspect the nearly-nude bodies of almost 200,000 Swazis in order to identify cases of an illness that, in the very same statement, Sowden himself had declared affected no more than 200 people in the country. The strategy appears to represent, in nearly equal parts, the hubris of the colonial mindset rooted in scientific optimism and the grim determination of the British to exercise control over the contagion of leprosy. No amount of effort seemed out of proportion with the perceived necessity of eradicating the disease as a medical threat to human wellbeing.

The councilors of Sobhuza II had words of both support and caution for Sowden at their meeting. One of them had a wife who had been sent away from Swaziland, most likely to Pretoria, many years earlier in order to receive leprosy treatment, and he warmly welcomed news that promised the end of the disease in that country. Several asked questions about the diagnosis and spread of the disease, which they regarded as a relatively new one in Swaziland. When one of them suggested that they would need time for discussion about a course of action, Sowden informed them that he had already

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15 Minutes of Meeting of the Acting Government Secretary with the Paramount Chief and Council in Lobamba, 23 August, 1946, File 100A, SNA.
decided on a strategy, as he planned to travel with District Commissioners on their tax
tours to various parts of the country, starting the very next week at Piggs Peak. Most of
the councilors immediately saw problems with this strategy, as the elderly, women, and
children did not commonly turn up at these tax camps and doubted whether a special
appeal for their attendance would be adequate. However, sensing that Sowden was not
anxious to change his plans, one of the councilors simply observed that the plans he had
already made for visiting Piggs Peak should proceed, as they would undoubtedly “... enable Mr Sowden to get useful experience of the difficulties he will have to face.”

The existing files do not tell us whether Mr. Sowden actually did go to Piggs Peak
or whether he shifted his strategy after the meeting. We do know, however, that Sowden
soon began working on arrangements for the leprosy survey to be conducted at the royal
kraal in Lobamba, which he hoped would elevate the public profile of the survey and
increase the level of cooperation that he received. What ensued was something of a
comedy of errors. The government’s First Assistant Secretary presented Sowden’s
request to the Paramount Chief’s council on September 6, and the council passed on the
request to the Ndlovukazi, the Queen Mother, who responded quite swiftly on September
9. The trouble was that her response indicated that Sowden should come to Lobamba the
very next day, a logistical impossibility. At the next meeting of the Paramount Chief’s
council on September 27, the administration repeated the request, while stressing the
need for adequate warning of a suitable date. Sometime between the September 27
meeting and a subsequent meeting on October 18, Sowden did visit Lobamba for the

16 Ibid.
purposes of conducting a survey of the inhabitants of the royal kraal. The results had been exceedingly disappointing:

(Sowden) had examined only 33 people and many people were away from the kraal. There had been no discipline and youngsters had been peeping into the office while he was engaged in examining people. He would be prepared to arrange to come another day if he could be assured that the people would turn out properly and some order could be maintained.¹⁷

Sobhuza reacted decisively to the news of this disappointment, directing most of his displeasure at one of his councilors, J.J. Nxumalo, who had been charged with facilitating Sowden’s visit. Nxumalo protested that he had fallen ill on that day and been compelled to leave the survey site, though he acknowledged that the real trouble was that there had been inadequate attention to protecting patients from the inquiring eyes that routinely looked in through open office windows, which caused others to refuse to participate. Another councilor added that there had been inadequate time to inform people of the need to turn out for the survey. Sobhuza refused to accept any of the various excuses, specifically admonishing Nxumalo for trying to pass on the responsibility for organizing the survey to the Ndlovukazi instead of seeing to matters himself. He ordered that another date be arranged, yet a virtually identical scene played out at the council’s meeting on November 15, when Sobhuza “enquired whether arrangements had yet been made for a second visit by Mr. Sowden and took Councillor J.J. Nxumalo to task when he found that nothing had been done.”¹⁸ One week later,

¹⁷ Minutes of a Meeting of the First Assistant Secretary accompanied by Lord Hailey and Mr. W.H. Cairns with the Native Authority at Lobamba, 18 October, 1946, File 100A, SNA. Minutes of the meetings and relevant correspondence referenced in the preceding paragraph can also be found in File 100A, SNA.

¹⁸ Minutes of a Meeting of the First Assistant Secretary with the Native Authority at Lobamba, 15 November, 1946, File 100A, SNA.
Councilor Nxumalo’s absence from the meeting made it impossible to fix any date for a follow up visit.\textsuperscript{19} By February of 1947, Sowden had made two additional visits to Lobamba, but the turnout apparently continued to be unimpressive.\textsuperscript{20}

The inauspicious beginnings at Lobamba proved a relatively accurate indicator of the progress of the leprosy survey throughout the country more generally. Sowden continued the survey work through the opening of the Mbuluzi Leprosy Hospital in September of 1948 and into 1949, but the results rarely varied. By the end, Sowden had developed a remarkably disdainful attitude towards the people of Swaziland. His 1949 report on work done in the southern region of the country encapsulates his frustrations:

\begin{quote}
The people of this area are typically bush veldt indigents; indolent and inert, the male population seem to have no apparent respect for their Chiefs or the Administration. A comparison between the number of Tax-payers on the register and attendances at the Tax Camp will justify this criticism. Despite this, I have no doubt that the attendances would have been improved upon had the Chiefs and Ndunas passed on to their people the information given them concerning the Survey. I personally spoke to two Ndunas and arranged to visit their area four days later, when I arrived there I found that, despite their insistence that they had called their people, kraals within shouting distance of the Nduna’s were ignorant of the purpose of my visit. Dates and times seem to have no significance for the inhabitant of the bushveldt and the kraal to kraal search for “utshwala” (kaaffir beer) seems to be the full time occupation for the majority.\textsuperscript{21}
\end{quote}

The problems forecast in Sowden’s first conversation with Sobhuza’s councilors had proven to be just as troublesome as they had predicted. Sowden had attempted to use the Tax Camps for the survey, but had learned relatively quickly that it was nearly

\textsuperscript{19} Minutes of a Meeting of the First Assistant Secretary with the Native Authority at Lobamba, 22 November, 1946, File 100A, SNA.

\textsuperscript{20} J.C. Callanan, internal memo, February 12, 1947, File 100A, SNA.

\textsuperscript{21} A.J. Sowden, “Leprosy Survey in Hlatikulu District, 11th July 1949 to 13th August, 1949,” File 100A, SNA.
impossible to get entire households to turn up for inspection there, as the payment of
taxes required only the presence of chiefs and headmen from surrounding communities.\textsuperscript{22} And concerns about the privacy of the inspections continued to crop up. In September of 1948, when Sobhuza’s councilors heard complaints from the administration about the lack of cooperation given to Sowden in the Stegi district, including the assertion that there was some evidence of people with leprosy being intentionally concealed, the councilors noted that “the lack of cooperation on the part of the Chiefs might in part be due to the fact that Mr Sowden had not made arrangements in past surveys for the examination of womenfolk in private.”\textsuperscript{23}

The assertion that he had paid inadequate attention to issues of privacy provoked a rather forceful reply from Sowden, defending the steps he had taken to address the issues. Sowden acknowledged that problems had existed in early stages of the survey, but protested that this was chiefly because he had been working “...single-handed - and that when engaged in the examinations one is intent on the work in hand with no time to observe the wilful activities of the umfaans or those of the would-be ‘peeping Tom.’”\textsuperscript{24} Sowden had attempted to amend his strategy in later surveys by employing a policeman at the survey site, whose job was to monitor the orderliness of those waiting for examinations and to help keep members of the opposite sex apart from one another.

\textsuperscript{22} A.J. Sowden, “Leprosy Survey, 1947,” File 100A, SNA.

\textsuperscript{23} Minutes of a Meeting of the Acting Government Secretary and the Council at Lobamba, 15 September, 1948, File 100A, SNA.

\textsuperscript{24} A.J. Sowden to the Director of Medical Services, October 21, 1948, File 100A, SNA. “Umfaans” is Sowden’s anglicized, plural version of the isiZulu word, umfana, which would ordinarily be rendered bafana in Zulu. In siSwati, the related words are umntfwana and bantfwana.
Furthermore, whenever possible, he made sure that women were examined in the presence of the chief’s head wife, or her appointed substitute, and more recently he had been accompanied by Nora Earnshaw, the Coloured nurse from the Nazarene mission who was now part of the staff at the Mbuluzi Leprosy Hospital, which had just opened the previous month. Meanwhile, examinations of men took place in the presence of the chief and often the Assistant District Commissioner, and all examinations took place indoors or in a Bell Tent that Sowden carried with him on his survey visits. He had endeavored to “observe any tribal custom” of which he was aware and had attempted to accommodate those who requested private examinations or who were denied access to the chief’s kraal for any reason. Women wore their skirts during the exam and men a loin cloth.

The accumulated list of defensive declarations in Sowden’s letter clearly demonstrates his exhaustion with the questions about his concerns for people’s privacy, as well as his frustrations with the work in Swaziland. Nor did his protest have the desired result. At the following meeting of Sobhuza’s council, Sowden’s letter was read in full, only to have one of the council members explain that, “…their main objection had been to the fact that groups of women had been examined at one time, instead of singly.” Whether Sowden made any attempt to accommodate this additional

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25 Ibid

26 Sowden’s final comment in the letter is to simply note that during his time working in Nigeria and Sudan, families had been examined in a much more public way, either in their home compounds or out in the open air.

27 Minutes of a Meeting of the Acting Government Secretary and the Council at Lobamba, 26 November, 1948, File 100A, SNA.
prescription for solving his problems with the survey is not clear, but if he did, it is extremely unlikely that it made any measurable difference in his results.

Certainly, in terms of the lived experience of the majority of the people Sowden reached in the survey, there was nothing about the way in which he had carried it out that would have been recognizable as a means of addressing health concerns. Nowhere in the literature on traditional Swazi healing practices will one find descriptions of people being examined en masse in search of illness; rather, individuals or family units would seek out a healer with a reputation for skill in dealing with particular complaints. A consultation with a Swazi traditional healer might involve diagnosis by a wide range of methods, including trance-induced divination, the throwing and reading of bones, or the oral rehearsal of symptoms by the patient. What particular methods the healer employed would depend upon the particular complaint and/or the training of the traditional healer in question.28 Yet none of this makes up the substance of the council’s complaints against Sowden; instead, they repeatedly focus on the issue of the privacy of women during their examinations. This complaint makes relatively little sense coming from a council that even in these years had actively initiated a national umcwasho, a chastity rite for women.

28 Different authors have categorized Swazi traditional healers in slightly different ways, but the most common differentiation is made between tinyanga (who rely upon herbal remedies that do not necessarily depend upon any supernatural qualities for their healing properties) and sangoma (diviners who rely upon communication with spiritual beings for their healing abilities). For more on the distinctions and the diverse practice of traditional Swazi healing practice, see Lydia Phindile Makhubu, The Traditional Healer (Kwaluseni: The University of Botswana and Swaziland, 1978); Ria Reis, “The ‘Wounded Healer’ as Ideology: The work of ngoma in Swaziland,” ch. 4 in Rijk van Dijk, Ria Reis, Marja Spierenburg, eds., The Quest for Fruition through Ngoma: Political Aspects of Healing in Southern Africa (Cape Town: David Philip, 2000); John M. Janzen, Ngoma: Discourses of Healing in Central and Southern Africa (Berkeley: University of California Press, 1992); Enid Gort, “Changing Traditional Medicine in Rural Swaziland: The Effects of the Global System,” Social Science & Medicine 29, no. 9 (1989): 1099-1104.
in which participants wore no more clothing than they did during Sowden’s examinations and whose general attitudes towards the female body and female sexuality could only be regarded as considerably more relaxed than those of the British. This, perhaps, was yet another example of Swazis making use of Western language and norms to accomplish their own ends, as discussed in the previous chapter. Whatever the case, it seems evident that the endless debates about the privacy of patients were actually an indirect way of communicating to Sowden that the Leprosy Survey was simply not a priority.

From the Swazi perspective, Sowden was pouring a relatively immense amount of energy into addressing an illness that had never affected very many people and that had never been a source of special concern. Sowden and the administration’s failure to align their priorities with the social, cultural, and economic concerns of Swazis undermined any chance they might otherwise have had of obtaining necessary local cooperation.

What Sowden and Callanan critiqued as apathy on the part of Swazi leadership regarding the wellbeing of their people was more likely the result of a simple calculation of the benefits of the survey as compared to the effort involved in making it succeed. This sort of failure of alignment when it came to the priorities of people was certainly not a problem uniquely confined to Swaziland’s administration. Melissa Graboyes’s work on medical research in East Africa demonstrates that the failure to align priorities and values

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often frustrated medical researchers who found that living, breathing Africans consistently refused to accept objectification in the way that photographs and cadavers had during the researchers’ training.30

Despite the problems, the Leprosy Survey was not a complete failure as a tool for information gathering. For one thing, it had not become, as Walter Johnson feared it would be back in 1938, the cause of unnecessary alarm among Swazis. The full-body inspections that Johnson thought might be the cause of this alarm had been a bone of contention, certainly, but there is nothing in the records of the Swaziland Leprosy Survey to suggest that these inspections caused people to feel anything stronger than annoyance or embarrassment. Swazis were apparently not quite as ready as Johnson expected to take on Western stigmatization of the disease. Secondly, the survey did uncover some additional cases of leprosy, many of whom became patients at Mbuluzi and underwent successful treatment. One of my informants in Swaziland was a student at the South Africa General Mission’s high school just a mile removed from the site of the Mbuluzi Leprosy Hospital. Diagnosed by Sowden as a part of his survey work, she became one of the first patients at Mbuluzi, where she met her eventual husband. After completing their treatment, the two of them married at the hospital’s church; he eventually became hospital chaplain, and she worked there as a teacher for many years afterwards. Finally, the survey work convinced Sowden that leprosy’s distribution in the country was essentially nodal, with the greatest concentrations in the northern and western highveld.

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regions of the country.\textsuperscript{31} This observation held up reasonably well during the following decades of leprosy work in Swaziland; even as Swaziland’s public health system grew, few cases of leprosy came out of the lowveld regions that dominated the country’s southern and eastern portions.

These modest victories, however, were inadequate to counteract Sowden’s conviction that the Survey had been a failure. In his final report from the Hlatikulu District, he wrote, “I am convinced that no Survey has yet given the true picture of the incidence of leprosy - it has been only too obvious that a number of cases have evaded examination.”\textsuperscript{32} During the three years of the Leprosy Survey, Sowden had accumulated a long list of explanations for its failures to achieve his vision of success. Each of them placed the blame squarely on other people, primarily on the Swazi people. Aside from his earlier comments about the laziness of the people (especially in the lowveld) and the disregard of their leaders for timeliness or communication, Sowden had blamed the “Swazi’s fear of witchcraft,” which prevented people from giving “any information freely.”\textsuperscript{33} On this point, he enjoyed considerable support from Callanan, the Director of Medical Services, who thought Swazis compared poorly to other African peoples whom

\textsuperscript{31} A.J. Sowden, “Leprosy Survey, 1947” and “Leprosy Survey in Hlatikulu District, 11th July 1949 to 13th August, 1949,” File 100A, SNA. Sowden’s early work in northern portions of the country, particularly near Mbabane, had turned up 5.9 people with leprosy per thousand, a relatively high rate but nearly four times as high as the rates in any other region visited by the Survey.

\textsuperscript{32} Sowden, “Leprosy Survey in Hlatikulu District, 11th July 1949 to 13th August, 1949,” File 100A, SNA.

\textsuperscript{33} A.J. Sowden to J.C. Callanan, September 9, 1948, File 100A, SNA.
he judged as having a “more enlightened attitude ... towards measures designed for the
general welfare of the community.”

But Sowden also found fault with the actions and policies of his fellow British
officers in Swaziland, arguing, for example, that the policies followed in the
establishment of the Ncabaneni settlement had naturally led to a situation in which the
“fear of segregation for life is ever-present” for Swazis affected by leprosy. Sowden
was also not overly impressed with the initiative shown by government officers in
supporting his survey work, though he was always careful to tread cautiously around this
subject. For example, in his year end report on the Leprosy Survey for 1947, Sowden
had gone to great lengths to praise Mr. Fanin, the Assistant District Commissioner for the
Mankaiana District. Although given only a few days notice, Mr. Fanin had personally
accompanied Sowden to the kraals of many chiefs in his district, a task that had required
the two of them to walk nearly 60 miles in a week by Sowden’s estimate. Fanin’s
personal engagement was important not just to Sowden but also reportedly to the chiefs
they visited; many of them indicated that Fanin was the first A.D.C. to visit their kraals.
The end result had been perhaps the most successful local survey in terms of cooperation
in Sowden’s entire experience. The positive depiction of Fanin’s engagement and effort
stood as a tacit critique of other officer’s who did not invest the energy and time that
Fanin had.

34 J.C. Callanan to Government Secretary, October 27, 1949, File 100A, SNA.
In light of these failures, Sowden favored a shift in strategy, particularly with regard to the leprosy situation in lowveld areas where incidence appeared to be quite low. Instead of relying upon the survey, with its obvious dependence on local cooperation, as a primary instrument for identifying new cases, the administration now puts its faith in something that offered them a greater sense of certainty and control: an institution grounded in science. The objective would now be to use the anticipated positive testimonies of patients discharged from the new Mbuluzi Leprosy Hospital as inducement to motivate other potential cases to come to Mbuluzi voluntarily.\textsuperscript{37} This view enjoyed the full support of the administration’s Principal Medical Officer, J.C. Callanan who felt that in light of the survey’s manifest failures, “The propaganda results of treatment must be our sheet-anchor in the attempt to eradicate the disease.”\textsuperscript{38} In suggesting this change of strategy, Sowden and Callanan in essence affirmed the position that Sir Walter Johnson had suggested for Swaziland back in 1938 when he argued that a full scale leprosy survey was unlikely to produce satisfactory results and favored instead the concentration of energy on the construction of a new hospital facility for leprosy patients, as the most important step in remedying Swaziland’s leprosy situation.

In laying out this second facet of his strategy for leprosy control, Johnson had focused most of his report on describing the kind of institution he felt Swaziland needed, as well as the costs associated with operating such a facility. At the time, there were essentially two options under consideration. One site was in the Mankaiana District, just

\textsuperscript{37} Sowden, “Leprosy Survey in Hlatikulu District, 11th July 1949 to 13th August, 1949,” File 100A, SNA.

\textsuperscript{38} Callanan to Government Secretary, October 27, 1949, File 100A, SNA.
a few miles from the site of the Ncabaneni settlement, and the other was a site near Bremersdorp, which had been proposed as the site of a joint venture between the missionaries of the Church of the Nazarene and the government. Johnson saw virtues in both proposals, but ultimately favored the government site near Mankaiana. His reasoning was relatively straightforward: the Manakaiana site offered appropriate isolation, located more than a mile off the road between the government station for that district and Piet Retief; it was native land which the Paramount Chief was apparently prepared to yield for this purpose; it offered reasonably suitable ground and water supply for agricultural production; and its supervision could be readily taken over by Mr. Lunnis, the Mankaiana hospital assistant who was already responsible for visits to the patients at Ncabaneni. The only significant drawback of the site, in Johnson’s estimation, was that its isolation was almost too complete. Mankaiana was a tiny administrative station, well off the main roads between Mbabane, Bremersdorp, and Hlatikulu, the economic centers in Swaziland. Johnson anticipated that this would make it difficult to provide the “social service for the patients which is a valuable asset in their treatment.”

The Bremersdorp proposal represented nearly the inverse problem. Johnson felt that the site was too near the growing town, which would make appropriate isolation of the patients difficult, perhaps even impossible. In that same vein, the proposed site already had a number of Swazi kraals located near it, and was on native land in a part of the country where higher population density meant that land was already quite scarce.

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39 Johnson, “Report on the Leprosy Position in Swaziland,” August 3, 1938. Johnson’s report is quoted extensively throughout the following four paragraphs and without further citation, except where I have provided additional commentary.
He also suspected that the geography of the area would require extensive anti-malarial measures, and had additional concerns about schistosomiasis. But, more than any of these issues, the problem that Johnson gave the most emphasis was his concern that allowing a mission to operate the leprosy work would inevitably create more problems than it would solve.

On the one hand, Johnson was quite certain that the Nazarenes intended to use the leprosy work as an opportunity for gaining new converts to their mission. This, he thought, was not a serious problem at the time of the report, when by far the largest portion of the Swazi population was still categorized in the census as “heathen.” However, “as the country becomes more christianised it may become important.” The problem, in other words, was not that the government was trying to discourage links between medical work and mission evangelization, as from their perspective the conversion of increasing numbers of people to Christian faith out of Swazi traditional religious life was nearly inevitable. Rather, the problem came from the government’s need to avoid appearing to favor one mission’s activities over another and their conviction that the Nazarenes would likely use the leprosy work as an opportunity to poach converts from other missions. It was not evangelizing that they wanted to prevent but proselytizing, the word that administration officials consistently used in discussing this particular issue and which implied the idea of taking people from one Christian denomination into another. At a leprosy colony operated by the government, there would

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40 Ibid. Johnson’s report references a 1936 census figure which categorized 68.8% of the population as heathen.
be opportunity for every mission to “make provision for the religious exercises of their particular converts,” while under Nazarene guidance, Johnson doubted “if any other church would be permitted to obtain a footing in the settlement.”

The other problem in cooperation with the Nazarene mission was Johnson’s perception that the moral stringency of the Nazarene missionaries posed a significant challenge to segregation. Tensions already existed in Swaziland at this time between missionaries of many denominations and the Swazi state under Sobhuza II who, three years prior to Johnson’s visit, had re instituted the umcwasho, the national reed-cutting rituals that marked a transition for female Swazis into maturity. Because the ceremony involved costume that missionaries regarded as sexually provocative, they had vocally expressed their opposition to the event, which had compelled Sobhuza to make participation voluntary. But if the missionaries in Swaziland more generally expressed hostility to elements of traditional Swazi culture, the Nazarene mission stood out as being particularly conservative. As explained in chapter one, holiness denominations such as the Church of the Nazarene certainly had high expectations for members, relative to their lifestyle choices. Of particular relevance in this case were the denomination’s instructions for church members to avoid the use of “tobacco in any of its forms” and “intoxicating liquors as a beverage.” On the subject of alcohol, the Manual further declared that, “The Holy Scriptures and human experience alike condemn the use of intoxicating drinks as a beverage... Total abstinence from all intoxicants is the Christian


rule for the individual, and total prohibition of the traffic in intoxicants is the duty of civil
government.”

Knowing how explicit the Nazarene prohibitions were, Johnson was concerned
that the mission would try to extend such strictures to the leprosy institution. Although
he thought that medical staff should discourage the consumption of what he called “kaffir
beer,” the traditional home brew of the Swazis and other neighboring African peoples,
Johnson maintained on the basis of his experience at Botsabelo that, on the whole, its
availability made for greater contentment among the patients, thereby more than
compensating for the troubles that also resulted. The prohibition on tobacco he found
entirely unreasonable, and he feared that such restrictions would pose considerable
obstacles to convincing patients to remain at the new institution for the lengthy period of
time that would often be necessary. As Johnson saw it, Swaziland’s new leprosy colony
should employ a model of voluntary segregation, yet he believed that it would often
require “considerable pressure on the part of the chiefs... to prevail upon patients to go to
the settlement,” and in the case of highly infectious patients, “there must I think be a
clause in the Public Health Regulations which will be required to allow for compulsory
treatment.” In other words, this vision of voluntary segregation was one that carried
significant coercive power behind it, and Johnson feared that this combination of coerced
isolation and mission morality would create a potent discontent among Swaziland’s
leprosy patients. Johnson’s priorities align well with Edmond’s analysis of the Western
fixation with isolation as the chief purpose of a leprosy colony.

43 Ibid, paragraph 35, section 1.
Johnson’s feelings on the problems of sharing the leprosy work with the Nazarene mission were not unique to him, nor even to the Swaziland administration. In many parts of the British Empire, colonial administrators dealt with rivalry and competition between missions. This was particularly acute when Catholic and Protestant missions found themselves in proximity to one another, but even many Protestant missions struggled to cooperate well with other Protestants.\textsuperscript{44} When Swaziland’s Resident Commissioner, C.L. Bruton, wrote to Sir Edward Harding, the British High Commissioner, in 1940, regarding the plans for leprosy work, he echoed Johnson’s sentiments, referring to “a certain amount of antagonism between the various missions,” which he thought might lead to “reluctance on the part of other Missions to send their followers to an institution run by a rival mission.” Bruton hardly felt the need to contain his disdain for this problem: “I appreciate it is incredibly petty but it nevertheless exists.”\textsuperscript{45} Inter-mission rivalry, however, was not the only factor contributing to Bruton’s disdainful attitude towards the Nazarene mission.

Bruton further supported Johnson’s conclusion that the “rigid views” of the Nazarene mission on alcohol and smoking were likely to be a serious impediment to establishing an effective leprosy colony.\textsuperscript{46} From the administration’s perspective, then, it was clear that the first choice would be to go their own way rather than to cooperate with

\textsuperscript{44} For example, see Holger Bernt Hansen’s “The Colonial State’s Policy Towards Foreign Missions in Uganda,” ch. 13 in \textit{Christian Missionaries & the State in the Third World}, ed. Holger Bernt Hanson and Michael Twaddle (Oxford: James Currey, 2002).

\textsuperscript{45} C.L. Bruton to Sir Edward Harding, October 23, 1940, File RCS 577/38, SNA.

\textsuperscript{46} Ibid.
the Church of the Nazarene. This reality runs somewhat in tension with the dynamics described by other scholars regarding leprosy care in other African contexts. Megan Vaughan describes leprosy as the “one medical problem of Africa” that remained a “missionary ‘baby’” late into the twentieth century, and Kathleen Vongsathorn has described leprosy as a natural point of cooperation between the Uganda colonial administration and both Protestant and Catholic missionaries because of the ways in which leprosy work made possible “enacting the ‘civilising mission.’”\footnote{Vaughan, \textit{Curing their Ills}, 75. Kathleen Vongsathorn, “‘First and foremost the evangelist’? Mission and government priorities for the treatment of leprosy in Uganda, 1927-48,” \textit{Journal of Eastern African Studies} 6, no. 3 (August 2012): 550.} The contrast between the Swaziland and Uganda situation appears to be primarily a consequence of the fact that the Nazarenes were by and large an American mission with evangelical and holiness leanings, while in Uganda, the administration was dealing chiefly with Anglican missionaries from the Church Missionary Society. British colonial administrations may well have been open to sharing responsibility for leprosy care with missionaries, but this was apparently not quite as automatic a partnership as some scholars have assumed; it took a certain convergence of shared values, financial pressures, and personnel to bring these sorts of partnerships into existence.

In the end, of course, the Swaziland administration and the Nazarene mission did join hands in a cooperative leprosy venture at Mbuluzi, but the sequence of events that brought this about was hardly straightforward, taking a full decade to play out in its entirety. Understanding the process of negotiation that created the eventual partnership provides some interesting insights into the limits of mission-government cooperation and
the seemingly slight but very real differences in their approaches. From the mission perspective, the ultimate goal was connected to the spiritual resonance of leprosy work, a theme that will be explored more carefully in chapter four, but the limitations were related to financial resources and the necessity of receiving government approval from both the British and the Swazi administrations. From the perspective of the British administration, the goal was to build a modern colony that could maintain a level of isolation in keeping with their vision of controlling leprosy as a public health concern, but they likewise were limited, especially by the financial exigencies created by the onset of World War II. These realities dictated the ebb and flow of negotiations towards mission/government partnership.

The tensions inherent in the government position were visible in the very same 1940 letter in which Bruton had informed Harding of the reasons why he thought that joining hands with the Nazarene mission was problematic. For all his misgivings, he also had to concede that Hynd’s offer to operate a leprosy settlement merited consideration given that “Government funds are not available.”

Harding readily agreed to Bruton’s suggestion, underlining the point that no additional money would be forthcoming from U.K. sources for some considerable period of time, but laying down the stipulation that the mission must agree not to proselytize among the patients and allow ministers of other denominations access to the members of their congregations.

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48 Bruton to Harding, October 23, 1940, File RCS 577/38, SNA.

49 Sir Edward Harding to C.L. Bruton, November 6, 1940, File RCS 577/38, SNA.
administration hoped to achieve the objective of opening an institution for leprosy treatment without stirring up what they saw as unnecessary trouble for themselves.\textsuperscript{50}

Fortunately for the government, in the intervening period between Johnson’s 1938 report and this 1940 decision to revisit the idea of a partnership with the Nazarenes, the administration had been careful not to share any more information than was absolutely necessary with Hynd, who had maintained a keen interest in knowing the government’s plans with regard to leprosy but who knew nothing specific about their concerns regarding a possible partnership with the Nazarene mission. As explained in the two previous chapters, Dr. Hynd had been working diligently for more than a decade to position the Nazarene mission as a natural partner with the government of Swaziland in leprosy work, an effort bolstered in 1935 by the arrival of Elizabeth Cole. One of the chief reasons why Sir Walter Johnson had been invited to Swaziland, in fact, was that Hynd had initiated a conversation about leprosy with Dr. Drew, Swaziland’s principal medical officer, in early May of 1938. Still in his first year as the principal medical officer, Drew knew only that conditions at Ncabaneni had become “deplorable,” and

\textsuperscript{50} The British had been known to express disapproval of missions proselytizing members of other mission churches. See, for example, James Campbell, “African American Missionaries & the Colonial State: The AME Church in South Africa,” in \textit{Christian Missionaries & the State in the Third World}, ed. Hansen and Twaddle, 231. For an example from an earlier time period, see Desmond K. Clinton, \textit{The South African Melting Pot: A Vindication of Missionary Policy, 1799-1836} (London: Longmans, Green and Co., 1937), 65. Clinton’s work, as its title suggests, is chiefly a defense of the activities of the London Missionary Society during the early years of British rule in the Cape Colony; however, he makes a brief reference to a government policy that forbid missionaries from working within three miles of any established church, a policy clearly aimed at the same sorts of ends as the concerns of administrators in Swaziland some 140 years later.
preferred to draw in outside expertise before committing to any additional course of action, which ultimately brought about Johnson’s visit in July of that same year.\(^{51}\)

Even as the government drew in Johnson’s expertise and planned its course of action, Hynd had not been passively waiting for their decision, though his interaction with government officers about the leprosy work had lulled considerably since the failure of his 1930 proposal, described in chapter 1. Hynd seems, however, to have perceived that the late 1930s were the right time to revive his initiative regarding leprosy work. The retirement of Jamison, the “failure” of the Ncabaneni settlement, and the addition of Elizabeth Cole to his nursing staff created a conjunction of events in which Hynd saw new opportunity. So even before he reached out to Drew, Hynd was reaching out to his network of supporters hoping to find the resources to make the mission’s leprosy work a reality.

His first approach, in November of 1937, was to the Mission to Lepers, with whom he had initiated communication during his furlough of 1931-32. Soliciting help from a Christian organization, Hynd emphasized the fact that Ncabaneni provided nothing from “the religious point of view” and appealed for their assistance in covering many of the startup costs, which he estimated at £400 chiefly for buildings, and the salaries of a native evangelist (£60/annum) and a nurse matron (£120/annum).\(^{52}\) Hynd’s request was a substantial, but not unreachable one, for the Mission to Lepers. The

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\(^{51}\) For more on this sequence of events, see the correspondence between April and July of 1938 in File RCS 839/36 at the Swaziland National Archives. Drew’s description of conditions at Ncabaneni as “deplorable” came in a letter to the Government Secretary, April 27, 1938, contained in this same file.

\(^{52}\) David Hynd to W.H.P. Anderson, 28 November 1937, David Hynd Collection, Nazarene Archives, Lenexa, Kansas.
proposed salary for the native evangelist, for example, would have represented a wage on the upper end of the pay scale for ordinary Swazis. By comparison, a Swazi miner in 1940 received no more than about £12/annum, though they could also expect to have food and housing provided during their periods of employment. Closer in value, a driver in the Public Works Department would receive approximately £48/annum with quarters but no food provided. The wages for the nurse matron, on the other hand, were modest compared to rates for people in comparable positions; in the late 1940s, a European nurse working at one of Swaziland’s mines received £360/annum. With this support in hand, Hynd believed that he could persuade the government medical department to provide the funding necessary for general maintenance of the settlement.

The initial response of the Mission to Lepers was receptive, but after their Executive Committee reviewed the proposal in early 1938, they decided not to support the Swaziland work, primarily because they saw signs of possible government reluctance in cooperating with a missionary society. This, they thought, might leave both the Nazarene mission and their own organization with too great a responsibility in terms of both financial contributions and personnel. They advised Hynd that they would have preferred to see a situation in which the government was approaching Hynd about the partnership, rather than the other way around. Word of this rejection would have

53 Simelane, *Colonialism and Economic Change in Swaziland*, 150.


55 W.H.P. Anderson to David Hynd, 25 January, 1938; Hynd to Anderson, 10 February, 1938; Anderson to Hynd, 23 May, 1938, David Hynd Collection, NA.
undoubtedly been discouraging for Hynd, but, in a coincidence that would surely not have escaped the notice of the missionaries, on the very same day on which the General Secretary of the Mission to Lepers wrote to Hynd, May 23, 1938, another source of support materialized. Hiram Haskin, a long time friend of Elizabeth Cole from Montana, wrote to Emma Word, the General Treasurer for the Church of the Nazarene, enclosing with his letter a gift of $500 intended to support the construction of buildings for a leprosy colony. Haskin’s gift was further supplemented by his designation of an additional $2200 from his life insurance policy to be paid out upon his death. Haskin’s letter indicated that his gift, given in memory of his late wife who had been “keenly interested in (Cole’s) chosen work among the lepers,” had already been discussed with Cole and Hynd, and the knowledge of Haskin’s support had surely played some part in encouraging Hynd to reach out to Drew earlier in the month.56

Haskin’s support bolstered Hynd’s initiatives, but $500 U.S. was only £100, which brought the resources of the Nazarenes to about £200 on hold for leprosy work, only about half of the amount that Hynd had hoped to receive from the Mission to Lepers for buildings alone. So while Hynd and his fellow missionaries may have been masters of stretching financial resources to the utmost, he knew that he needed to use this gift to leverage his position with the Swaziland administration. To this end, he wrote to Drew on June 16, 1938, offering a detailed proposal for the Bremersdorp site and requesting a commitment from the government of £500 in capital expenditures for building

56 Hiram Haskin to Emma Word, May 23, 1938, David Hynd Collection, NA.
construction and an additional £500 per annum towards maintenance.\textsuperscript{57} This proposal would have constituted a significant savings for the administration; Johnson’s proposal following his visit the next month called for expenditures that at least doubled each of Hynd’s estimates. But by the time Drew received this proposal, he had already settled on a visit from Johnson as the next step in his decision-making process, and so made no formal reply to Hynd’s offer.

The outcome of the report was, of course, not at all favorable to Hynd’s proposal, despite the potential financial savings, for all the reasons outlined above. Nevertheless, neither Drew nor anyone else communicated anything about the results of the report to Hynd, which left him to initiate communication with the administration once again. Hynd first reached out to Drew and was told that Johnson’s report had been forwarded to the offices of the High Commissioner and that he would have to request details of the report from them. Hynd wrote to the High Commissioner’s Office in November requesting “the privilege of seeing a copy of the report as we have many mission friends who are interested in doing something to alleviate the condition of the lepers in Swaziland...” Hynd went on to indicate that he understood from Drew that Johnson had some reservations about the Bremersdorp site and went on to state, “If that were the only objection I am sure another site could be found.”\textsuperscript{58}

The reply to Hynd demonstrates clearly just how much the government wanted to avoid alienating Hynd. H.E. Priestman, the High Commissioner’s Administrative

\textsuperscript{57} David Hynd to Principal Medical Officer, 16 June, 1938, David Hynd Collection, NA.

\textsuperscript{58} David Hynd to High Commissioner William Clark, November 29, 1938, File RCS 577/38, SNA.
Secretary, explained to Hynd that Johnson’s report was classified as a confidential government document, but that he had been authorized to share the main objections Johnson expressed to the Bremersdorp proposal. These, according to Priestman, were chiefly related to the concerns about malaria and schistosomiasis, the proximity to Bremersdorp, and the presence of Swazi homesteads around the site.\textsuperscript{59} The letter omits entirely any hint of Johnson’s more thoroughly elaborated concerns about the moral strictures of the Nazarene mission regarding tobacco and alcohol or the fear that missionary control would further the unseemly scramble among Swaziland’s Christian missions for converts, something that many administration figures seemed to accept as a near inevitability. It must surely have struck Hynd as incongruous that the one issue on which he had preemptively expressed flexibility, the question of location, was the only objection seriously raised in Priestman’s response, yet there was no opening for further discussions at this time. The government clearly intended to go its own way.

Though it had gone completely unmentioned in the correspondence to this point, all of this activity had been carried out in the shadow of growing Nazi power in Germany and looming fears of another major war for Great Britain. Johnson’s visit to Swaziland came just four months after Hitler’s \textit{Anschluss}, which united Germany with Austria, and just three months prior to the Munich Conference negotiations, which handed over Czechoslovakia’s Sudetenland to the Nazis. The looming uncertainties about the intentions of the German state undoubtedly figured somewhere in the calculations of the

\textsuperscript{59} H.E. Priestman to David Hynd, 10 December, 1938, David Hynd Collection, NA. The letter can also be found in File RCS 577/38, SNA.
Secretary of State’s Office when, in January of 1939, they indicated to the High Commission government that, although they supported Johnson’s proposed Swaziland leprosy project in principle, they would need to see corresponding fiscal cuts in other areas since the proposed expenditures had not appeared in the initial estimates for 1939-40.\textsuperscript{60} Freeing up additional money was simply not in the equation. Furthermore, when Drew wrote to his Government Secretary in Swaziland indicating that he could not justify the kinds of cuts that would consequently be necessary to make the leprosy settlement a reality during the current fiscal year and acknowledging that it would, therefore, be necessary to delay action one more year, he coincidentally did so on the very same day in which Nazi forces completed the occupation of Czechoslovakia by seizing Prague.\textsuperscript{61} And when David Hynd wrote to Hiram Haskin to inform him that the Swaziland government had “not come to any definite decision yet about (a cooperative leprosy work),” it was six days after the Molotov-Ribbentrop Non-Aggression Pact between the Soviet Union and Germany, which opened the door to the invasion of Poland just three days after Hynd wrote.\textsuperscript{62}

The fear of war may not have directly entered into the correspondence of missionaries and government officials regarding the foundation of a leprosy work, but once it came, everyone recognized its decisive effect. Drew’s plan to ask for additional money in the 1940-41 estimates never came about, as British resources were directed to

\begin{itemize}
\item \textsuperscript{60} Malcolm MacDonald to High Commissioner, January 25, 1939, File RCS 577/38, SNA.
\item \textsuperscript{61} D. Drew to Government Secretary, March 16, 1939, File RCS 577/38, SNA.
\item \textsuperscript{62} David Hynd to Hiram Haskin, August 29, 1939, David Hynd Collection, NA.
\end{itemize}
the war effort. For Hynd’s part, he recognized that the redirection of material resources to the war effort had reopened the opportunity for the Nazarene mission. As he wrote to Hiram Haskin in February of 1940, “The Government has no more money to allocate than what they have been allocating, and with Britain at war there is not likely to be more money that they could spend on developing their present place, so that they should be more sympathetic to my proposal.” And, as mentioned earlier, Hynd’s calculations were precisely right. His June 24 letter to the Principal Medical Officer revisiting his earlier proposals and once again reaffirming the Nazarenes’ flexibility with regard to location was ultimately the impetus for the exchange of letters between Resident Commissioner Bruton and High Commissioner Harding in which they agreed that, subject to their specific conditions, a partnership with the Nazarene mission was the best approach for dealing with Swaziland’s leprosy situation.

As a consequence of this exchange, Drew wrote to Hynd on November 27, 1940 requesting the specific terms under which the Nazarenes “would be prepared to take charge of the leper patients of the Territory,” especially the 52 cases housed at Ncabaneni at the time of Drew’s writing. In turn, Hynd responded with a burst of letter writing.

63 D. Drew, Annual Medical & Sanitary Report, 1939, File RCS 31/40, SNA. In his note that accompanied the copy of Drew’s report forwarded to the High Commissioner’s Office, Swaziland’s Government Secretary, J.R. Armstrong, affirmed Drew’s regrets that plans for a new leprosy institution had to be abandoned due to the war, noting that opening such an institution was “the most urgent medical need in the Territory” but accepting at the same time that “funds for this purpose cannot be forthcoming during the war.” See J.R. Armstrong to the Administrative Secretary of the High Commissioner, September 19, 1940, File RCS 31/40.

64 David Hynd to Hiram Haskin, 26 February, 1940, David Hynd Collection, NA.

65 D. Drew to David Hynd, 27 November, 1940, File RCS 577/38, SNA. A copy of the same letter can also be found in the David Hynd Collection at the Nazarene Archives.
week later on December 5, attempting to seize the opportunity that now presented itself. In his response to Dr. Drew, Hynd readily accepted the conditions of the government: the Nazarenes would not proselytize among the patients, nor would they deny clergy of other denominations access to their own converts. He also agreed to abandon his original proposed site near Bremersdorp and submit alternative proposals for Drew’s approval just as soon as possible.66 Interestingly, there was no mention in any of this communication about the government’s concerns regarding the moral stringency of the Nazarene mission and the possible negative effects that this might have on the willingness of patients to stay at a leprosy institution. The government’s concerns in this regard certainly did not go away; reference to these issues continued to crop up in internal correspondence and personal conversations in the years leading up to Mbuluzi’s opening in 1948.67 However, the government never openly pressed this issue in its correspondence with the Nazarene mission, a sign of the particularly pragmatic spirit that prevailed on this issue.

Hynd’s other letters on that day were focused on the core issues he now needed to address: raising adequate money for the startup costs and finding an alternative piece of land. For money, Hynd wrote to two supporters, Hiram Haskin back in Montana and a

66 David Hynd to the Principal Medical Officer, 5 December, 1940, File RCS 577/38.

67 Examples of this can be found in a hand-written note David Hynd wrote for himself, following a meeting in December, 1942 with Drew and the the Resident Commissioner, H.K. Featherstone, in which Hynd had disagreed with Featherstone’s assertion that the prohibition of beer in a voluntary settlement might well keep people from coming for treatment. Hynd argued that a “well-run institution could provide counter attractions & beer would add tremendous problems...” Five years later, in a personal and off-the-record letter from A.J. Sowden to Hynd (May 18, 1947) regarding the objections of the government to Nazarene involvement at Mbuluzi, Sowden explained that the administration had “some weird ideas about such things as the ration of tobacco; snuff and beer - that (a missionary nursing sister) would be spending her time attempting to convert the lepers to total abstinence and so on...” Both items can be found in the David Hynd Collection at the Nazarene Archives.
Dr. Stauffacher, whom he knew as the representative of the American Mission to Lepers in South Africa. For land, he turned to his missionary colleagues in the South Africa General Mission (SAGM) whom he felt to be interested in leprosy work but also non-competitors in this area, as they had no medical mission in Swaziland. Hynd knew that the SAGM had just recently completed a new church building at a large mission station called Bethany, located about 8 miles west of Bremersdorp and not far from the main road running from there to Mbabane. Would the mission, Hynd wondered, consider donating the 500+ acres of land surrounding the old church building as a contribution to the development of leprosy work in Swaziland?

The request was a bold one, but the SAGM responded sympathetically, though it took some time for them to clear the decision through the church hierarchy. In fact, they seemed happy to cooperate. The official reply, dated June 27, 1941, indicated that “the disposal of so much of the Bethany property in this way has given very real pleasure throughout the Mission. We are glad that this property now that it is longer (sic) required by our Mission, is to be put to such blessed service and ministry.”

The only conditions

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68 Founded in 1889 by famed South African minister Andrew Murray and two of his associates, the South Africa General Mission (later, the Africa Evangelical Fellowship and now today, part of SIM) was probably the mission with which the Church of the Nazarene cooperated most closely in Swaziland, as the two constituted the primary representation of evangelical Protestantism in the country. When the leprosy hospital opened in 1948, SAGM was already operating a school for girls less than a mile from the hospital grounds. Missionaries and students from that school, which is today Mbuluzi High School, featured prominently in the archival records of the hospital’s opening and, in subsequent years, continued to feature regularly in the life of the hospital community.

69 David Hynd to E. Boyce, 5 December, 1940, David Hynd Collection, NA. Hynd’s letters to Haskin and Stauffacher, written on the same date, are held in this same collection.

70 E. Boyce to David Hynd, 27 June, 1941, David Hynd Collection, NA.
attached to the grant of the land were that SAGM representatives would have the 
opportunity to visit the leprosy patients at the new institution, that any transfer and 
surveying fees would be the responsibility of the Nazarene Mission, and that, should the 
land ever cease to be a leprosy colony, the SAGM Executive wished to be consulted 
about its future use.

Thus, June of 1941 was probably the moment when Hynd, Cole, and the Nazarene 
mission came closest to establishing a leprosy institution on more or less their own terms, 
and the tenor of Hynd’s correspondence from the period suggests his excitement and 
confidence in the emerging possibilities. But questions of land were always tricky at best 
in Swaziland, and the momentum swung quickly in another direction. Sometime in late 
July or early August, Hynd met the Resident Commissioner, the Principal Medical 
Officer, a representative of Sobhuza II, and the European settler whose farm was closest 
to the Bethany Mission on the site of the proposed new leprosy hospital to discuss the 
proposal. At the meeting, the farmer and the representative of Sobhuza, whose royal 
kraal at Lobamba was nearby, both raised concerns about the use of the site. Hynd 
initially felt that these concerns had been adequately addressed during the meeting, but by 
the middle of September, he had received word from Drew that the High Commissioner 
had vetoed the use of the Bethany site, primarily in response to these concerns.71

Hynd refused to accept defeat and continued to correspond with Drew and others 
in hopes of finding an alternative solution, but he had clearly lost the initiative. The 

71 David Hynd to Hiram Haskin, 7 August, 1941; David Hynd to D. Drew, 15 September, 1941, David 
Hynd Collection, NA. David Hynd to Elizabeth Cole, 18 May, 1942, File 1366-6, Hynd Letters to 
Missionaries, 1936-42, A-F, NA.
The Nazarene situation was further complicated by Cole’s abrupt departure in early 1942 on furlough, a decision expedited by the news that her father was dying. In the end, it would be more than two years before Cole returned to Swaziland, as war conditions greatly complicated the process of booking her return passage to South Africa. The war also hindered the Church’s efforts to send additional missionaries to Swaziland, and Hynd found himself carrying an increasingly heavy load as the sole physician available for the growing medical work at Bremersdorp. In the absence of Nazarene initiative and with the initial shock of the war now behind them, the administration had begun exploring other options for leprosy care in Swaziland.

If the crisis of the war during the years 1940-41 had inclined the British administration to pass the baton for leprosy care to a third party, the slow reversal of the tide of the war in 1942, after the stalling of Germany’s invasion of the Soviet Union and the Allied victories at El Alamein, saw a corresponding increase in the assertiveness of the British administration in Swaziland with regard to leprosy. For his part, Dr. Drew had become fed up with his inability to control the lives and actions of the patients living at Ncabaneni. Whereas his report written in 1940 in the midst of the war crisis had expressed regret over the loss of the scheme for a new leprosy institution due to war time economies, his report submitted early in 1943 deplored the situation at Ncabaneni and the government’s lack of an alternative:

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72 The correspondence contained in File 1366-6, Hynd Letters to Missionaries, 1936-1942, A-F and other related files from this period held at the Nazarene Archives provide substantiating details regarding conditions in Swaziland during the war and the strains created by staff shortages in particular.
There were 50 lepers in the leper settlement at the beginning of the year, 13 were admitted during the year, none were released, but 8 escaped and there were 4 deaths; one was transferred to an institution in the Union, leaving 50 inmates at the end of the year. As yet there has been no improvement in the conditions under which the lepers are confined, and no decision has been communicated to the Medical Department as to a new and less primitive (sic) institution for accommodating them. It is not at all surprising that so many run away, when one takes into consideration the conditions under which they live at present.  

Not everyone in the administration agreed that the situation was quite as bad as Drew depicted in his report. One reader commented critically in response that the report gave “the impression that conditions which obtain at present are so bad as to be intolerable,” to which another responded emphatically, “They (conditions) are intolerable.” However badly the representatives of the administration felt about the conditions under which the people at Ncabaneni lived, they were not prepared to lose control of their movements, particularly when it came to those who opted to run away. In late 1942 and early 1943, the government drafted a proclamation in accordance with Transvaal Ordinance no. 23 of 1904 to have Ncabaneni declared an asylum. As explained in chapter one, this ordinance granted the government wide ranging powers of compulsion and meant that the people living at Ncabaneni would be in the legal custody of the state. This increased assertiveness was likely the cause of a noticeable spike in

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74 Authors unknown, internal memos, April 28, 1943, File 333, SNA. Internal memos often lacked clear markers of authorship, but the likely author of the first comment was Government Secretary H.B.A. McCarter, and the likely author of the second was Resident Commissioner E.K. Featherstone.

75 The relevant correspondence on this matter occurred between 24 December, 1942 and 11 January, 1943 and can be found in File 100, “Leper Settlement General,” SNA.
the population of people living at Ncabaneni, such that one year after Drew’s report, their numbers had reached 63.\textsuperscript{76}

Though regarded as necessary under the circumstances, compulsion made for wearying work and contributed greatly to resentment among those who experienced it. So even as these steps were taken, the Swaziland administration had submitted an application for funds made available through the Colonial Development and Welfare Act. As Acting High Commissioner Walter Huggard noted in his cover letter accompanying Drew’s medical report for 1942, the hope was that this would allow them to create an institution “more in accord with modern ideas,” in order to attract cases voluntarily and “do away with the necessity for compulsory measures to secure the return to the settlement of lepers who have run away from it.”\textsuperscript{77} Control was the ultimate objective in this vision of leprosy care, and the administration recognized that control did not necessarily pair well with compulsion. It was the success of that application for funds that made possible both the Leprosy Survey discussed earlier and the final selection of Mbuluzi as the site where a leprosy settlement would be established and their final concerted effort to enact their vision of control over Swaziland’s leprosy sufferers.

In February, 1944, Sir Walter Johnson returned to Swaziland for a three week tour of the territory in his new capacity as Director of Medical Services for the High Commission Territories. Although his new job title required him to deal with a number

\textsuperscript{76} Walter Johnson, “Report on the Visit of the Director of Medical Services for the High Commission Territories to Swaziland, 3rd-26th February, 1944,” File 674, SNA.

\textsuperscript{77} Walter Huggard to Clement R. Attlee, Secretary of State for Dominion Affairs, 4 August, 1943, File 333, SNA.
of issues regarding the development of Swaziland’s medical services, the chief priority was the final resolution of the settlement site question. In the almost six years since his previous visit, all of the previously considered sites had been rejected for various reasons: the Nazarene site at Bremersdorp primarily because of its proximity to the growing urban center and the SAGM mission at Bethany because of the objections of neighbors. Even the site favored by the government near Mankaiana had by the time Johnson returned to Swaziland “been turned down on account of the heat and a superstitious reluctance against this area by the Swazis.” What exactly Johnson believed that superstition to be and how it compared in importance to the heat factor are, unfortunately, impossible to say. My research and personal inquiries have turned up absolutely nothing to substantiate the idea that there was any sort of significant belief about the area that might help provide some sort of context for the meaning of this statement. In fact, it is not at all certain that Johnson even understood personally what the superstition was; Johnson had a fairly reliable habit of using passive voice, such as he employed in his statement above, when talking about decisions that originated with other people. However, the fact that he either did not bother to inquire as to the substance of the claim or did not see any reason to include further comment in a report meant for government eyes only is a relatively good indicator of the extent to which the absence of Swazi voices typified the whole process of selecting a site for the leprosy hospital.

With the decision to abandon the previously identified possibilities, two new sites had more recently come under consideration. One of them Johnson rejected because it

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78 Johnson, “Report on the Visit of the Director of Medical Services, 1944,” File 674, SNA.
was land already under use by the Agricultural Department for raising stock and because it lay in a malaria zone. But the other site, along the course of the Black Mbuluzi River, both Johnson and Drew strongly favored. The site was a piece of government owned land that lay about 10 miles northeast of Mbabane, which would make it relatively easy for the government medical officer to provide supervision. Like Mbabane itself, the Mbuluzi property was located in Swaziland’s highveld region, with an elevation well over 3000 feet above sea level, which meant cooler temperatures and freedom from concerns about malaria. Furthermore, its proximity to the Black Mbuluzi meant that there was a steady water supply that could be tapped by means of gravitation, and Johnson hoped it would be enough to also generate electricity for the site.

The objections were relatively few. The site had relatively hilly terrain and rocky soils which meant that it was hardly an ideal environment for agriculture, but Johnson downplayed the idea that the colony should attempt to be self-sustaining. What mattered was that the patients be kept occupied with work, not whether or not that work was ultimately very productive. Besides, he argued, with the proposed 600 acres of fenced land for the settlement, there would be ample room for raising stock for both milk and meat. A second concern was that opening up the site would require a considerable amount of both labor and capital, including the grading of at least two additional miles of road that did not exist at the time of his report. Thirdly, the land was not uninhabited, with an estimated twenty families on the site, but because it was government-owned, these people were regarded as squatters and their removal would be far less complicated than it would have been on land that was in Swazi hands, which would have meant securing the
approval of Sobhuza, whose voice had been noticeably absent from discussions about the
site for Swaziland’s proposed new leprosy hospital.

Sobhuza’s absence from the conversation was telling and almost certainly not
coincidental; in fact, relations between Sobhuza and the British administration under
Resident Commissioner Featherstone and his predecessor Bruton had been notably tense
since the years just prior to the start of World War II. The problems ran the gamut of
issues that had regularly plagued British relations with Swazi leadership; the question of
uniting Swaziland with the Union of South Africa had resurfaced at the outbreak of the
war, for example. Sobhuza and the administration, furthermore, were nearing the
conclusion of a prolonged and heated debate over the Native Authority Proclamation,
which Sobhuza felt infringed upon his traditional powers, particularly his right to appoint
and dismiss chiefs. And, of most immediate relevance to the Mbuluzi situation, there was
continued controversy over land. At the very time of Johnson’s report, Sobhuza was
disputing the implementation of a series of Native Land Settlement Schemes, which the
British meant to address the Swazi demand for the return of land but which often did so
in ways that favored private land ownership over the notion of all land belonging to the
Ngwenyama. By 1946, Sobhuza had initiated his own land purchasing arrangements
by means of the Lifa Fund, which required cattle owners to contribute ten percent of their
cattle for purchasing land in the name of the monarchy. In light of these swirling
controversies, the administration was undoubtedly happy to avoid asking for Sobhuza’s

79 For more on each of these points of tension, see Kuper, Sobhuza II, especially chapters 9-11.
80 Leroy Vail and Landeg White, Power and the Praise Poem: Southern African Voices in History
(Chattanooga: University Press of Virginia, 1991), 177.
input on virtually any decision, much less asking him to provide significant support for an institution that would displace more of his people.

Johnson’s report may have marked the high water mark in British optimism about what could be done for leprosy in Swaziland. Flush with the cash infusion of CD&W money, the administration was spending on development projects in unprecedented ways. In the context of these modernizing visions, the administration sketched out a somewhat grandiose scheme for what they could accomplish at Mbuluzi. In short, the government’s expectation, as articulated by Sowden and Callanan, was that the attractiveness of Mbuluzi, derived from both its facilities and its medical effectiveness, would allow them to achieve their vision of controlling leprosy by means of isolation without resorting to compulsion. Swazis, in other words, would be anxious to embrace the isolation of Mbuluzi once they heard from others about its advantages. Furthermore, it would allow them to repatriate several Swazi leprosy cases who had entered the Westfort facility in the interim since Madolwane Maziya and her associates had been repatriated in 1934, which would alleviate pressure that the administration felt from South African authorities. 81

Lastly and most grandiosely, it seems evident that many within the government felt that Mbuluzi would allow them to eradicate leprosy swiftly. While the public pronouncements made by Swaziland administration officials in this regard could be easily dismissed as a calculated public relations campaign, the internal correspondence of the

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administration through the first few years of Mbuluzi’s existence shows that they genuinely expected the fulfillment of their optimistic public pronouncements.\textsuperscript{82}

The man who best encapsulated the optimism of 1944 was A.J. Sowden who settled in Swaziland late in that year ready to take on the challenges of leprosy care. Within months of arrival, Sowden published an account in the \textit{BELRA Quarterly Magazine} exclaiming the virtues of Swaziland’s planned settlement, which he hoped would be “one of the finest equipped leper settlements in the whole of Africa.”\textsuperscript{83} The account emphasized the beauty of the location and the amenities to be provided to the settlement’s inhabitants: electric lighting, a school playroom for non-infected children, a herd of dairy cows, a work shed for artisan craftwork, and various recreational facilities, “including a bioscope.”

Less visible in Sowden’s description of the virtues of Mbuluzi were the realities that he touched upon only briefly in noting the arrangement of the residences for patients. Mbuluzi’s relative expansiveness made it possible to segregate people in ways that had long been impossible at Ncabaneni. The Mbuluzi settlement was laid out over nearly 1000 acres of ground located on two neighboring mountainsides. From the Mbuluzi River, which formed much of the property’s northern and eastern boundary line, the elevation rose steeply some 400 feet to the top of the first peak, which was the site of the

\textsuperscript{82} By comparison to the pronouncements of some government officials, A.J. Sowden’s prediction referenced earlier about eradicating leprosy in 50 years was quite modest. In 1947, for example, at a meeting of the Swaziland Development Committee, both the Government Secretary and the Director of Medical Services argued that it might not take more than 15 to 20 years to rid Swaziland of leprosy.

\textsuperscript{83} A.J. Sowden, \textit{BELRA Quarterly Magazine} (January 1945): 6. Irene Allen, the journals manager and assistant editor for LEPRO (the renamed successor to BELRA) provided me with this excerpt as part of a larger volume she has been compiling from the BELRA Archives entitled \textit{BELRA Overseas Workers}. 176
hospital, the kitchens, the agricultural buildings, and the housing for uninfected children and staff. To reach the residential area for leprosy patients, one had to first descend towards and cross a small stream that flowed between the two mountains and then begin another ascent towards the concrete block structures that housed the patients.

The structures themselves made possible further subdivisions among Mbuluzi’s residents. At the top of the hill were two small units devoted to housing married leprosy patients; below them housing for the rest of the patients had been arranged in four separate divisions, laid out in a roughly square configuration across the mountainside, each with four buildings and able to house approximately 32 patients. The two sets of structures on the eastern side were reserved for women, while those on the western side housed the men, accomplishing one of the chief goals of the administration by segregating the sexes. But the creation of two areas for men and two for women also made it possible to envision further segregation by degree of infectiousness, with patients regarded as highly infectious removed from the rest of the population. The distances involved in the layout of Mbuluzi’s buildings were not overwhelming; an adult walking at a steady pace could cover the ground between any two buildings on the property in 30 minutes or less. Yet the symbolic gaps between them and the clear geographical markers that defined the settlement communicated a clear message of division, whether along lines of race, sex, or disease, and the necessary isolation of these groups from one another. The habit of many Europeans who worked at Mbuluzi of referring to each of
the individual divisions as a “village” or “kraal” only reinforced the idea that categories of difference mattered a great deal in this environment.\textsuperscript{84}

Although the groundwork appeared to have been laid to achieve the administration’s vision of control without compulsion, the optimism of 1944 was relatively short lived. Problems appeared almost immediately upon commencement of road construction in early 1945. The sloping and rocky terrain made for difficult labor, while rainy season conditions further slowed the progress of work and often made the road out of Mbabane to the construction site impassable for larger vehicles carrying necessary supplies. In addition, labor itself was in short supply for two reasons. First, the rainy season was the period when Swazis focused their most intensive labor on their own gardens and thus would be less likely to be seeking wage employment.\textsuperscript{85} Secondly, Swaziland’s economy was experiencing a relative boom period, based especially on the expansion of its timber industry, sugar plantations, and other sectors that attracted direct foreign investment.\textsuperscript{86} It was also during this early period that Sowden abruptly departed on home leave upon receiving news of the illness of his mother.

\textsuperscript{84} In addition to Sowden’s previously mentioned report in the \textit{BELRA Quarterly Magazine}, much of the information here about the configuration of the Mbuluzi site is derived from various correspondence found in File 100, “Leper Settlement General,” SNA.


By March of 1946, a few months prior to Sowden’s commencement of the ill-fated Leprosy Survey, construction was underway on the buildings at Mbuluzi, but the pace of the work did not significantly improve. The chief obstacle was the one that had perpetually plagued previous schemes for leprosy control in Swaziland: finances. Dr. Drew, in his final days as the administration’s medical officer, recently retitled the Deputy Director of Medical Services, wrote to the government secretary explaining that “the frequent revisions of plans necessitated by the fluctuating financial fortunes of the scheme” had undoubtedly caused “a good deal of confusion,” which was causing a number of issues in the construction, such as the failure to construct a garage for the superintendent’s house or the start of a home for a Swazi staffer for which there was no apparent use under the current scheme.87 Just over two weeks later, Drew’s replacement, J.C. Callanan, visited the Mbuluzi site in order to get himself up to speed on the state of this major undertaking that he inherited with his new position.88

Within months, Callanan was exchanging snippy correspondence with E.R. Roberts, the Director of Public Works, about Mbuluzi. Callanan clearly felt the need to advocate for a clear minimum standard that would not compromise patient health and that the decisions being made regarding construction standards were “likely to result in high maintenance costs, for which there is no financial provision.”89 Roberts, for his part, wanted to support Callanan’s expectations but clearly felt trapped by the conflicting

87 D. Drew to the Government Secretary, 4 March, 1946, File 100, SNA.
88 J.C. Callanan to the Government Secretary, 20 March, 1946, File 100, SNA.
89 J.C. Callanan to the Government Secretary, 16 July, 1946, File 100, SNA.
pressures that resulted from the urgency of completing the project, the necessity of building to a reasonably high standard, and the reality of financial limitations.

In the midst of these concerns over finances, a decision was made to bring a select group of leprosy patients up from the Ncabaneni settlement to work under the supervision of Sowden at some of the essential tasks of preparing the grounds, such as the planting of trees. Roberts had some concerns about the idea of his labor crew intermingling with leprosy patients, but he indicated that “Enquiries give no evidence ... that strong objection will be made by the building gang...”90 The plan, however, backfired before it could even be implemented. On August 31, 1946, the foreman in charge of the work at Mbuluzi wrote to Roberts to inform him that:

All white labour refuses. All unskilled labour refuses and there is no possible chance to persuade them as they will walk out as one man. I have tried to tell them that they will be kept clear of the Lepers, but they still reckon that everyone of them will get the disease (sic). I prefer the (Medical Officer) and yourself to come out and hear for yourselves.91

As the only extant letter on this incident, there is no choice except to reason out what may have happened in this relatively unique incident.92 On the one hand, one might well anticipate the reaction of the European workers; we have seen that there was clear

90 E.R. Roberts to the Government Secretary, 12 July, 1946, File 100, SNA.
91 J.H. Groenewald to E.R. Roberts, 31 August, 1946, File 100, SNA.
92 Just how unique this incident was is illustrated to some extent by comparing it to other archival materials I examined in the research process. In compiling my notes, I kept a spreadsheet file listing the individual pieces of correspondence I read and categorizing them according to their primary subject. The spreadsheet contains well over 1000 entries, but this was the ONLY entry for which I noted “Leprosy Fears” as the subject of the letter. In fact, I had no other comparable category such as “Leprosy Stigma” which might provide correlating evidence. In other words, although there were many letters that discussed the possible fearful reactions of people to leprosy patients, this was the only letter in which clear evidence of enacted stigma figured at the center of the correspondence.
evidence that the European population of Swaziland was legitimately, if perhaps not universally or equally, concerned about the spread of leprosy as a contagious illness. On the other hand, I have argued in previous chapters that there is no evidence for leprosy stigmatization among Swazis, nor is there any reason to expect that the Swazi laborers at Mbuluzi would have been concerned had they had an unmediated encounter with the men that Sowden would likely have selected to bring to Mbuluzi. Being needed for manual labor, these men would logically not have been patients suffering from severe disability or manifesting leprosy in its most contagious (and usually visually dramatic) forms. But everything about these circumstances was highly mediated through a European worldview, and in point of fact, no true encounter of any sort likely ever took place. The striking workers at Mbuluzi, both European and Swazi, were responding not to a physical encounter with leprosy sufferers but to their fears of what such an encounter might mean for them. It seems to be the first recorded example of Swazis learning to stigmatize leprosy by way of their exposure to Western ideas, a theme that will be picked up in the following chapters.

The end result of these budget problems and construction delays was that the facility that finally opened in September of 1948 was not at all what Sowden and others had envisioned when work had begun nearly four years earlier. Far from being one of the “finest equipped” facilities in Africa, as Sowden had anticipated back in 1945, the facilities at Mbuluzi had no electricity until 1954, and telephone service was delayed several more years after that. Several of the buildings were badly damaged in the first few years of its operation, in part because of cost cutting measures in construction, such
as the absence of lightning rods, a critical oversight for buildings that were to be located on exposed mountaintops. In the first four years of operation, at least five buildings at Mbuluzi were struck by lightning and suffered serious structural damage as a result, to say nothing of the deleterious effect such incidents had upon patient morale. But, perhaps most significantly of all, Mbuluzi was no longer a purely government operation.

The missionaries of the Church of the Nazarene had never fully given up on their hopes of playing a significant role in leprosy work, but they did recede significantly into the background during the period between 1944 and 1947, as the administration spearheaded the work at Mbuluzi. But the drawn out delays and the continually under revision financial outlook for the Mbuluzi scheme presented new opportunities. In this case, it was not only the Nazarene missionaries who were suggesting the need to investigate alternatives. For example, at a meeting of the Swaziland Development Committee in December of 1946, the Resident Commissioner, Government Secretary, and Director of Medical Services had faced pointed questioning from one settler about the Mbuluzi scheme, which he argued had been very poorly conceived from the start. Would it not, he wondered, be preferable even at such a late stage in the process to start fresh in partnership with a mission society? Leprosy work, he felt, was “more suitable as a Missionary than as a Government activity.”

A less overtly critical example was the letter of Mrs. Fernande Homan, who lived in Stegi, to Callanan requesting information that she could use for an article she was

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93 The details on the facilities issues at Mbuluzi are chiefly described in the correspondence contained in File 3021D, “Mbuluzi Leper Hospital,” SNA.

94 Minutes of the Meeting of the Swaziland Development Committee, 5 December, 1946, File 100, SNA.
writing about the new leprosy work, at least in part in hopes of raising some material support for the new work. Homan was well informed about the Ncabaneni situation, which she said always “used to upset me terribly ... whenever we passed there.”

Although not a missionary, Homan was also quite well informed about the interests of Elizabeth Cole in work among leprosy patients, most likely because Cole had been working at the Nazarene clinic located in Stegi for the previous year, and she did not hesitate to inquire about the possibility of Cole being given a role in the work at Mbuluzi. Callanan’s response regarding Cole was noncommittal, but the renewed possibility of Nazarene involvement at Mbuluzi was only gaining steam.

Hynd himself had reopened communication with the government in April of 1947 after he had been forwarded a copy of the minutes of the Swaziland Development Committee meeting the previous December, at which the question of scrapping Mbuluzi and revisiting the idea of mission partnership had been so pointedly discussed. His letter tactfully suggested that, “In view of the financial difficulties facing the Administration ... and in view of the great value of the social and spiritual factor in the rehabilitation of the leper I would be prepared to discuss ... the possibility of our Mission making some contribution to the solution of the leper problem.” Nothing specific came of this inquiry, though Hynd did receive an invitation to meet with Resident Commissioner Beetham to discuss the issue of leprosy the next time he was in Mbabane. More might have come of Hynd’s inquiry were it not for the staunch opposition of Callanan. When asked to

95 Fernande Homan to J.C. Callanan, 20 October, 1947, File 100, SNA.

96 David Hynd to the Government Secretary, 7 April, 1947, File 100, SNA.
provide his input regarding Hynd’s offer of assistance, Callanan first pointed out that expenditures at Mbuluzi had already exceeded £16,000 and that contemplating any change of location would, in light of the expenditures, be “foolhardy.” And although he did not object to letting Hynd offer proposals that narrowly addressed the “sociological and spiritual angles,” Callanan was of the opinion that even turning over management of the work to a mission society, such as the Church of the Nazarene, could only lead to the neglect of leprosy prevention:

Leprosy Control, which must play an important part in the general scheme, if it is to be successful, is a public health responsibility which cannot well be delegated to a Missionary body, and the curative and preventive aspects of the problem are so closely associated, that they could not be divorced without creating serious administrative difficulties.  

Callanan’s letter clearly suggests that he found the missionary approach to the practice of medicine to be an inferior one, out of line with the practice of medicine as a secular and scientific endeavor that delivered “control” of disease and environments. It is not entirely clear how he reached this conclusion; he was not apparently overtly hostile to religion, as the letter itself left room for the Nazarene missionaries to make proposals regarding the “spiritual angles” of leprosy work. Nor was he overtly hostile to having religious people involved in the practice of medicine. For example, in late 1947 and early 1948, when the Swaziland administration entered into talks with the Nazarene mission about the possibility of having Elizabeth Cole seconded from the mission to the administration to work in leprosy care, Callanan was a major advocate of the transfer, calling the mission’s offer to release her for this work “most generous, and her services

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97 J.C. Callanan to the Government Secretary, 23 April, 1947, File 100, SNA.
would be of greatest value to (the Mbuluzi) institution, as she is keenly interested in leprosy work.”

Callanan did, however, seem to feel very strongly that the administration ought to keep direct oversight of the public health system in Swaziland, including the work of leprosy care. For this reason, his relationship with Hynd and with the Nazarene mission in general was never strong; in fact, David Hynd’s son, Dr. Samuel Hynd, recalled Callanan as a very difficult man and recounted several stories of difficulties his father encountered in dealing with Callanan, including some that were rather public in nature.

Callanan, of course, was not the only administrator in Swaziland or elsewhere in the British Empire who saw missionary medical endeavors as somehow suspect or suboptimal, but it is also perhaps unsurprising in light of these tensions that when in March of 1948, the administration decided that it was time to approach Hynd about reopening the discussion of a formal partnership between mission and government, it was not Callanan, but Resident Commissioner Beetham who took the initiative.

On March 31, 1948, Beetham wrote Hynd a personal letter inquiring as to whether the Nazarene mission might still have interest in taking over the leprosy work, stressing both the private nature of the inquiry and its tentative quality until the financial implications could be clarified. Given the investment that the Nazarenes had shown up to this stage of the game, particularly in arranging for Elizabeth Cole to visit the Westfort

98 J.C. Callanan to the Government Secretary, 5 January, 1948, File 100E, “Miss Elizabeth Cole, Secondment to Mbuluzi Leprosy Settlement,” SNA.

99 Dr. Samuel Hynd, personal conversation with author, July, 2010.

100 E.B. Beetham to David Hynd, 31 March, 1948, David Hynd Collection, NA.
Leprosy Institution the previous December for three weeks of training prior to her secondment to Mbuluzi, Beetham likely felt quite assured of the mission’s response.\(^{101}\) Indeed, Hynd’s response ten days later was warmly open to the administration’s proposal. The terms he laid out in that letter became, in essentials, the basis for the Memorandum of Agreement signed by the two parties in September of that year, after the basic scheme had received the necessary approvals from supervising authorities.

The memorandum essentially ceded all control of the daily operations at Mbuluzi to the Nazarene missionaries, placing Hynd in charge of the medical supervision and placing Sowden at his disposal, though retaining for him the privileges pertaining to other public service figures in Swaziland.\(^{102}\) The government also agreed to pay the Nazarene mission a fixed sum of £1574 annually for operational expenses and assumed the responsibility for building maintenance costs. For their part, the missionaries agreed to staff the hospital with personnel salaried by the mission and to maintain the property and quality of care at a level deemed satisfactory by the Director of Medical Services who retained the right to call for any reports he deemed necessary to ensure the responsible operation of the institution. The agreement also ensured that representatives of the

\(^{101}\) On the subject of Elizabeth Cole’s secondment to Mbuluzi, the relevant correspondence is chiefly found in the David Hynd Collection at Nazarene Archives. See especially his letter to A.J. Sowden on 11 December, 1947.

\(^{102}\) “Memorandum of Agreement between the Government of Swaziland and the General Board of the Church of the Nazarene,” 1 September, 1948, David Hynd Collection, NA. A copy of the Memorandum can also be found in Correspondence File 22 at the Raleigh Fitkin Memorial Hospital in Manzini, Swaziland. The Swaziland National Archives also likely has a copy in File 1420, “Handing Over the Leper Hospital to Nazarene Mission.” Unfortunately, although this file appears in the index, it was missing at the time I completed my research in 2010, and I was unable to examine its contents.
administration, Sobhuza's parallel government, or any recognized church in operation in Swaziland would have appropriate access to the people at the Leprosy Hospital.

Ensuring the oversight of the Director of Medical Services and the access of these particular persons to the hospital helped address some of the concerns that had been expressed over the years about turning over control of Swaziland’s leprosy program to a mission organization. The access granted to church representatives, for example, was clearly intended to address concerns about proselytization, though the memorandum contains no specific language forbidding the Nazarenes from this practice. The more specific concerns that had been raised about the Nazarene mission and its holiness inclinations were left out of the memorandum; the agreement, for example, does not explicitly say anything about alcohol or tobacco. Nevertheless, some understanding seems to have been reached on these points. On alcohol, the mission stood its ground; Mbuluzi was a dry institution throughout its existence. Many of the former patients I interviewed remembered sneaking off to get alcohol to have been one of the more common rule infractions, though this hardly seemed to have been rampant. The missionaries did make certain concessions, at least temporarily, regarding tobacco, which we know because Hynd was meticulous about thanking all contributors to the work at

103 Existing missionary correspondence does provide evidence, however, that the missionaries were sensitive to this concern. In 1954, Elizabeth Cole wrote to David Hynd indicating that she had 3 or 4 patients at Mbuluzi who were candidates for baptism and wondered whether this could be arranged during the upcoming campmeeting at the Bremersdorp mission station. Hynd replied that he thought it unwise “...to baptise them (at Bremersdorp) while they are patients in the Colony, as we might have some repercussions.” See Elizabeth Cole to David Hynd, 21 June, 1954; Hynd to Cole, 26 June, 1954, Box 2499, Unprocessed Correspondence, David Hynd Collection, NA.
Mbuluzi, even when their gifts could not have met his personal approval. On November 30, 1953, he wrote to a Miss Mearns of Mbabane:

> Miss Cole informed me that you had some tobacco which you wish to give to any of the leprosy patients, who use it. There are five who chew tobacco and one who smokes cigarettes. If you will send the tobacco along to me, I will see that they get it, if their condition permits.

> Thanking you for this gift and for the other things which come from Mbabane from time to time and which all the other patients can enjoy.104

It is possible to hear in Hynd’s letter a hint of the ways in which such compromises grated against his conscience and his vision for leprosy work, but they did little to dampen his fervor or that of Elizabeth Cole for taking up the work at Mbuluzi. On Sunday, September 12, 1948, Hynd wrote to Cole who had recently moved to Mbuluzi still in limbo on the question of her secondment to the government for leprosy work, “Dr. Callanan was on the phone with me 2 days ago, saying that the cable had been received saying we had to take over the Leper Hospital as from Sept. 1st. So you see we are running it now!!!”105

With an agreement finally in place, it still remained to open the hospital by populating it with patients. Nearly fourteen years after the arrival of Madolwane Maziya and her fellow Swazis from Westfort, Ncabaneni now housed dozens of leprosy patients who needed to be transferred up to Mbuluzi. Within a week of learning that the Nazarene mission had been approved to operate the leprosy work, Hynd and Sowden, accompanied

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104 Hynd to Mearns, David Hynd Collection, NA. Even this concession was constrained by other rules in place at Mbuluzi, which forbid smoking in the hospital building, the building used for church and school, or inside any of the residence buildings unless no one in the room objected. See David Hynd’s memo, “Tobacco Smoking at the Leper Colony,” 6 February, 1951, David Hynd Collection, NA.

105 Hynd to Cole, David Hynd Collection, NA.
by some others from the Nazarene mission, had visited the people living at Ncabaneni to announce to them the new arrangements for leprosy care. By Monday, September 20, the first patients were ready for transfer to Mbuluzi, with the sickest cases being transported by Sowden in an ambulance while others climbed into the back of a lorry with their possessions for the 36 mile drive into the mountains above Mbabane. By Saturday, September 25, the move was largely completed, save for a few who temporarily remained at Ncabaneni to finish clearing out the place.106

In the meantime, the Nazarene missionaries had worked quickly to appropriate the site in order to build its association with the religious symbolism of leprosy. Before the patients were transferred, the missionaries assigned the “villages” in the housing area names, each evoking one of the fruit of the Spirit described in the fifth chapter of the Apostle Paul’s letter to the Galatians: Ekutandaneni (“love”), Ekujabuleni (“joy”), Ekutuleni (“peace”), Ekubekezeleni (“long-suffering”), and Emuseni (“gentleness”). The entire settlement was named Tembelihle (“good hope”). By Sunday, September 26, 1948, they were ready for the official dedication of the Mbuluzi Leprosy Hospital. Whatever disappointments existed in government circles about the shortcomings of Mbuluzi relative to the vision that had existed at the start of construction in 1944 were dramatically downplayed by the mission in a public display of renewed optimism. Marjory Burne, a young South African woman who was helping with office work in the

106 Most of this timeline of events has been surmised from the entries recorded by David Hynd in his diaries, Microfilm Reel #363, “Diaries of David Hynd,” NA. See also David Hynd to the Director of Medical Services, 29 September, 1948, David Hynd Collection, NA.
Bremersdorp hospital, published the fullest account of the dedication, capturing the prevailing optimism of the missionaries:

The sun shone brightly on that Sunday morning ... and our hearts rejoiced. On our arrival, Miss Cole, dressed in her white nurse’s uniform and radiantly happy, greeted us with these words, “It’s true, my friends, it’s not a dream!” One of the newly erected, white buildings was used for the service; for there is, as yet, no church. This was an unusual service, and our hearts were strangely moved as we looked upon this congregation of lepers who were seated on one side of the hall, while the staff and visitors were seated on the other.107

Burne’s narrative emphasizes the hopefulness of the moment, evoking the images of the bright sunshine and the whiteness of both Sister Cole’s nursing uniform and the building wherein the dedication service took place. The “lepers,” by contrast, not only sit apart during the service but are described within Burne’s article chiefly in terms of their physical bodies as “deformed,” “diseased,” and “decayed.” The service itself contained reminders of transformation the missionaries hoped would come about in the lives of these patients at Mbuluzi. David Hynd preached a message that called on the patients to “determine to walk after the Spirit in their new home and not after the flesh.” Another message, given by a Swazi Nazarene minister from the Bremersdorp area named J. Malambe, reminded everyone of the great love of God. By the time Agnes (Nema) Hynd, the wife of David Hynd, pronounced the benediction to close the service, “we felt that God had truly been with us.”108 All of this dedicatory activity was carried out largely in the absence of representatives of the Swaziland administration. Given the administrative transfer of responsibilities and what it symbolized in terms of the vision for what kind of

107 Marjory Burne, “He Hath Done All Things Well,” The Other Sheep (March 1949): 7.
108 Ibid.
place Mbuluzi would come to be, it was perhaps fitting that the guests of honor were Nazarene missionaries, as well as missionaries, a Swazi minister, and school girls from the neighboring SAGM mission station rather than the Resident Commissioner or the Director of Medical Services.

Present on that day but perhaps somewhat less than fully enthralled with this new dispensation for Swaziland’s leprosy work was A.J. Sowden whose relationship with the new Nazarene management of Mbuluzi would soon come to symbolize all of the clashing expectations that existed around leprosy. Sowden’s ideas about leprosy care as a modern medical endeavor and his understanding of himself as the lynchpin in its success would very quickly contribute to a breakdown in his relationship with Hynd in particular, but according to Burne, he played his role on the day of the hospital dedication well.

Sowden, an Anglican who had been named a subdeacon in the Diocese of Zululand and who took up religious work back in the U.K. after his time at Mbuluzi, had addressed the congregation during the service, “pointing those who thirsted to Jesus, the source of the Water of Life.”

And Sowden had attempted to keep a positive outlook on things during the delays of the previous years. Early in 1948, he had published a piece in the BELRA Quarterly Magazine that sounded themes much like those used by the Nazarene missionaries to describe the leprosy situation in Swaziland. It began with a “view of one

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109 Ibid. Sowden’s appointment as a subdeacon in the Anglican Diocese of Zululand was noted in an undated newspaper clipping from an article entitled “Millom Man in Swaziland: Jack Sowden Coming Home,” The Whitehaven News. The clipping is contained in the David Hynd Collection, NA. The note about his taking up religious work in the U.K. after Mbuluzi is from a brief reference to this effect in David Hynd’s “Annual Report of Mbuluzi Leprosy Hospital for the year ending 31st December, 1951,” File 3021D, “Mbuluzi Leper Hospital,” SNA.
part of Swaziland,” in which Sowden recounted many of the standard tropes about life at Ncabaneni: uninfected children living with infected family members, the problems of overcrowding, the dilapidated structures, the misery of Swazi “lepers” with their mutilated bodies and apathetic spirits, living in “this financially forgotten corner of the Empire.”

The article then moved to the contrasting view of developments at Mbuluzi, and if Sowden’s earlier declarations about opening one of the “finest equipped leper settlements” were no longer in evidence, he could at least hold up the natural beauty of the settlement site, its spaciousness, and its provision for properly ordered care as reasons for hope. And although BELRA was not an explicitly religious organization, Sowden nevertheless resorted to Christian imagery as he closed his article: “A difficult time lies ahead, but why should we fear? At least one of the ten lepers returned to give thanks to the Great Healer, and we have never found the leper unthankful in the past. Faith and trust will grow and give birth to the spirit of thankfulness which, like a leaven, will permeate the whole settlement.”

Kathleen Vongsathorn has recently described such language as part of the standard approach for “selling leprosy” as a humanitarian concern within the British Empire, and Sowden’s appeal certainly checks off most of the key points that she has identified: using the Bible as a key point of reference, emphasizing the vulnerability of innocent children, and appealing for philanthropic generosity as a


11 Ibid.
measure of patriotic duty.\textsuperscript{112} The particulars might vary in terms of emphasis dependent upon the audience of a particular organization, but both Christian missions and secular humanitarian philanthropies such as BELRA relied upon these familiar themes in a relatively intense competition for funding.

Given their reliance upon these standard tropes, it might be easy to dismiss the parallels between Sowden’s language and that of the missionaries as superficial, and in some sense, this proved true. Yet prior to the 1948 transfer of administrative responsibilities, Sowden and the Nazarene missionaries appeared to be well on their way to establishing a warm working relationship. For example, as the missionaries and Sowden had their first introductions in 1945, Elizabeth Cole wrote that she was “very happy to hear Mr Sowden’s views concerning leper work and missions,” which had led her to think that “our mountain shall be removed before too long.”\textsuperscript{113} In 1947, when Hynd needed insights into the thinking of the administration regarding Nazarene involvement at Mbuluzi and specifically about finding a role for Elizabeth Cole, he exchanged personal and rather frank letters with Sowden in which Sowden expressed continued support for the idea of Nazarene involvement, especially by Elizabeth Cole. Even at the point when the transfer of administration took place, Hynd was still writing sympathetically to Sowden, expressing his confidence that “our cooperation ... will mean something


\textsuperscript{113} Elizabeth Cole to David Hynd, March 19, 1945, File 1366-6, “Hynd Letters to Missionaries 1936-1942, A-F,” NA.
worthwhile for these Swazi lepers whose mental, physical and spiritual rehabilitation is such a crying need.”¹¹⁴

But by September of 1948, Sowden was just coming off his frustrating survey work in the Stegi district, and seemed to be souring generally on Swaziland. Moreover, there were significant signs of an emerging clash of cultures between himself and Hynd. In early October, when Hynd drew up a memo outlining the division of responsibilities for administering the Mbuluzi Hospital, Sowden responded very poorly to what he perceived as Hynd’s “distinct change of attitude towards me.”¹¹⁵ In a lengthy letter of complaint addressed to Callanan, Sowden explained on the basis of his reading of the memo and a conversation with Hynd that he felt he had been demoted unfairly from “Superintendent in charge of the Hospital” to merely “Lay Superintendent,” a title that Hynd had used to refer to Sowden’s position in one previous letter but that he had already agreed to cease using in a concession to Sowden’s protests.¹¹⁶ As a consequence of the demotion, Sowden felt excluded from “any matter relating to the treatment of the lepers” and consequently would be deprived “of the opportunity of sharing in the only side of the

¹¹⁴ David Hynd to A.J. Sowden, 12 September, 1948, David Hynd Collection, NA.

¹¹⁵ A.J. Sowden to the Director of Medical Services through the Medical Superintendent, Raleigh Fitkin Memorial Hospital, 6 October, 1948, David Hynd Collection, NA. The Hynd Collection also includes the memo entitled, “Administration of Umbuluzi Leper Hospital,” 1 October, 1948.

¹¹⁶ The offending letter was written by David Hynd to A.J. Sowden, 27 September, 1948, David Hynd Collection, NA. Hynd consented to avoid using the term in a letter to Sowden, written on 2 October, 1948, David Hynd Collection, NA. In his concession, he tried to indicate that he found the use of the term “Lay Superintendent” helpful merely because it clarified the distinction between that position and his own as the “Medical Superintendent.”
work which offers any degree of encouragement.” When Hynd responded to Sowden’s letter a few days later, he tried to downplay the tensions, making reference to the clause in the administrative memo that left room for Sowden to carry out “any other duties assigned to him by the Medical Superintendent for the well-being and rehabilitation of the patients” as providing ample room for Sowden’s participation in the medical work. Besides, Hynd insisted, many of the duties assigned to Sowden in carrying on “schemes initiated for inculcating in the patients the ideal of self-help by teaching them handicrafts and the raising of their own food” were of “vital importance” and would likely “consume a large part of his time if they are to be done properly.” Hynd eventually also agreed to rewrite portions of the administrative memo to give Sowden more explicit responsibilities for patient treatment, which patched things up enough for the work to proceed at Mbuluzi, but the proverbial handwriting was on the wall.

In the end, Sowden remained just under two years from the time that Nazarene administration at Mbuluzi took effect. By the end of 1949, Sowden’s Leprosy Survey work had been completely closed down, and although there is no record of further public conflict between himself and Hynd, their relationship seems always to have been tense.

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117 Sowden to DMS, 6 October, 1948. Curiously, Hynd’s administrative memo clearly refers to Sowden’s title as that of “Superintendent of the Leper Hospital” and not as the “Lay Superintendent.” But, given that Mbuluzi now had a designated “Medical Superintendent” in the person of Hynd, rather than the former arrangement in which Sowden would have been responsible for treatment under the supervision of a Medical Officer, it does seem clear that his medical responsibilities had been reduced.

118 David Hynd, “Administration of Umbuluzi Leper Hospital,” 1 October, 1948. David Hynd to J.C. Callanan, 11 October, 1948, David Hynd Collection, NA.

119 David Hynd to The Superintendent, Mbuluzi Leper Hospital, 8 November, 1948, David Hynd Collection, NA.
and characterized by a thousand little slights. They had terse exchanges over all manner of minor issues, for example, whether it was better to translate the name of the Ekubezeleni village as “long-suffering” (Hynd’s default translation) or “patience” (which Sowden felt to be less morbid), whether “Mbuluzi” should have a “u” at its beginning, whether Hynd had the right to open correspondence addressed to “The Superintendent” during periods of Sowden’s absence, whether patients should be granted an overnight absence from Mbuluzi, whether or how soon Sowden needed to inform Hynd if he himself had to depart Mbuluzi for emergency reasons, and more. In one particularly illustrative incident, Sowden had abruptly hung up on a phone conversation with Hynd in which the two of them had strongly disagreed about the participation of Mbuluzi’s newly organized Girl Guide troop in the King’s Birthday parade in Mbabane. The disagreement started over Hynd’s reluctance to allow the girls to participate at all, but by the time Sowden hung up on him had degenerated into a squabble over who should be responsible for the lorry that would transport the girls to Mbabane and then through the parade in order to keep them segregated from the public. The seven letters exchanged over two weeks both before and after the phone incident and the parade itself only further illustrated the tense relationship between the two men.

It is clear that neither party was overly distressed when the time came for Sowden’s departure; in fact, the Nazarenes were genuinely glad for him to go. Shortly

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120 The correspondence between Hynd and Sowden on all of these issues took place between September of 1948 and June of 1949 and is part of the David Hynd Collection, Nazarene Archives.

121 All of the relevant correspondence on the issue of the King’s Birthday parade took place between 2 June, 1949 and 16 June, 1949 and is part of the David Hynd Collection, Nazarene Archives.
before Sowden’s departure in June of 1950, Hynd wrote to A. Donald Miller, the General Secretary for the Mission to Lepers in the U.K. who had recently visited Mbuluzi, commenting that, “Mr Sowden is going on his regular overseas leave in June. For the reasons we mentioned to you when you were here, we would be very happy if he could find another sphere for his labours.”¹²² Though the “reasons” were not enumerated again in the correspondence, it seems not to have been entirely coincidental that Hynd immediately followed up his news of Sowden’s departure with expressions of hope for a season of special spiritual blessings in the leprosy work. Indeed, the view of Sowden as a chief obstacle to the advancement of the spiritual dimensions of the leprosy work was very much on the rise.

The suggestion that the missionaries had come to see Sowden as an impediment to the spiritual work at Mbuluzi is significantly stronger in Hynd’s correspondence with Elizabeth Cole, who had returned to the United States on furlough at the time. In his first letter commenting on the Sowden situation, he remarked that, “Things go much better with them away,” and that, “If any opportunity arises to close the door for (their return) I shall certainly avail myself of it...”¹²³ Two months later, Hynd wrote again upon hearing from acquaintances in Mbabane that Sowden “was taking holy orders and was not coming back. ‘Taking holy orders’ in the church of England means getting ready for ordination as a minister!!”¹²⁴ Hynd’s double exclamation points expressed his

¹²² David Hynd to A. Donald Miller, 17 April, 1950, David Hynd Collection, NA.


¹²⁴ David Hynd to Elizabeth Cole, 26 November, 1950, File 1366-17, NA.
astonishment at the idea of Sowden becoming a minister, as he noted in a subsequent letter to Cole, “... with the news of Mr. Sowden not coming back I believe the spiritual help and blessing which can be given to these unfortunate souls (the patients at Mbuluzi) will be greatly enhanced.”¹²⁵ In the Nazarene view, Sowden had become not altogether different from those Swazi patients and staff people at Mbuluzi whose refusal to accept the pattern of life under Nazarene administration made them a problem to overcome, a subject that will be addressed more fully in the subsequent chapter. But when Hynd welcomed Cole back to her post at Mbuluzi as Matron, he explicitly linked his wishes for a “blessed term of service for both you and the patients” with the hope that “it will be easier without the distraction of Sowden and Ntisane’s attitude,” referring to the agricultural demonstrator supplied by the government to Mbuluzi until the year prior to Hynd’s letter.¹²⁶

Along with being an impediment to the spiritual side of the work that was such a high priority for them, the missionaries also clearly feared that Sowden was poisoning their already frayed relationship with the administration in Mbabane. When Hynd wrote to Cole about the news that Sowden was taking up ministerial work in England, he also noted the welcome news that Resident Commissioner Beetham, whom he “felt had been influenced by Mr. Sowden,” had received a transfer to the Bechuanaland Protectorate. And when Cole returned to Swaziland and heard from Mbuluzi’s Swazi chaplain a rumor (ultimately proven unfounded) that Sowden was returning to Swaziland and to Mbuluzi,

¹²⁵ David Hynd to Elizabeth Cole, 30 January, 1951, File 1366-17, NA.
¹²⁶ David Hynd to Elizabeth Cole, 23 August, 1951, File 1366-17, NA.
she wrote to Hynd that she felt it most urgent that they immediately address the plowing and some other maintenance work around Mbuluzi. This would offer proof “that we are able to handle the work without Mr. Sowden (so that) we might be able to counteract public opinion in Mbabane and among the lepers,” which would give the mission “something to stand on in fighting Mr. Sowden’s return.”

Clearly, the Nazarene missionaries lived with the sense that their hold on the leprosy work remained somewhat tenuous at this early stage and were anxious to do whatever was necessary to maintain or strengthen that position.

In truth, the missionaries may have had an exaggerated sense of Sowden’s influence in administration circles, as illustrated by the government correspondence surrounding his resignation. Sowden waited almost six months after his return to the United Kingdom to inform the government of Swaziland of his intention not to return. Although the tone of his letter was properly deferential, apologizing for the delay in making the decision and expressing appreciation for the kindness the administration had shown him and his wife, the other correspondence in the files regarding Sowden suggests that the administration believed Sowden had made his decision some time earlier and had only waited to announce his decision because it allowed him to remain on the government’s payroll for a longer period of time. In the end, removing Sowden from the administration and closing out questions regarding compensation proved almost as difficult as it had been to negotiate his compensation package with the government in the

127 Elizabeth Cole to David Hynd, no date (c. August, 1951), File 1366-17, NA.
first place. Much of that correspondence is, as one would expect, very tedious in its nature, but one telling observation that emerges from the correspondence and the entirety of Sowden’s experience in Swaziland is the sense that he felt his role as a leprosy field worker warranted a great deal of special treatment, even a somewhat entitled attitude. Sowden was not alone in feeling this way; some of the correspondence from administration figures made reference to his “excellent service” under “difficult conditions” or the need to treat his compensation as a “special exception” because of the “nature of his duties.” But when Sowden did not feel adequately appreciated or able to execute his vision of leprosy control, as in the case of the survey or in light of the transfer of Mbuluzi to the Nazarenes, these things grated against his sense of the distinction and seem to have contributed greatly to his departure from Swaziland.

Sowden’s departure was just one indication of the waning of the government’s vision for Mbuluzi during its early years of operation. The expiration of the original Memorandum of Agreement between the administration and the Nazarene Mission in March of 1956 further marked the ascendance of the mission over the government. Per the terms of the agreement, the government retained the right, upon expiration of the

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128 Sowden’s official letter of resignation, addressed to the Government Secretary, was dated 10 December, 1950, roughly two weeks after Hynd had heard from his Mbabane acquaintances that Sowden would not be returning. Sowden’s letter, and most of the other correspondence related to his resignation from government service are found in File PF205 (2 folders), “Sowden, A.J.” in the Swaziland National Archives.

129 J.R. Stebbing to the Administrative Secretary, High Commissioner, 13 September, 1948. T.J.R. Dashwood to the Secretary of State’s Office, 9 April, 1951, File PF205, SNA.

130 The exact date of the expiration of the Memorandum of Agreement is something of an open question. The Memorandum lists the expiration date as 31 September, 1956, but the correspondence between Hynd and the administration in 1956 all clearly identifies the date of expiration as 31 March, 1956.
original contract, to resume control of Mbuluzi free of any need to compensate the
Nazarene mission except for “permanent improvements” that had been carried out with
the approval of the administration, minus some reasonable amount for depreciation in
value. For his part, Callanan, who continued to serve as Director of Medical Services
throughout the years of the agreement, persisted in regarding the arrangement with the
Nazarenes as a temporary expedience, driven by the need to “effect a saving of some
£18,000, and secondarily to finalise our commitment during the life of the Scheme.”
Because of this, Callanan often proved resistant to Hynd’s requests for assistance that
might have financial repercussions for the government.

As the date of expiration of the agreement approached, Callanan clung to the idea
that Mbuluzi should and could still fulfill the government’s original vision, some of
which was, in fact, already becoming reality. Since the opening of Mbuluzi, for example,
a number of Westfort patients for whom the administration had assumed financial
responsibility were repatriated to Swaziland, largely without incident. The one notable
exception was the case of Audrey Masimula, a female patient who remained at Mbuluzi
only about three weeks in 1950 after her transfer from Westfort before fleeing back to
Pretoria where she complained bitterly about the poor quality of food, the miserable
sleeping conditions, and the inadequate quality of medical treatment she had experienced
at Mbuluzi. Although Hynd disputed her allegations, the administration decided that it
was better not to force her return to Swaziland. She thus remained at Westfort until July

131 J.C. Callanan to the Government Secretary, 26 May, 1952, File 1420 (II), “Handing Over the Leper
Hospital to Nazarene Mission, SNA.
of 1953 when, for reasons unknown, she ran away from that institution as well and disappeared.\footnote{The correspondence relating to the transfer of patients from Westfort to Mbuluzi can be found in File 3021F, “Leper Patients,” SNA. On the case of Audrey Masimula, see especially J.C. Callanan’s telegram to the Medical Superintendent at Westfort, 24 April, 1950; the letter of the Acting Secretary of Health, Pretoria, to Callanan, 23 May, 1950; J.C. Callanan to the Government Secretary, 26 May, 1950; David Hynd to Callanan, 8 June, 1950; and Callanan to the Government Secretary, 16 September, 1953 in that same file.}

Masimula was not the only patient to disappear from Mbuluzi without permission during its first few years, but the cases were scarce enough that Callanan and the administration could feel confident that they were gaining control of leprosy on something approximating their own terms. Even more important, perhaps, was the fact that the number of resident patients appeared to be in decline, which lent credence to the administration’s view that the eradication of leprosy was readily attainable. The annual reports submitted by Hynd showed that the high water mark for resident patient numbers at Mbuluzi was reached in the first two full years of its operation, when he reported 75 and 78 patients in residence during 1949 and 1950 respectively. But midway through 1950, Hynd introduced Diaminodiphenylsulphone (D.A.D.P.S.) or Dapsone, as it is more commonly known, as the preferred method of treatment at Mbuluzi. As a result, at the end of 1951, there were only 57 patients in residence at Mbuluzi, and the year after that, only 43.\footnote{The relevant annual reports referenced can be found in File 3021D, SNA.} With patient numbers cut nearly in half in just two years, the administration, and especially Callanan, became increasingly bold in imagining the other uses to which it might put Mbuluzi if it could be reclaimed from the Nazarene mission in 1956.
Callanan and the administration chiefly hoped that Mbuluzi might fit into a scheme for tuberculosis treatment, a disease related to leprosy in that its causative agent was also a microbacterium and also in the sense that it was generally regarded as wise to keep patients with tuberculosis isolated from the general population. Although one government officer would later comment on an internal communication that it had “always been the long term intention” to use Mbuluzi for tuberculosis treatment once the leprosy numbers had declined, it was actually Callanan who first seriously raised this suggestion in 1952 after the report of the first dramatic drop in patient numbers.\textsuperscript{134} No one openly discussed potential alternatives with Hynd, which was probably just as well since there is nothing to indicate that the missionaries shared this vision. The two diseases may have been related in biomedical terms, but tuberculosis never had anything like the symbolic power of leprosy in the mind of Christians, in Swaziland or elsewhere. Nevertheless, behind the scenes, Callanan became increasingly insistent that tuberculosis was now the medical crisis that needed the attention of the government. In 1955, Callanan wrote a confidential memo arguing that because of “… the ill-informed and mischievous criticisms to which Government is constantly being subject in connection with Tuberculosis and the prospect of these undesirable tendencies being accentuated unless there is evidence of further progress in a field in which there is ample scope for improvement,” the government needed to prioritize the necessary actions to resume

\textsuperscript{134} J.C. Callanan to the Government Secretary, 4 March, 1952, File 1420A, “Mbuluzi Leper Hospital Lighting Plant,” SNA. The comment about the government’s “long term intention” was made by an unknown author (not Callanan) in a handwritten internal memo dated 13 March, 1956, File 3021D, SNA.
management of Mbuluzi and make provision for isolating tuberculosis patients there.\textsuperscript{135} The administration as a whole was on board with this approach, as the hundreds of new tuberculosis diagnoses each year during this time period made it clear that this was a growing public health issue. The problem, as Callanan well knew, was that the financial position of the Swaziland administration made such actions impossible to consider, nor was there any immediate hope for a significant change in their position.\textsuperscript{136}

In light of this, the administration decided that it was best to see if the Nazarene mission would be open to the continuation of the Memorandum of Agreement on a year to year basis. If not, there would be little choice but to give the mission another long term arrangement, as there simply was no money available to cover the additional expenses that would be incurred if the Leprosy Hospital resorted to government control at this stage. Whether Hynd and the Nazarenes were unaware of the strength of their bargaining position at this moment or simply preferred not to exploit their advantage, they apparently indicated their acceptance of the year to year arrangement. On April 3, 1956, Callanan wrote to Hynd indicating that the Government Secretary had given approval of the continuation of the previous scheme. In his letter, Callanan used language indicating that it was still the government’s intention to take over management of Mbuluzi at some point in the future, writing that the continuation would last “until

\textsuperscript{135} J.C. Callanan to the Government Secretary, 21 July, 1955, File 3021D, SNA.  

\textsuperscript{136} Callanan’s Annual Medical & Sanitary Report for 1955, for example, showed 444 admissions for tuberculosis at government hospitals, as compared to 38 for leprosy. When Callanan’s idea of converting Mbuluzi into a mixed-use facility for isolating both leprosy and tuberculosis cases failed, he pivoted quickly to addressing the tuberculosis problem in other ways. The Swaziland Annual Medical & Sanitary Reports for these years show that by the end of 1955, a 12-bed unit for TB patients had been opened at the government’s Hlatikulu Hospital and a 24-bed unit at the Mbabane Hospital opened in October of 1958.
such time as Government is in a position to resume control of the Institution.”¹³⁷ But, in truth, the decision to continue the previous arrangement was not seriously revisited for the next several decades, and Mbuluzi became more and more an institution wholly associated with the medical work of the Nazarene mission.

When the partnership between mission and government was first created in 1948 and then continued in 1956, it opened the door for Mbuluzi and leprosy care to become more fully a missionary “baby,” as Megan Vaughan characterized it. Ultimately, the disease was simply a higher priority for them than it was for the administration, and this was almost entirely because of its deep spiritual importance. It cannot be said with any accuracy that the administration was somehow uninterested in leprosy; they clearly had a significant and specific vision to pursue, and they did so with notable consistency over the course of two decades. And it is worth reiterating the frequency with which they objected to the idea of simply surrendering the work to the mission. However, the difference was clearly in the way that leprosy connected at a symbolic or spiritual level for the missionaries, which elevated it as a priority on their agenda to a place that it never could attain in the British vision. How that mission vision played out in the daily life and operation of the Mbuluzi Leprosy Hospital is the chief subject of chapter four.

¹³⁷ J.C. Callanan to David Hynd, 3 April, 1956, David Hynd Collection, NA. The letter can also be found in File 3021D, SNA.
Chapter 4

The sum total effect of the developments in medical science that characterized the years of operation for the Mbuluzi Leprosy Hospital was to render leprosy treatment a much more routine procedure that generally followed a predictable course. This rapidly shifting medical knowledge and the increasingly routine nature of leprosy cures, however, did little to reduce the interest of the missionaries of the Church of the Nazarene or within the wider networks of their supporters, which extended well beyond Nazarene circles to a global network of mostly-Christian organizations concerned with leprosy. From a medical perspective, Mbuluzi was never a large or “important” institution; Hynd’s year end report for 1950, which recorded 78 patients in residence, would stand as the high water mark for patient population. This fact, however, could hardly have been less relevant to the people associated with the Nazarene mission whose narratives became, after 1948, the chief representations of Mbuluzi. For them, the hospital remained a central point of interest and a frequent destination for overseas visitors, vacationing missionaries, and others who were attracted by the spiritual heroism of leprosy work and the secluded splendor of Mbuluzi’s mountainous surroundings. This chapter frames that legacy of Mbuluzi’s peculiar prominence in terms of Christian pilgrimage and explores how this position shaped the identities of patients whose lives were consequently put on display.

1 An abbreviated version of this chapter has been published under the same title in Studies in World Christianity: The Edinburgh Review of Theology & Religion 20, no. 1 (2014): 54-69.
The animating ideas for this chapter grew out of my first encounter with Gogo Shiba and her narrative of the declining quality of her life after her time as a patient at the Mbuluzi Leprosy Hospital, described in the Introduction. Gogo Shiba helped me see that the narratives of Mbuluzi’s visitors were not merely ephemeral fantasies and that the behaviors of outsiders towards the people who lived at Mbuluzi had very real, if not always predictable, consequences that played themselves out over the rest of their lives. It was not, in other words, an inconsequential thing to live as the object of someone else’s pilgrimage.

My argument is that the leprosy work produced an unusual spiritual resonance in the minds and hearts of the Nazarene missionaries and their global supporters, which now could finally take full form in Swaziland as the responsibility for leprosy work passed more or less exclusively from government into missionary hands. This combined with Mbuluzi’s isolated mountainous environment to make it a kind of ‘destination’ for Christians. I do not want to overextend the metaphor, but I have found it helpful to think of the hospital as an informal pilgrimage site for European and American visitors to Swaziland. I refer to it as an informal site of pilgrimage only because none of these visitors from abroad, mostly steeped in an evangelical Protestant worldview, described their visits to Mbuluzi as such, but the hallmarks of a pilgrimage are all present. People who wished to visit Mbuluzi were required to complete a relatively lengthy and sometimes difficult journey to reach their destination, frequently brought with them gifts or offerings to present, always participated in prayer and worship with the leprosy
community, and generally reported receiving some sort of spiritual blessing as a result of their journey.

The second part of my thesis is a little more difficult to tease out: how did this status as an informal pilgrimage site affect the people living there as patients and even as staff? What did it mean to live for an extended period of time as the object of someone else’s pilgrimage? Did it unintentionally foster a new identity for Mbuluzi’s patients as ‘lepers,’ an identity rooted in dependency? Following James Ferguson’s recent work, I argue that the dynamics in play at Mbuluzi were readily understood by Swazis as offering a viable form of richly social dependence that created deep moral bonds between them and the Western pilgrims who visited them. The construction of those bonds helps explain the dislocation and even embitterment experienced by Gogo Shiba and other patients after the closing of Mbuluzi.

Using this lens of an informal pilgrimage site helps distinguish my analysis of Mbuluzi from other recent work on leprosy institutions throughout Africa, which have ultimately leaned heavily on questions about government relationships with missions and with patients. Works like that of Kathleen Vongsathorn in Uganda or John Manton in Nigeria provide examples of the dynamics of mission-government relations, and leprosy work as a site where the two of them continually negotiated their relationships. As illustrated in the last chapter, this was an important dynamic in Swaziland, but one that decreased significantly after the government’s 1956 decision not to reassert its

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administrative role at Mbuluzi. Shobana Shankar and Barbara Cooper have also recently highlighted the dynamics of American missionaries at work in Nigeria and Niger, where their relative distance from the colonial administrations added unique dimensions to their work and their sense of priority. Geographically closer, studies like those of Harriet Deacon and Simonne Horwitz in South Africa have emphasized the operation of leprosy institutions such as Robben Island and Westfort as mirrors of the policies of racial segregation that characterized the governance of the larger society. Again, this is not an irrelevant issue in Swaziland or at Mbuluzi, where the positions of greatest prominence were clearly collected in the hands of people of European descent. Nevertheless, as I will argue below, the relatively small size of the Mbuluzi institution and its particular spiritual ethos reduced, though it certainly did not eradicate, the significance of racial difference.

In some ways, my analysis here may follow most closely the model laid out by Eric Silla’s social history of leprosy in Mali, which tries to bring the patient experience and their initiatives in community and identity construction into the center of the story. Yet even in this case, the patients in Mali were part of a much larger group, both per capita and in total numbers, and experienced much higher levels of social stigma than Swazis did. And so rather than focus exclusively on the ways in which patients forged their new identities, I argue that the process of identity formation needs to be understood as a
cooperative (though not always intentional) intersection of ideas that connected at Mbuluzi.  

Although Mbuluzi would be the most enduring Nazarene work with leprosy sufferers and the one that most fully gave them the opportunity to enact their vision of leprosy care, it was not the first such Nazarene work in the region. Preceding Mbuluzi by 18 years, the Nazarenes had briefly operated a leprosy colony in the southern portion of Portuguese East Africa (Mozambique). The Nazarene mission in the Portuguese colony had been opened in the early 1920s when an independent missionary had asked the denomination to take over his growing work that had begun among migrant laborers on the mines of the Witwatersrand and then spread back to their home areas. In 1930, the security of this fledgling work had been endangered by a Portuguese edict declaring that no church would be allowed to operate in its East Africa colony without permanent buildings, something the Nazarene mission still lacked. At the last moment, an abrupt end to Nazarene work in the region was avoided when Dr. William C. Terril, the Superintendent of the South East Africa Mission Conference of the Methodist Episcopal Church, agreed to transfer to the Nazarene church a well-developed mission station at

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Tavane, which the Methodists had decided they no longer needed. In addition to his Methodist superintendency, Terril was also a representative of the American Mission to Lepers in the region and had, in conjunction with that organization, facilitated the creation of a leprosy colony just one mile away from the mission station site. Thus, in 1930, the Nazarenes inherited both a mission station and the supervision of a leprosy colony with support from the American Mission to Lepers.

For most of its existence, the colony housed somewhere in the neighborhood of 100 patients, larger than Mbuluzi in its peak years of patient population. But in the end, the Nazarene connection to the colony would last only six years, as the Portuguese administration opened its own leprosy colony in 1938 and required all leprosy patients from neighboring facilities to be transferred into the new one, some sixty miles away from the Nazarene mission. Despite the relative brevity of its operation, the Tavane colony foreshadowed in important ways the focus of Nazarene leprosy work, and because most of the people involved were quite close to the Swaziland missionaries (indeed, many of them served stints in Swaziland first), it set some significant precedents that would be more fully realized at Mbuluzi.

Nowhere was the overlap more clearly in evidence than with regard to the language used to characterize leprosy work. Here, the best examples come from the letters of an American missionary nurse from Oklahoma named Minnie Martin. Martin had already served more than ten years as a missionary in Swaziland when she came to

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Tavane to assume her role in the medical work there, which involved both supervision of the leprosy colony and the operation of a general clinic. In her letters, Martin emphasized the spiritual rewards of her work among the leprosy sufferers, “The Lord surely does love the lepers, and I love this work for Him.” Lacking effective medicines (like other leprosy facilities in the world at this time, the Tavane colony was using chaulmoogra oil), Martin and her colleagues emphasized the spiritual healing available to lift these men and women out of their misery. As significant numbers of the Tavane patients began to convert to Christianity, for example, Martin and the other missionaries began to emphasize the practice of tithing, asking them to donate one-tenth of the value of their peanut gardens to God’s work among leprosy patients elsewhere in the world:

I told them I was sure the Lord would bless their gardens, if they would do this. They promised joyfully, as it appealed to them very much... There are about 90 lepers usually and a number are not able to work at all, and most of them gave the tithe, although only about half profess to be Christians. We do give the dear Lord all the praise and the glory! It is truly marvelous, it is the Lord’s doing... as many, many people have no peanuts, as the locusts came in clouds and destroyed everything in many place. We do praise Him!

The spiritual and material blessings accrued by way of the patients’ decision to give their tithe faithfully received considerable positive press from Martin and the other Nazarene missionaries who had few hesitations about creating a firm link between the two. Martin’s co-worker, C.S. Jenkins, for example, composed a 1935 newsletter to his American supporters in which he contrasted the “shadow” of leprosy suffering and

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6 Minnie Martin to the Treasurer, General Board of the Church of the Nazarene, August 9, 1934, File 208-19, NA.
rejection (“No one cares for them except the Christians.”) with the “sunshine” of grace represented by many leprosy sufferers (so recently, “heathen”) giving their tithe: “The result is that they have another bumper crop this year again.”7 Yet another missionary, celebrating the tithe of the colony inhabitants, took the opportunity to “diverge for a moment” and expound upon the blessings he himself had received as a consequence of giving, not just his tithe, “... but no less than 50% during the whole of the past year, and God has not let me down yet, and I sincerely believe that Mrs. Ferree’s healing was one of the blessings poured out.”8 The stories of the tithing practice of those with leprosy thus became an example that others could build upon regarding the transformative fruit borne out of Christian conversion.

The Nazarene missionaries were disappointed when the Tavane colony closed, and the government removed its residents to the island colony in 1938, but this was not the end of their connections. In fact, the move opened up the development of some of the “pilgrimage” language that became so significant to Mbuluzi’s later identity. In an undated article from roughly 1940, for example, Minnie Martin wrote of the difficult and financially costly journey involved in a visit to the island: “... we waited and prayed and cried with a burdened heart for the poor lepers, who had waited so long for us to come again. Their disappointment was harder than ours, as they have such few bright spots in their lives.” The article went on, however, to describe the great joy of the missionaries

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when they discovered the men and women of the island in improved physical health and still faithful to their Christian commitments. Samson, the leader of the Christians in the colony, reported that 82 of 87 Christians had given their tithes during the past season for the benefit of those who could not garden for themselves. In light of this report, Martin noted, “No wonder God does bless the lepers as they do love Him and others, who are more helpless than themselves.”

The sacred nature of the journey to the island only increased when in December of 1941, the boat carrying Minnie Martin, one of her missionary colleagues, the Rev. Glenn Grose, two Mozambican Christians, Anna Mathuse and Antonio Manhique, and two oarsmen capsized in rough water on the return to the mainland. Though the others managed to reach the shore, Rev. Grose drowned, a major loss for the small mission at Tavane. Despite the tragedy, Nazarene missionaries continued to make the pilgrimage to the leprosy colony, especially at Christmas time, over the next two decades. Their role in the physical care of leprosy sufferers had long since ceased, but they still found significance in promoting the spiritual side of the work.

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10 Numerous accounts of the accident exist in letters and in publications. See, for example, Minnie Martin to Emma Word, December 18, 1941, File 208-20, NA; William C. Esselstyn to all missionaries, December 10, 1941, File 1366-6, “Hynd Letters to Missionaries, 1936-42, A-F, NA. For a published account, see Lorraine O. Schultz, Moçambique Milestones (Kansas City, MO: Nazarene Publishing House, 1982), 51-53. One reason why the mission felt the loss of Grose particularly strongly was that his death left behind an entirely female missionary staff at Tavane, a situation that remained in place until the end of World War II. His widow and young daughter remained at Tavane to work alongside Minnie Martin and three other single missionary women.
No one from Tavane ever took a direct hand in the leprosy work in Swaziland, but it still had some significant and rather specific effects on the shape of that future work. For one, it was the existence of the Tavane leprosy colony that had directly led to the arrival of Elizabeth Cole for missionary service in the region, as she named the work among leprosy victims in Portuguese East Africa as her specific “area of interest” on her 1934 application.\(^{11}\) Cole accepted assignment to Swaziland as a provisional step towards future leprosy work, and there was at least one opportunity in 1936 when she might have been transferred to Tavane to replace an ailing Minnie Martin, but Cole could not be released from the RFM Hospital at the time.\(^{12}\)

Probably more significantly, the Tavane work served as a primer for the Nazarene missionaries in the powerful spiritual resonance of leprosy work with overseas supporters and linked them to broader networks of outside support across denominational lines. C.S. Jenkins expressed some of the peculiar power of leprosy work in a 1930 letter to his superiors back in the United States when he explained to them that, because the American Mission to Lepers already provided adequate financial support to operate the leprosy colony, “I have felt that perhaps this (leprosy) work should not be stressed among our people too much at home. It seems to touch a responsive cord in nearly every consecrated heart.”\(^{13}\) Dr. Terril, the Methodist who arranged the 1930 transfer of the

\(^{11}\) Elizabeth Cole, “Preliminary Information Form,” September 5, 1934, File 211-54, “Foreign Missions Correspondence, Applicants,” NA.

\(^{12}\) Minnie Martin to J.G. Morrison, October 24, 1936, File 208-19, NA.

\(^{13}\) C.S. Jenkins to J.G. Morrison, July 16, 1930, File 207-43, “Foreign Missions Correspondence, Jenkins, 1929-31,” NA.
Tavane mission station and its leprosy colony into Nazarene hands, had also orchestrated, in that same year, the donation of £100 of American Mission to Lepers money as seed money to help David Hynd start a leprosy work in Swaziland (referenced in chapter 1). Although Hynd did not share Jenkins’s reluctance to push leprosy work in front of other Nazarenes, the links he established with with Christian agencies like the Mission to Lepers would play a crucial role in supporting the later work at Mbuluzi.

The Tavane experience, then, served as an important precursor to the subsequent Nazarene work in Swaziland, especially in establishing a pattern of leprosy care that placed the spiritual transformation of the leprosy sufferers at the center. As explained in the previous chapter, the Nazarene missionaries responsible for the Mbuluzi Leprosy Hospital moved quickly to shape it according to this particular vision. Many of their first efforts, however, were more or less superficial, such as the choice of names applied to the various villages where resident patients were to live. But as time went on, the missionaries were increasingly bold in shaping the institution according to their own norms. Some early concessions to government expectations, such as allowing the use of tobacco by patients, went by the wayside. A 1958 published list of rules for the institution, for example, expressly prohibited patients from smoking tobacco.¹⁴

Fittingly, in the year after the government’s decision to extend the memorandum of agreement with the Nazarene mission, the most permanent and visible symbol of the ascendance of the spiritual reached completion with the construction and dedication of Mbuluzi’s church building. Though by no means an elaborate building, the church stood

¹⁴ “Rules for Themb’elihle, 1958,” David Hynd Collection, NA.
prominently at the physical and visual center of the settlement, a stone’s throw from the hospital building. Some of the factors in this choice of site were practical: church services were often being held outdoors because, although a multipurpose recreational building with adequate space existed, the missionaries wanted patients with limited mobility and receiving care in the hospital building, which stood somewhat distant from the other original structures, to be able to attend alongside the other patients. Constructing the church in proximity to the hospital ensured that patients who were staying in the hospital could reach the church as needed. But the symbolic significance was also impossible to miss; the hospital and church building, standing virtually alone in the center of the colony reminded everyone that Mbuluzi’s staff aspired to healing for both body and spirit.

There is no evidence to suggest that the Nazarene missionaries ever lost their commitment to this dual role in leprosy work, or in medical missions more generally, nor their conviction that mission organizations were the preferred option for conducting leprosy work. To the contrary, in May of 1963, while consulting about the potential opening of a new leprosy work in Nyasaland, Hynd wrote, “BELRA is not a religious organisation, and we feel the deep spiritual and social need of these people would be met, as well as their physical need, by a missionary organisation like ourselves.” The fact that Hynd had approached BELRA, the British Empire Leprosy Relief Association, in earlier years to support his own work in Swaziland or the fact that it had many Christian

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15 David Hynd to A. Donald Miller, 16 March, 1955, David Hynd Collection, NA.
members and connections to Christian charities apparently was insufficient in Hynd’s perspective. Leprosy work was missionary work, a linkage that existed in most parts of British colonial Africa.

But Hynd and his colleagues certainly were not under the impression that leprosy work needed to be exclusively Nazarene work; rather they worked diligently to broaden the base of sympathetic supporters who would undergird their work and its spiritual vision. Here again, timing proved to be critically important, as the work at Mbuluzi was just getting off the ground at the same time that the Mission to Lepers was seeking to expand its reach in the region by opening an auxiliary branch in South Africa. Though the international organization had already given a grant of £150 annually to underwrite the secondment of Elizabeth Cole to Mbuluzi in 1947, the founding of a South African office made the Mission to Lepers the single most prominent ally of the Nazarene mission’s work at Mbuluzi over the coming decades.\(^\text{17}\) In launching its South African branch, the international organization in 1947 appointed as its secretary for the region the Rev. Frank Oldrieve, a Baptist minister living in Natal who had been a key figure in previous years for both the Mission to Lepers and especially for BELRA during its early years in the 1920s.\(^\text{18}\) As it happened, Oldrieve was visiting Swaziland consulting with the Nazarene missionaries, Mr. Sowden, and administration figures in March of 1948 when a stroke very suddenly took his life. After his burial in Mbabane’s cemetery, it fell to Hynd to cable the news of his passing to the international offices in London. Despite the

\(^{17}\) On the grant underwriting Elizabeth Cole’s salary, see David Hynd to A. Donald Miller, 1 September, 1947 and F.G. Torrie Attwell to David Hynd, 20 October, 1947, David Hynd Collection, NA.

tragedy, Oldrieve’s visit had helped seal the support of the Mission to Lepers for increased Nazarene involvement at Mbuluzi, and given the relative paucity of leprosy in the region along with the relatively well developed South African economy, Mbuluzi was well positioned to benefit from this growing relationship.\textsuperscript{19}

The church building itself was only the most visible fruit of this relationship. Hynd knew with certainty that the government, with its reluctance to pay for even an electric power supply, would never consent to paying for the construction of a church building, something that clearly lay outside their institutional vision. But early in 1955, having just assisted in the completion of a major filming production discussed later in this chapter, Hynd asked the Mission to Lepers to consider a grant of £600 for the construction of a church building with capacity to seat 120 people.\textsuperscript{20} It took less than a week for the organization’s council to agree to this request, though the project itself would take more than two additional years to complete. Over the years that followed, the Mission to Lepers would help supply the Mbuluzi settlement with many additional resources, such as clothing, medicine, and even vehicles. In nearly every case, the church, rather than the hospital, served as the backdrop of most of these interactions, both in stories told and in the photographic record.

Because it had been chosen with the idea that its doctor would travel up from the government center at Mbabane, the site of the Mbuluzi Leprosy Hospital was not particularly convenient for the missionaries of the Church of the Nazarene. But the

\textsuperscript{19} David Hynd to A. Donald Miller, 24 March, 1948, David Hynd Collection, NA.

\textsuperscript{20} Hynd to Miller, 16 March, 1955.
journey along the single dirt road that provided access to the hospital, which was not infrequently rendered impassable during the rainy season, became an essential part of the narrative that surrounded the leprosy work. While Cole made Mbuluzi her permanent residence, Hynd and his successors supervised the leprosy work from the growing Nazarene mission at Bremersdorp, approximately 35 miles away. The supervising doctor typically visited the leprosy hospital twice each month, prescribing treatment for new arrivals, following up on the progress of the other residents, and performing the occasional surgical procedure resulting from the progression of leprosy. The isolation of the hospital may have complicated the work from a logistical perspective, but it added significantly to the romance of leprosy work in many people’s minds, as well as the perceived heroism of those who carried on this work. Observers who made the pilgrimage to Mbuluzi frequently commented admiringly on Elizabeth Cole’s ability to endure the isolation of Mbuluzi, implicitly disregarding the fact that she had the company of dozens of leprosy patients at all times.

Indeed, life at Mbuluzi more closely resembled a rural village community than a secluded prison, albeit one suffused with a Protestant Christian ethos. Those patients physically able to do so contributed to building maintenance, growing crops, herding or milking cattle, and other activities aimed at the economic maintenance of the settlement. As in the Westfort model, patients who contributed to such activities received some minimal financial compensation for their labors, but wages were tightly controlled. Schooling was typically available for children, usually with yet another of the patients as their teacher, and when the numbers of girls was large enough, they organized a Girl
Guides troop. Church attendance was obligatory, and although only a minority of the patients came from any kind of Protestant background, it was Nazarene missionaries who generally conducted the services, and the most frequent non-Nazarene participants came from the neighboring station of the South Africa General Mission, which helped ensure a prevailing Protestant ethos.\textsuperscript{21}

Several of my informants also recalled participating in what was probably Mbuluzi’s most enduring ritual, the annual dramatization of the Christmas story enacted by the patients on the grounds of the hospital. Christmas and Easter, as days of high religious significance in the Christian tradition, had already for some time been seasons when the missionaries at Bremersdorp had prioritized visits to the Ncabaneni settlement, but the grounds at Mbuluzi provided a spacious canvas for enlivening these occasions. The idea of dramatizing the Nativity was actually Mrs. Sowden’s innovation, as she orchestrated a performance in 1949 entitled “No Room in the Inn.” In an article for \textit{The Times of Swaziland}, A.J. Sowden described the proceedings:

> The natural beauties of the Mbuluzi Valley provided a delightful setting for a Nativity Play... The play was performed out of doors and the parts of Shepherds, Inn-keeper and wife and Joseph and Mary were magnificently portrayed by leper patients... Visitors from the S.A.G.M. Girls School and from Mbabane were very impressed by the talent displayed and by the natural acting of the cattle in the stable and the donkey.\textsuperscript{22}

\textsuperscript{21} Tabulating the religious identities of Swazi patients at Mbuluzi is an imprecise science at best, but the admission cards of patients did include an entry for the patient’s “Religion.” For those patients whose cards had an entry, the most common identifiers were Roman Catholic and Zionist, the most numerous of Swaziland’s African Instituted Churches. On the Zionists, see Bengt Sundkler, \textit{Zulu Zion and Some Swazi Zionists} (London: Oxford University Press, 1976).

Such reenactments became the center point of Mbuluzi’s Christmas observation, with the performances enduring at least well into the 1970s. But the day also commonly included church services, feasting, and gift giving, typically funded by outside support. The significance of outside support was emphasized at that 1949 Christmas celebration by Resident Commissioner Beetham who was himself among the visitors and gift-givers that day. His address to the leprosy patients, as reported in Sowden’s news article, emphasized that there were “... many many people in Swaziland, and in fact all over the world who are thinking of you here at Mbuluzi.” Beetham meant his message to communicate to the patients their good fortune at having so many who cared about their condition as well as access to the medicines that would cure them of their leprosy, but it is more difficult to ascertain just what the Swazis made of these times when these ‘pilgrims’ from other parts of Swaziland, South Africa, and abroad visited.

The pilgrims to Mbuluzi were of different kinds: missionaries, resident commissioners, colonial health officers, OXFAM consultants, members of the local Red Cross chapter, and more. In its early years especially, when the hospital was still relatively strongly linked to the British administration, it may have received its most well known visitor, the Lady Baden-Powell, head of the international Girl Guides organization. On a tour of Africa in early 1950, Lady Baden-Powell stopped for an inspection of the Girl Guides Company that had been organized at Mbuluzi, again at the

23 Ibid.

24 Many of these visitors were just as impressed with the work at Mbuluzi as any of the missionaries. One sign of this came in 1961 when the British government awarded Elizabeth Cole the dignity of becoming an Honorary Member of the Civil Division of the Order of the British Empire.
initiative of Mrs. Sowden, who was working with the assistance of Miss Nora Earnshaw, a Nazarene nurse at the hospital. The programme for her visit included both traditional activities of Girl Guide Companies, such as the building of the Tree of Guiding on which the girls placed cards explaining the steps to different badges, and elements that were more peculiar to the leprosy colony context, such as demonstrations of the handicrafts the girls made in conjunction with occupational therapy and the preventive exercises which were meant to help the girls avoid the paralysis that could result from nerve damage associated with leprosy. Some months later, upon her return to London, Lady Baden-Powell would recall in a radio news interview that her visit to Mbuluzi was one of two chief highlights from her tour, particularly a display of Old English sword dancing that was included in the programme. Baden-Powell was herself not above the enchanting romance of the leprosy work, but her language in the radio interview is telling. Like Sowden in his news article for The Times of Swaziland, Baden-Powell referred to the company at Mbuluzi not as the “Girl Guides Company of the Mbuluzi Leprosy Hospital” but simply as the “Leper Guides,” an obvious reminder of their distinct status in the mind of this foreign pilgrim, as with so many others.

The most common pilgrims, of course, were local missionaries, many of whom journeyed to Mbuluzi on get-away excursions, seeking rest and spiritual renewal for their own work in other parts of Swaziland or South Africa. The correspondence files of Elizabeth Cole, David Hynd, and others are simply replete with examples of people

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visiting Mbuluzi at various intervals and for varying lengths of stay. The isolation of Mbuluzi attracted them for many reasons; in at least one case, an unmarried female missionary who had become romantically involved with one of the mission’s married men spent a few weeks at Mbuluzi simply to stay out of the public eye for a bit after being forced to resign.27 Another missionary was assigned to the leprosy hospital for educational work when her health had failed under the demands of her previous station, with the hope that the atmosphere at Mbuluzi would prove less demanding and allow her to physically recuperate while still engaged in productive activity. David Hynd himself, after his retirement from the RFM Hospital in 1961, took up residence at Mbuluzi and continued as the medical superintendent there until 1967.

Most of the pilgrims, however, were truly visitors. Some made the journey routinely and still remembered it with a fond nostalgia years later. In 1977, R.S.W. Ford, from the Mission to Lepers, recalled of his first journey to Mbuluzi in 1950 that his ‘old Pontiac scarcely took the indignities of long journeying and an appalling ten miles or so up a travesty road through Pine Valley to Umbuluzi.’28 Ford was, at a minimum, an annual visitor to the settlement, typically around the Christmas season, and always accompanied by ‘the usual cargo of comforts and good things for your patients.’29 Other pilgrims to Mbuluzi traveled greater distances. Overseas visitors with connections to the


28 R.S.W. Ford to David Hynd, 1 November 1977, David Hynd Collection, Nazarene Archives, Lenexa, Kansas.

29 R.S.W. Ford to Nita Clegg, 28 September 1976, David Hynd Collection, Nazarene Archives, Lenexa, Kansas.
mission, such as representatives from the U.S. headquarters of the Church of the Nazarene, made the leprosy hospital a routine stop on their itineraries. These journeys commonly sparked the kind of language found in this account from an anonymous visitor to Mbuluzi in 1957:

The winding road took us through Swaziland’s fascinating scenery … But my thoughts were suddenly cut short, for here was the end of the road, and before us the locked gate of the colony. I braced myself from the harrowing sights I was sure to encounter within. We were met by Miss Cole with a smile of welcome and a very acceptable cup of tea; and then to work, laden with oranges, sweets and bread from the Red Cross. We went in search of the patients in various parts of the grounds – some on the lawn, basking in the sun, some busy at tasks they were able to do; one old lady with only one hand was attempting knitting, and very proud of the result!

As we said our good-byes and heard the gate click behind us, a surge of admiration welled up in me for all those who devoted their lives and efforts to the alleviation of suffering, for doctors and nurses, for missionaries and Red Cross visitors, for the heroic staff who have chosen to live in comparative exile for the sake of a band of stricken people – and lastly for those who contribute funds so that this work of mercy may go on.30

Here, the stark contrast between the ‘stricken’ leprosy patients and the ‘heroic staff’ produces a profound paternalism. But it is problematic to conclude that this author’s condescending attitude was an expression of a generic paternalism applied to all Swazis. After all, most of the ‘heroic’ staff, who had chosen this ‘exile’ at Mbuluzi, were Swazis, including nurses, chaplains, and agricultural supervisors. It is true that people of European descent always held the senior positions of supervising physician and nurse matron, but Swazi Christians who answered the call to leprosy work could share in some of its heroic luster, if only in clearly circumscribed ways.

Within those limits, the Nazarene staff recognized the important roles that Swazi Christians played in helping them build their desired Christian community at Mbuluzi. A letter from Dr Hynd to the General Secretary of the Mission to Lepers, London, is indicative of this preoccupation with building a Christian community and the roles Swazis assumed within it:

One of our female Swazi teachers trained in our mission teacher-training course here at Bremersdorp came of her own accord expressing a call to give herself to the work of teaching in the school at the colony. She is one of our finest girls and we are deeply grateful to God for His Spirit’s working in her heart without any pressure from any other source. There has been a distinct improvement also in the general discipline and morale of the place since the admission as a patient of a very outstanding Christian Swazi. While sorry that this disease should have overtaken him, we are grateful that such a man should be living amongst them in the male village. He takes his stand on the side of right every time.31

Convincing patients of their need for a double cure of their physical and spiritual selves was, therefore, a process significantly eased with the participation of other Swazis.

Notably, those who filled these roles, such as the teacher referenced in Hynd’s letter, were responding to a spiritual “call,” the same sort of language that so powerfully shaped the life of Elizabeth Cole, as we saw in chapter two.

Conversely, when the missionaries found themselves dealing with Swazis who did not have a call to leprosy work and whose interest in the spiritual dimensions of the work may have been lacking, they were anxious to be rid of their influence as soon as possible. Just as Hynd and Cole were glad for Mr. Sowden’s departure because of the way in which they perceived that he was a detriment to the spiritual atmosphere at Mbuluzi, Swazis who did not share the vision became impediments to the work. A clear example of this

31 Hynd to Miller, 3 May 1952, David Hynd Collection, Nazarene Archives, Lenexa, Kansas.
was the tenure of Hugh Mason Ntisane, the government appointed agricultural
demonstrator who served at Mbuluzi during its first two years of operation. Although
praised by Sowden for his “loyal service” and as an “excellent worker,” the missionaries
quickly came to regard Ntisane as a troublemaker. Shortly after Sowden’s departure
and while Elizabeth Cole was in the United States on furlough in 1950, David Hynd
began conversations with the two missionary women serving at Mbuluzi regarding what
should be done about Ntisane. Arrangements had been made for his transfer to another
assignment within the Agricultural Department until, in July, Ntisane attended revival
services hosted by two female Bible students. As a consequence of those services,
Ntisane had reportedly confessed his wrongdoing (the exact nature of which is left
unspecified in the correspondence) and changed his behaviors in alignment with the
missionary expectations. This, in turn, caused the mission to request that his transfer
order be rescinded, and all was well until November, when the missionaries learned that
Ntisane was responsible for the pregnancy of Fanny Dlamini, the unmarried daughter of
Mbuluzi’s chaplain, Rev. Samuel Dlamini. This discovery brought Ntisane’s swift
removal and replacement with another man who had ties to the Nazarene church. In
Hynd’s assessment just weeks after these events, “Already there is a different atmosphere
about the place and a relief from strain.” Nearly thirty years later, a new generation of
missionaries found themselves dealing with a similar situation, trying to rid themselves of

1367-2, “RFMH Reports, 1941-1950,” NA.

33 David Hynd to Elizabeth Cole, 26 November, 1950, File 1366-17, “Letters to Missionaries, 1950-51, A-
G,” NA. See also, David Hynd to Elizabeth Cole, 27 September, 1950, File 1366-17, NA.
the perceived deleterious influence of an agricultural worker whose “spirit has not been
good from the beginning.” In the decades in between, the staff at the Mbuluzi Leprosy
Hospital had expended a considerable amount of energy working to maintain the proper
“spirit” about the place and to identify the people called to contribute to the work.

No individual Swazi more clearly embodied the significance of the divine calling
or played a more prominent role in the leprosy work at Mbuluzi than its first chaplain,
Rev. Samuel Dlamini. A member of a prominent family in Swaziland’s royal clan,
Samuel Dlamini had been one of the early converts of the Church of the Nazarene,
receiving baptism and membership in the denomination under the ministry of the
founding missionary, Harmon Schmelzenbach. He had gone on to become, in 1939, one
of the four men who became Swaziland’s first class of ordained elders during the visit of
General Superintendent J.G. Morrison. Just two years later, Dlamini volunteered, in
response to a calling from God, to serve as the chaplain for a unit of Swazi soldiers being
deployed to North Africa and, eventually, Italy. Dlamini served with distinction in the
army from 1942 until the end of the war in 1945, earning promotion to the rank of
sergeant major and five medals for his service. The service of the Swazi regiments
became an important feature in the collective identity of the Swazi nation,
commemorated, for example, in the praise poetry of Sobhuza II. Dlamini’s service to

34 Nita Clegg to Samuel Hynd, March 6, 1977, Correspondence File #24, “Leprosy Hospital (L6),

II: Aesthetics, Language, and Literature, ed. Steven P.C. Moyo, Tobias W.C. Sumailia, James A. Moody
(University of Zambia, 1986), 194-6.
his nation and his church earned him considerable stature as a recognizable leader with a strong reputation for holiness.

It was not long after his return from the war that Dlamini experienced the call of God upon his life once more, this time in the form of the prayers of his own twelve-year-old son, Allen. In 1949, an article in *Umphaphamisi*, the periodical of the Church of the Nazarene in Swaziland, had appeared reporting on the great need for a chaplain to come to the new Mbuluzi Leprosy Hospital to provide spiritual leadership for the patients. That night, during their family prayers, as Allen prayed for God to call someone to Mbuluzi, his father felt as though God were pointing directly at him, instructing him to offer himself for this role. The narrative of Samuel Dlamini’s decision to follow this calling was one that fit exceptionally well with the pietistic associations of the Nazarene missionaries with leprosy work, and the story was one that they told and retold in a variety of contexts. Its most extended form appeared in a short biography of Dlamini distributed by the church’s publishing house and missionary society to churches throughout the United States and beyond. In that account, Marjory Burne and Helen Temple described Dlamini’s decision and the reaction to it in the following language:

Many could not understand his willingness to go to such a place. Some were astounded that he would give up the honored position of district leader to take this humble and undesirable assignment with the leprosy patients. But to Samuel there
was no thought of stepping down. Any assignment God gave was an honor he was proud to accept.36

Careful attention should be paid to the depiction of his decision as one that was “humble and undesirable.” Just as Elizabeth Cole was heroized for her ability to endure the isolation of Mbuluzi in service of the “lepers,” so too, did Swazis such as Samuel Dlamini see their spiritual authority increased by the decision to join the work. In Dlamini’s case, the narrative was only further dramatized when, after about a year of service at Mbuluzi, his wife fell ill and passed away and then, beginning in 1956, his sight, which had first given him trouble during his military chaplaincy, began to fail more dramatically. By 1962, Dlamini was completely blind and ready to step aside from his service at Mbuluzi, though he and his second wife, who also became an ordained elder in the Church of the Nazarene, continued in ministry for more than twenty additional years.

The stories of personalities such as Samuel Dlamini emerged front and center as the missionaries of the Church of the Nazarene worked to frame the story of Mbuluzi in their own terms. Marjory Burne, in an article reflecting on the anniversary of the opening of Mbuluzi, wrote of the new found spiritual and physical health of the Mbuluzi residents, “We can attribute much of their spiritual well-being to the work of our Swazi Nazarene pastor, Rev. Samuel Dlamini, who is called of God to take up this work among the lepers.” Describing the “great burden he has for these people,” Burne made reference

both to Dlamini’s work in teaching and preaching, as well as his work aiding patients with their “difficulties, many of which are domestic problems resulting from their segregation from their families...” The result of Dlamini’s work, in tandem with the efforts of the missionaries, was that many of the patients had become Christians, and “some have real victory in their hearts,” a reference to the holiness concept of sanctification.

Some of this was forced optimism, of course, meant to cover over more complex realities. No public version of Dlamini’s life, for example, ever made reference to the troubles he experienced with his own children, which apparently went beyond the pregnancy of his unwed daughter. This, on the one hand, was just common politeness, but the missionary correspondence makes it clear that these family matters had tangible effects on his work at Mbuluzi, causing him to be absent for prolonged periods while dealing with matters at his Ndzingini home and leaving him vulnerable to allegations of hypocrisy from patients who were unhappy about his interventions in their own lives. And the patients themselves did not always cooperate with their own spiritual regeneration. Just months after the first anniversary about which Burne wrote such a glowing report had passed, in a more unguarded moment, Cole wrote to Burne the note referenced in chapter two about her feeling that everything would have been in vain if they did not soon see “the lepers turning to God.” For Cole, and for her missionary


38 See, for example, David Hynd to Elizabeth Cole, 30 January, 1951, File 1366-17, NA. Or, Elizabeth Cole to David Hynd, 1 February, 1954, Box 2499, Unprocessed Correspondence, NA.
colleagues, this was paramount. She went on to write, “I would rather be blotted completely out of the picture these folks can not be won for Jesus.” The public narrative about Mbuluzi never included these sorts of confessions or troubles and thus diverged in significant ways from the realities of the situation.

Nevertheless, the missionaries persisted in pursuit of the goal of causing lepers to turn to God, and in this endeavor, they very much had time on their side. If medical missionaries in other areas of work sometimes debated the dilemma of discharging a patient who was physically cured but who had resisted their offers of a spiritual cure, leprosy treatment at inpatient facilities like Mbuluzi rarely presented such a tension. Because the efficacy of leprosy treatments was uncertain and the course of the disease unpredictable even with the advent of Dapsone and other antibiotic therapies, patients generally stayed for years at a time, even when their leprosy symptoms may have subsided. This meant that there was ample time to present them the opportunity to take up an alternative life. The response of the leprosy patients to the alternative life offered at Mbuluzi varied significantly.

Mbuluzi’s relatively small size probably helped save it from experiencing the kinds of large-scale mobilization and rebellion that Eric Silla and Simmone Horwitz describe at the Djikoroni Institute in Mali and the Westfort Leprosy Institution in South Africa respectively. But this is not to suggest that the patients at Mbuluzi never raised

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39 Elizabeth Cole to Marjory Burne, March 10, 1950, File 1312-24, NA.
objections to the conditions of life at Mbuluzi. Segregation at Mbuluzi may have been nominally voluntary, but the mission still attempted to shape the life of the settlement according to its own social and moral norms. Not everyone was willing to accept the resulting curtailment of their choices. Some patients ran away, alleging neglect and very poor living conditions. My informants also mentioned instances of patients sneaking away to get alcohol or refusing to participate in church services.

Issues surrounding sexuality cropped up fairly frequently, as the mission ideal was for far-reaching gender segregation and for patients to abstain from romantic or sexual relations with anyone at all. The 1958 rules, for example, established clear boundaries: “Male and female patients are not allowed to enter the village of opposite sex, or converse with the patients there at any time without permission.” Furthermore, the exchange of letters between patients of opposite sexes, understood as a precursor towards engagement and marriage, was prohibited. Patients routinely tested those boundaries, whether in developing relationships with patients of the opposite sex or sneaking people in or out for sexual liaisons. The missionaries were more understanding when patients rebelled against their isolation from spouses, and they tried to offer assistance when family circumstances called for interventions. But even here, the line was drawn quite clearly on issues of sexual intimacy; when the wife of one patient who had been a


41 Miriam Mbila, interview by author, 29 June, 2009.

42 “Rules for Themb’elihle, 1958,” David Hynd Collection, NA.
repeated source of trouble on this issue also developed leprosy, the missionaries were restrained in their comments but clearly felt vindicated in their conservative approach to contact.

In one chapter of Elizabeth Cole’s book about Mbuluzi, she crafted a series of four stories regarding the various ways in which patients rebelled against the rules at Mbuluzi. The chapter first recounted how a search for “witchcraft paraphernalia” in the patient residences had left hospital staff “loaded with sacks and tins containing horns, bones, foul-smelling concoctions, huge teeth, and many weird objects.” This was, in turn, followed by the uncovering of a scheme for brewing traditional Swazi beer in one of the men’s villages and the confiscation of “eight gallons of very intoxicating liquor.” Not long after this, Cole learned from the incensed wife of a male patient that young women from “just over the mountains” were visiting the men’s villages at night, which led to yet another intervention by Cole. Finally, Cole discovered that patients were growing dagga (marijuana) around their residences. This story, one of the more commonly recollected stories that former missionaries recounted to me came in varying renditions: one version claims that it was an agricultural agent of the government who duped the unwitting patients into growing dagga for him. Another version, and the one Cole herself recorded in her book, suggests patients were growing the dagga for themselves. But the best evidence suggests that Cole was convinced that the patients were knowingly growing dagga at the direction of Hugh Mason Ntisane, the former agricultural demonstrator who was sneaking back into the colony at night to remove the dagga and export it to South

43 Cole, Give Me This Mountain, 57-60.
Africa for sale. In the letter Cole wrote to Hynd in which she made this accusation, she was very careful in her choice of words, as she believed that not only Ntisane, but the man who was serving as the colony’s school teacher were involved, and she was afraid that there would be trouble in the colony if the information was revealed prematurely, including possible reprisals against the patient who had been her informant.  

Whether reprisals were likely or not, these incidents do help us understand something of the cultural gap that existed between Swazi patients and missionary ideals.

I have already made reference in chapter one to the reluctance of Swazis to rely exclusively upon Western medical regimes for treatment, and there is nothing in the documentary evidence relative to Mbuluzi’s history to suggest that the patients as a whole ever ceased using traditional Swazi remedies more than temporarily. Beer brewing and consumption were likewise firmly entrenched components of traditional Swazi social life, especially during the rainy season (as was the case in this incident) when beer was the one essential reward for participation in the communal work parties that undertook the difficult labor of preparing and maintaining fields for the year’s crops. What Cole condemned as both illegal and immoral behavior, the patients involved likely saw as

44 Elizabeth Cole to David Hynd, c. January, 1952, Box 2499, “Unprocessed Correspondence,” David Hynd Collection, NA. In her letter, Cole carefully avoided naming Ntisane, but made an unambiguous reference to the man responsible for this activity as “the father of Fannie’s baby.” I have found no further evidence regarding any further possible fallout from this incident.

merely a reasonable reward for their completion of the labor that Cole and her associates compelled them to do.

The Swazi perspective on dagga was in some ways similar to the beer issue. Although difficult to establish with precision the date for the arrival of dagga in the region, Brian du Toit has compiled a convincing case for dating its migration into Southern Africa via Indian Ocean and East African trade routes to a period at least several centuries prior to the advent of European voyages of exploration. Consistent with du Toit’s assessment of dagga use across the region, Brian Marwick described the smoking of dagga as “a habit very firmly entrenched” in Swaziland, especially as a leisure activity among older men and as a stimulant for men in the army before entering into battle. In P.A.W. Cook’s 1931 collection of *tibongo* (praise poems) connected with the men who had ruled as the Swazi Ngwenyama, dagga and the implements used for smoking it appear in two of the poems in a totally matter-of-fact fashion. Similarly, a proverb used among the Swazi declares, “indzaba itfungelea egudwini,” which roughly translates, “He is a topic for discussion over dagga smoking pipes.” While one has to be careful about generalizations across wide spans of time, there certainly seems to be evidence that

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moderate dagga consumption was a relatively common occurrence in Swaziland and across the region, which might legitimately lead to confusion or consternation among Mbuluzi’s patients at the harsh condemnation of the practice by the missionary staff.

But the incident at Mbuluzi is further illuminated by some knowledge of the particular moment in which it transpired. In the same year as the incident at Mbuluzi, for example, South Africa’s *DRUM* magazine ran a feature story painting a picture of a very lively dagga trafficking system operating throughout the region and arguing that it constituted a major public menace that needed to be corrected. Furthermore, in the late 1940s and early 1950s, law enforcement agencies in both South Africa and Swaziland had embarked upon concentrated efforts to squelch this black market exchange both between and within the two countries. Also in 1952, the South African government published a major study on dagga abuse in the country, which included an investigation of the traffic by way of Swaziland and the other High Commission territories. The report affirmed the idea that dagga consumption had a long history in the region and the view that police forces across the region needed to be cracking down on trafficking as a public menace. Of all the surrounding territories, the investigation found Swaziland to be the heaviest source of imports, though it was unclear how much was locally grown and how much Swaziland served as a conduit for trafficking dagga from Portuguese East Africa and Zululand into the urban centers of the Reef.


Swaziland’s dagga trade flourished not just on its environment’s ecological suitability for growing the plant, but also on the exceptionally high regard for the quality of its product around the region, a reputation that has apparently held true right up to the present. The 1952 government investigation noted that Swazi dagga commanded a higher price than that from other areas because of its popularity, and du Toit’s research in the 1970s found the same thing to be true.\textsuperscript{52} He found numerous individuals who placed “their only faith in cannabis from Swaziland,” and referenced one informant who made the following report:

\begin{quote}
.... he always gets his cannabis from Swaziland because his ‘wise’ forefathers who were in charge of Shaka’s ‘impis’ (regiments) used to make an expedition to Swaziland to get dagga for the Royal family and ‘indunas’ (chiefs) because it was believed it was the best obtainable in the country.\textsuperscript{53}
\end{quote}

High demand meant that individuals continued to grow the crop in the face of police action aimed at disrupting the illegal traffic, and this seems to have been what was happening at Mbuluzi. The 1952 and 1953 annual reports of Swaziland’s Police Commissioner indicated that his force had made a concerted effort in those years to disrupt dagga production, which the authorities believed was having the desired effect. The report for 1953 concluded:

\begin{quote}
Police patrols are now engaged in obviating this traffic at its source by seizing and destroying plants before they reach maturity. Reports reveal that growers are now resorting to growing plants in containers suspended in the branches of large trees
\end{quote}

\textsuperscript{52} Ibid, para. 92.

in an endeavour to conceal them from Police patrols. Obviously only a very small quantity can be produced in this way.\textsuperscript{54}

Interestingly, in the South African government’s report on the police patrols in Swaziland and the other High Commission territories, it noted they they relied significantly upon “officials of the Veterinary Department” to help them identify areas for patrol, since their activities naturally took them to a wide variety of rural contexts where people commonly grew the plant.\textsuperscript{55} In other words, the police strategy relied precisely upon men such as Hugh Mason Ntisane, which may well have provided him with the confidence to attempt to develop his own dagga trafficking business on a government-controlled piece of property. The potential financial gains clearly outweighed the obvious risks, and Ntisane was apparently not the only one who saw it this way. In 1956, \textit{DRUM} published a two-part exposé on the dagga trade in and around the South African town of Bergville where a 1954 police raid had resulted in widespread violence and the eventual execution of twenty-two men. Even with the tragedy fresh in everyone memories, the \textit{DRUM} reporter found a flourishing dagga trade in the area, as the lure of ready profits proved too much


How much Elizabeth Cole and her missionary colleagues understood about this larger context is uncertain, but it certainly was not important to them in their recounting of the stories. In Cole’s book, each of these incidents with the patients became an opportunity for the Christian staff to overcome the “giants in the land.”\footnote{Ibid, 56. The phrase is itself a biblical image, drawn from passages in Genesis 6 and, especially, Numbers 13 that refer to the Nephilim and their descendants as giants. In the Numbers passage, these giants were the obstacle that caused the spies sent to spy out the Promised Land to give a negative report on the possibility of the Israelites taking control of the land and thus leading the forty years of wandering in the wilderness.} The resolutions were consistently the result of God’s provision, as he worked supernaturally to overcome the darkness that ensnared those who “for so many years had been in the midst of Satan’s strongholds.” In the dagga case, for example, the guilty patients, when confronted by the police with their wrongdoing, had suddenly become “very religious” protesting that the destruction of the plants should be delayed because it happened the the police had come.
on the Sunday. In Cole’s telling, her quick prayer for an answer to this plea was answered by the sudden recollection to her mind of the Gospel of John’s account of Jesus driving moneychangers from the temple: “The scripture was quoted and a comparison was made between the Temple that had been built for God at Jerusalem, and Tembelihle, which was built for God at Mbuluzi.” In this way, the deceitful intentions of the patients were overcome, and the “the old giant dagga... was literally chopped to death” under the watchful eye of the police and the chaplain.58 The stories, as framed by Elizabeth Cole, all dramatize the mission perception of their work as a fundamentally spiritual one, but each story also demonstrates the limits of mission control even over this small community. The nature of both the written and oral sources makes it impossible to quantify in any serious way the frequency with which such incidents occurred, but it is clear that the patients at Mbuluzi never surrendered their ability to act as autonomous human beings.

When issues of patient behavior did arrive, the missionaries were quick to invoke the moral and spiritual character of the community as a means of restoring order. In early 1975, for example, Sister Nita Clegg, who had replaced Elizabeth Cole after her retirement in 1972, found herself dealing with many of the same kinds of behavioral issues that Cole had described in the early years of the hospital. In need of assistance, Clegg wrote to Dr. Samuel Hynd, who had replaced his father as the Medical Superintendent at RFMH and for Mbuluzi, explaining her concerns about sexual relations between several unmarried patients and a recent incident in which one patient had

58 Ibid, 60-62.
attempted to use “muti” (traditional medicines) to harm another patient. Hynd’s response attempted to leverage the still considerable influence of his father, who, though at this time retired and living in Mbabane, was as well known a public figure as almost any other in Swaziland. He asked David Hynd to visit Mbuluzi to reinforce the rules that governed the institution, which he did on March 12, 1975. Summarizing his meeting with the patients, the elder Hynd explained that after meeting with the Swazi chaplain and his wife to get their assessment of the situation, he had called together a meeting of the patients in the church:

I gave them a little bit of the history of the Colony and how we had the backing of the Government and Swazi authority in the running of the place and that the laws we had set up for everyone to live happily and profit from their treatment etc. were in accord with Swazi custom, the laws of the Government and the laws of the church. I then went over all the type-written laws that we had set up and elaborated on each one. After reading each law and elaborating on it, I asked them if they heard well and if they agreed with the law, and all said ‘Yebo’ to each law. So I hope it may help them to have heard the laws all together in the church and that when any tend to break the laws some of the other patients may remind them of what I said.

Hynd’s account emphasized his position of authority to obtain the agreement of the patients to comply with community expectations. But choosing the church as the gathering place communicated clearly the significance of the spiritual considerations at play and the necessity of operating as a community that would abide by the rules.

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59 Nita Clegg to Samuel Hynd, 20 January, 1975, Correspondence File #23b, “Leprosy Hospital, 1974-1975,” Raleigh Fitkin Memorial Hospital Archives, Manzini, Swaziland.

60 Aside from the list of achievements referenced in chapter 1, David Hynd had served as a representative of the Swazi nation during the negotiations leading up to Swaziland’s independence in 1968.

61 David Hynd to Samuel Hynd, 21 March, 1975, Correspondence File #23b, RFMH.
Sister’s Clegg’s observations of the event emphasized the spiritual nature of the activity even more directly:

When your father gave out the rules it was a ‘blessed’ service. It was very impressive to me since I’d never seen anyone make rules such a ‘good thing.’ After reading each rule he would make them agree that it was a very good rule. It made me think he was Moses reading out the 10 Commandments and after each one saying to the people how good each commandment was. In spite of our difficulties with witchdoctor medicine and ‘izindabas’ this past year has been a blessed year and one of the busiest and happiest years of my life.62

Clegg was no novice missionary, overawed by the cultural dexterity of one of her seniors; she had been in Swaziland for 19 years at this stage. It was Hynd’s ability to evoke the spiritual authority necessary to restore the proper order of things that earned her admiration and which she understood to be the key feature in stamping out patient rebellion.

But while some rebelled in ways large or small, others embraced their life at Mbuluzi and the peculiar connections they derived from their presence at this mountaintop locale, which existed simultaneously as a medical institution and a sacred site. Certainly, embracing the identity of a ‘leper’ could bring a person unexpected notoriety in this context. At Mbuluzi, there was one patient, in particular, whose story brought unusual celebrity to himself and to the colony as a whole. That patient, a man by the name of Salakwanda Zulu, became in 1954 the subject of a biographical film produced by the Mission to Lepers, London. Shot in full color and sound, the 30-minute film recounts the story of Salakwanda Zulu from his rebellious early years living as a gangster working on the Rand, including a stint smuggling dagga across the Swaziland-

62 Nita Clegg to Samuel Hynd, 24 March, 1975, Correspondence File #23b, RFMH.
South Africa border while posing in a clerical collar, through his experience of rejection by family and friends while suffering from leprosy at Ncabaneni, to his later years as a disabled but joy-filled leprosy patient and Christian convert at Mbuluzi.\(^{63}\)

The Mission to Lepers used the film, *Salakwanda Zulu*, to great effect as a fundraising tool, and the film drew the Nazarene work at Mbuluzi quite tightly into their sphere of interests, enough that a subsequent film, entitled *The Good Heart*, was also shot on location at Mbuluzi. The staff and patients at Mbuluzi also generally seemed to appreciate the production. Patients at Mbuluzi watched *Salakwanda Zulu* in October 1955, and Dr. Reginald Jones, another Nazarene medical missionary who was supervising the Mbuluzi work while David Hynd was on furlough, reported that ‘they were very thrilled with it all.’\(^{64}\) One suspects that this comment may actually mask a more divided range of feeling among the patients, but it is difficult to believe that the patients at Mbuluzi would not have recognized that the film raised the overall profile of the leprosy work and brought them very tangible benefits, such as clothing, blankets, meat, medicines, bandages, school supplies, books, and more. It was not that such gifts were never sent to other areas of the work, but the pool of people willing to give in support of leprosy work was undoubtedly wider and deeper than it was for other areas of the

\(^{63}\) *Salakwanda Zulu*, director unknown, 1954 (London:??), 16 mm. film. Regarding Zulu’s use of clerical garb as an aid to drug smuggling, du Toit also noted men using the same trick while running drugs between Greytown and Pietermaritzburg in the 1970s (du Toit, *Cannabis in Africa*, 175).

\(^{64}\) Samuel Hynd to R.S.W. Ford, 27 October 1955, David Hynd Collection, NA.
mission’s work.\textsuperscript{65} As Megan Vaughan has noted, ‘It is not easy to assess the degree to which African leprosy patients ‘learned to be lepers.’”\textsuperscript{66} The case of Salakwanda Zulu, however, makes it relatively easy to see how powerful the appeal of this new identity as a Christian leper might be.

Zulu’s biography, in being told and retold in a variety of public settings, became the patient narrative equivalent of Samuel Dlamini’s heroic ministry narrative. His story was particularly appealing because he had suffered the most dramatic ravages of leprosy, ultimately losing his sight, most of his fingers, and both legs, which David Hynd was forced to amputate in order to halt the spread of a toxic infection. In his published testimony, Zulu affirmed what the film only implied when he shared with people that, ‘My present physical state, however, does not surprise me, for I believe that I am reaping that which I have sown.’\textsuperscript{67} Zulu, far from being beaten down by the hardships that resulted from his physical condition, was by all accounts a vibrantly alive personality. Outfitted with special boots to cover the stumps of his legs and a shortened set of crutches that preserved some degree of mobility, his boisterous singing and Christian devotion became one of the defining memories of Mbuluzi for those who lived, worked, and visited there in the years prior to his death on January 15, 1960.\textsuperscript{68}

\textsuperscript{65} People I spoke to at the Johannesburg office of the International Leprosy Mission (the renamed Mission to Lepers) suggested that this remains true today; even in the current global economy, they reported relatively little decline in giving to their leprosy work.

\textsuperscript{66} Vaughan, \textit{Curing Their Ills}, 85.

\textsuperscript{67} Quoted in Elizabeth Cole, \textit{Give Me This Mountain} (Kansas City: Nazarene Publishing House, 1959), 30.

\textsuperscript{68} David Hynd to F.G.T. Attwell, 16 January, 1960, David Hynd Collection, NA.
Following the production of the film about his life, Salakwanda Zulu became absolutely central in the relationship between the Mbuluzi Leprosy Hospital and the wider world. Whenever Hynd would write to staff members of the Mission to Lepers, for example, whether in South Africa or in the U.K., he would consistently make reference to Zulu’s life and general physical condition. In July, 1957, for example, when Hynd was communicating with Reg Ford about the dedication of the new church, built with Mission to Lepers money, the only specific detail he referenced about the dedication service was that “Salakwanda Zulu sang a solo at the dedication service, which was very touching.”

And they, in turn, would reliably inquire about his health or recall their personal interactions with him. In addition to his starring role in the film, Zulu was also one of Mbuluzi’s specially supported cases, and his sponsor was the Honorable Mrs. Arthur Gordon, one of the chief patrons of the Mission to Lepers in the U.K. who had visited Mbuluzi in 1951. Reginald (Reg) S.W. Ford, the Secretary for the Southern Africa branch of the Mission to Lepers, routinely used the story of Salakwanda Zulu in his work as he traveled the region raising awareness and drumming up support for leprosy work throughout the area.

When Salakwanda Zulu died, the patients and staff of Mbuluzi interred his body in a small graveyard, located along the western periphery of the colony, “surrounded by a group of sorrowing friends who had learned to love and respect him for the wonderful example he had set - a wonderful example of the victory of the spirit over the flesh.”

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69 David Hynd to R.S.W. Ford, 9 July, 1957, David Hynd Collection, NA.

70 David Hynd to R.S.W. Ford, 14 March, 1960, David Hynd Collection, NA.
Fittingly, perhaps, his passing was also commemorated in the London offices of the Mission to Lepers where “... an opportunity was taken at our Morning Prayers to pay a tribute to this fine old servant of the Lord.”\textsuperscript{71} The graveyard at Mbuluzi was generally only for those few patients whose families would not or could not come to retrieve their bodies upon their death, a small number indeed since the majority of patients at Mbuluzi eventually received their discharge and returned home healthy. In Salakwanda Zulu’s case, such rejection by family had become positively central to his new-found identity, and although one might look critically at the narrative of his life as chiefly a construct of the missionaries who relayed it to the world at large, there is little grounds to suspect that the narrative was one that he was reluctant to embrace for himself. Former patients old enough to remember Zulu, who were mostly children at the time, recalled both the fear they felt when confronted with the ravages of the disease on his body but also the warm and encouraging personality they encountered once the initial visual shock had passed. Whatever its unquantifiable spiritual effects on him, enacting the role of redeemed Christian “leper” seems to have been quite a sensible choice for Zulu personally.

Vaughan goes on to say that it is also difficult to tell how patients ‘felt about ceasing to be ‘lepers’ when they were cured, ‘cleansed,’ and sent home.’\textsuperscript{72} But, in Swaziland and elsewhere, it was possible for patients to maintain an identity as ‘lepers’ even after they were sent home. Their leprosy may have been cured, but there were continual fears that the condition might recur, to say nothing of the disabilities many

\textsuperscript{71} F.G.T. Attwell to David Hynd, 5 February, 1960, David Hynd Collection, NA.

\textsuperscript{72} Ibid.
incurred as a result of leprosy. For this reason, patients were always encouraged to return for follow up examinations, and many of them received visits in their homes from social workers charged with helping them cope with their disabilities. Patients did not always turn back up at the expected intervals for their medical follow up, but it was not unheard of for patients to simply reappear during the Christmas season, sometimes after extended absences. Others, whose permanent disabilities and/or advanced age meant that they were not necessarily warmly welcomed in the homes of their families became permanent residents of Mbuluzi, even if they no longer required treatment for leprosy. In some ways, cutting ties with the leprosy work was more challenging than continuing in its sphere of influence.

These dynamics of life at Mbuluzi resonate markedly with the kinds of dependence that James Ferguson describes with regard to the nineteenth century period of Ngoni expansion and development of an industrial capitalist complex in southern Africa. The parallels are imprecise, of course, between a militarily expansionist state, the labor recruitment and employment practices of the Witwatersrand Native Labor Association and its ilk, and a specialized medical institution whose only prolonged effort at active incorporation of new members (in the form of the Leprosy Survey) had been a rather abject failure. But Mbuluzi clearly was a place that drew people into a form of membership that was inherently unequal and yet fully social.

The Swazi men and women who submitted themselves to the treatment regime and peculiar patterns of social life at Mbuluzi, living as the objects of other people’s pilgrimage, seemed to see this, not as a humiliation, but as an opportunity to enter into
their own “quite full-bodied social membership.” Men and women like Salakwanda Zulu who allowed themselves to be assigned the “leper” identity received in return a fixed position within an identifiable hierarchy of people and resources in which both superior and subordinate had specific obligations to one another, a model of social relationships that likely resonated well with their own expectations. As Ferguson has argued, the people living within such systems did not understand relations of dependence as oppressive to their individual liberty; rather, those very relationships helped define both their personhood and that of their superiors, based upon a moral bond of mutual benefit to all parties. The leprosy patients at Mbuluzi, then, willingly entered into a relationship of dependence upon the pilgrims from the outside, because it created a strong mutual bond between them, one that they believed would continue to be beneficial to everyone.

Entering into this hierarchical relationship of dependence meant, to some degree, accepting a position defined by stigmatization leading to separation, concepts firmly rooted in a Western conception of the disease. There is, simply put, no evidence that Swazis ever developed a general fear of leprosy or any pattern of people being separated from households as a consequence of contracting the illness. The only patients who somewhat regularly experienced difficulty in returning to their homes after a stay at Mbuluzi were those like Salakwanda Zulu who were elderly and suffering from physical disabilities that would have made them a significant burden for any household. The correspondence between the various medical superintendents and nurse matrons who

73 Ferguson, ‘Declarations of Dependence,’ 225.
served at Mbuluzi over the years generally reflect some awareness that leprosy was not a particularly contagious disease, yet the mission’s public language reflected a more dramatized view of the disease as a contagion. Two of my informants, nurses who trained in the Nazarene nursing college in the 1950s and 1960s, remembered the anxieties that circulated among nursing students before their required visit to Mbuluzi for leprosy training. Others reported feeling anxious about leprosy as a consequence of stories they heard in mission schools and churches. Such fears were rather clearly not natural but the product of some Swazis’ encounter with Western culture.

Even if the staff generally knew in their minds that the dangers of leprosy contagion were relatively low, old habits of separation proved tough to shake. Hear again, for example, the language of Mr. Sowden and Lady Baden-Powell in remarking on the activities of the “Leper Guides,” holding up their distinctive quality as defined by their illness. In fact, nearly everything about the way Mbuluzi was organized reminded all of its inhabitants of the distinctions between “clean staff” and “lepers.” The housing area where the staff lived was off limits to patients. The church had two entrances, one for patients and one for staff, located at opposite ends of the building from one another. One of my informants, a frequent pilgrim to Mbuluzi as both a student and a teacher at the SAGM school nearby, recalled being given very clear instructions as to how to avoid infection by limiting her contact with the patients and washing her hands carefully with antiseptic solutions after attending services. Another pilgrim, this one a nurse from the RFM Hospital, devoted a whole letter to her friends and supporters at home to recount
her overnight visit to Mbuluzi, which included speaking at a Sunday evening service held weekly for just the “clean staff.”  

The rules of the colony further reinforced the centrality of separation. Of twelve rules published in the 1958 list, nine dealt explicitly with patient movement and communication. In addition to those rules regulating contact and communication between patients of opposite sexes, Mbuluzi patients were not to leave their assigned (and fenced) village communities without permission, except to go to the hospital. Their visitors were not allowed to enter the village areas, nor were they allowed to stay at the designated residence outside the colony for more than two nights. Patients were not even allowed to speak with visitors unless they had permission to do so. Such rigid and even dehumanizing rules stand in contrast to Elizabeth Cole’s seemingly conscious decision to abandon the use of the word “leper” quite abruptly in the year 1951. In part, she seems to have become conscious of the debates over the use of the word that were even then in the air as a result of a visit she made during her furlough to the Carville National Leprosarium in Louisiana, which was in the midst of a transformative era of its own thanks to the activism of its patient population and their battles against leprosy stigmatization. But even in Swaziland, the daily experience of life among Mbuluzi’s residents, her awareness of the differences in the progress of their illness, and the varying ways in which they responded to the life offered at Mbuluzi must surely have helped her

74 Elizabeth Clark to Friends, September, 1950, File 577-26, “Miscellaneous Newsletters, 1950s,” NA.

see the problems inherent in using a word that lumped together such divergent experiences.\textsuperscript{76}

If the experience of life with leprosy patients had a humanizing effect, what then accounts for the rigidity of the rules and their fundamental presumption of the need to create separation? The rules, it seems, provided the staff at the hospital a measure of control to which they could resort in times of crises such as the one Nita Clegg encountered in 1975 when David Hynd returned to the colony and compelled the patients to affirm the essential goodness of the rules for the community. But both written and oral sources regarding life at Mbuluzi suggest that these times were the exception and that what most patients experienced at Mbuluzi was a more humane connection constructed upon the mundane interactions of daily life. Despite the occasional crackdown on patient behavior in pursuit of a mission-inspired vision of orderliness, most patients willingly accepted these conditions as a means of gaining access to resources.

Certainly, there was room for them to be concerned. If the period of Mbuluzi’s construction had been a period of relative economic boom for Swaziland, new foreign investment had dramatically slowed by the 1960s. Nor was the newly independent Swaziland immune to the macroeconomic challenges confronting much of sub-Saharan Africa during the 1970s and on into the 1980s, as the visions of development offered by

\textsuperscript{76} Cole never explicitly explained her rationale for dropping the word, but in a letter dated 21 June, 1954 to David Hynd, she expressed her concerns to him about the intended use of the word in the narration of the Mission to Lepers film, \textit{Salakwanda Zulu}, noting that, “If the film is shown in America, Carville will go up in smoke if the word and the sickness are not dealt with wisely.” (David Hynd Collection, Box 2499, Unprocessed Correspondence, NA) Whatever the case, the shift in her language is quite pronounced; after her return to Swaziland from furlough in 1951, she abruptly ceased all use of the word “leper” and used the term “leprosy” as little as possible.
many post-colonial governments met mostly with disappointment. This, in combination with rapid population growth meant that many Swazis were once again left in search of bonds that provided certain basic kinds of security.\textsuperscript{77} The phenomenon that had played out a generation earlier within the confines of Ncabaneni was now amplified by the greater size of the Mbuluzi site and the permanent presence of Western missionaries who kept Mbuluzi connected to resources that never existed at Ncabaneni.

In its thirty-four years of operation, the Mbuluzi Leprosy Hospital never ceased to be an institution of medical care, and as noted in chapter three, its existence corresponded with some very dramatic developments in terms of the effectiveness of available medical treatments. There is no evidence that David Hynd and his missionary successors, acting in their role of Medical Superintendent of the hospital, were ever anything but conscientious about keeping the medical work at Mbuluzi apace with established best practice in medical care. Hynd’s personal papers, for example, contain substantial numbers of medical reports from outside sources on leprosy treatment as well as notes from several conferences he attended at the Westfort Leprosy Hospital. His annual reports, as well as those of his successors, routinely contained data on the medicines in use, the places from which new cases came, and other data useful in tracking the distribution of the disease around Swaziland. We have already seen how this commitment to best practices in medicine produced a dramatic, although temporary,

decline in patient numbers within the first two years of the introduction of Dapsone as the chief drug for patient treatment at Mbuluzi, and the medical staff continued to approach leprosy treatment in a dynamic fashion throughout the years. In the following chapter, we will see how the move towards using the WHO-recommended course of Multi-Drug Therapy contributed to the decision to close Mbuluzi entirely.
When Mbuluzi finally closed its doors in 1982, more than 600 patients had passed through the institution, for varying lengths of time. In most ways, the hospital was simply a victim of its own success. With dwindling patient numbers and increased confidence in the effectiveness of available medical treatment, a dedicated institution whose primary purpose had been to isolate leprosy patients from the general population was no longer necessary, a luxury that no one thought that Swaziland could afford. In place of the institutional model, Swaziland now adopted an outpatient model of leprosy control, no longer under the direction of Nazarene missionaries but in a new government partnership with the Leprosy Mission (Southern Africa), which introduced Multi-Drug Therapy into the country and ultimately helped Swaziland meet the World Health Organization’s definition for disease elimination.¹ By the time the partnership with the Leprosy Mission came to an end in 2005, the work of leprosy control in Swaziland was chiefly a rehabilitative one, checking up on a few cases, like Gogo Shiba, whose illness had led to their suffering permanent physical disabilities. The period defined by the final years of Mbuluzi’s operation through the eventual, albeit unofficial, shuttering of Swaziland’s entire Leprosy Control Programme saw circumstances in which there were

¹ In 1991, the WHO adopted a goal of eliminating leprosy by the year 2000, which meant fewer than one case per 10,000 people in a country’s population (as opposed to “eradicating” leprosy, which would imply that there were no cases remaining). See http://www.who.int/lep/strategy/wha/en/ for details.
some striking new developments, but also some very noticeable continuities with the approaches to the disease that had characterized the work over the prior seventy years.

If the need to be attentive to how one positioned oneself relative to shifting medical, financial, and political realities had been a constant thread in the narrative of this dissertation, then the final decade of Mbuluzi’s operation was entirely in tune with its past. Even in the latter years of Elizabeth Cole’s time of service, there had been some major shifts in the program itself. In fact, the year 1969 was particularly crucial. Prior to this, Mbuluzi had typically housed a resident population of between forty and fifty patients in any given month, numbers that had remained relatively stable since the introduction of dapsone in 1950. But in 1969, those numbers fell off dramatically. On December 31, 1968, Mbuluzi had forty-five patients in residence; by July, the number was down to just fifteen. And although the number rebounded slightly in the remaining months of the year, the patient population on December 31, 1969 was twenty-six. Only rarely in the remaining years of its operation did patient numbers climb back above thirty.²

Why did numbers fall? Some of the decline resulted from continued improvements in medical knowledge. 1969 was the year that the staff at Mbuluzi started using Clofazamine, which they referred to as lamprene, though only in five patients and

² Statistical data drawn from the “Monthly Return of Lepers: Mbuluzi Leper Hospital” reports, which can be found in Correspondence Files #22-24, RFMH Archives.
chiefly as a tool for treatment when patients were experiencing severe leprosy reactions.\textsuperscript{3} This soon became one of the frontline drugs in leprosy treatment and remains today one of the three drugs used in the treatment of multi-bacillary leprosy via multi-drug therapy. In and of itself, however, this would not explain a sudden drop in patient population numbers.

In the bigger picture, the Mbuluzi work and Swaziland’s health infrastructure in general were also experiencing the hardships of diminished government appropriations, as Swaziland’s newly independent government established its priorities in face of mounting financial difficulties. When Dr. Stark composed his March 7, 1969 letter thanking the Leprosy Mission for its subventions in aid of the Mbuluzi work, he wrote ominously: “This year, it looks as if we are going to need as much help as we can get, as the Government of Swaziland is having to cut down on appropriations to every department. Unfortunately the medical departments have come in for their share of the cut as well.”\textsuperscript{4} He clearly anticipated lean times ahead, and although it is difficult to get a clear sense of how the actual balance of payments worked out, his feelings were clearly not anomalous. The Annual Medical and Sanitary Reports from the late 1960s and early 1970s frequently make reference to budgetary constraints as a major hindrance in

\textsuperscript{3} Dudley Jacobs to Samuel Hynd, 12 January, 1970, Correspondence File #22, RFMH Archives. Jacobs was a doctor working for the South African drug company Geigy, which had supplied the drugs to Mbuluzi. At this time, leprosy workers suspected that dapsone aggravated leprosy reaction, and Dr. Stanley Browne had recently recommended that patients with reaction cease taking dapsone for two weeks. In the RFMH Archives, there is a July, 1969, document entitled “Treatment of Leprosy” that suggests this change on the basis of an article by Browne in the September, 1968 issue of the British Medical Journal, though Browne himself had visited Swaziland in that same year.

\textsuperscript{4} Kenneth Stark to the Leprosy Mission, March 7, 1969, Correspondence File #22, RFMH Archives.
progress on other government-funded projects such as building construction and the
development of the national tuberculosis control programme.

Even more telling was a document that Samuel Hynd composed in June of 1969. A sort of manifesto on the condition of Nazarene medical missions in Swaziland, Hynd’s essay emphasized two essential points:

1.) That medical work in Swaziland had always been and must remain into the future “a legitimate part of the whole ministry of the Church and an integral part of its witness to the Gospel,” which meant that the mission needed to address the need for a properly motivated Christian staff.5

2.) That the challenges of acquiring adequate financial support for the work were greater than they had ever been.

Hynd and his colleagues clearly recognized that the coming of political independence raised new questions about the place of medical missionary endeavors. Would the government of the new Swazi nation view them as partners for future development or as vestiges of the previous era of domination by European interlopers? In the essay, Hynd emphasized that missionaries must be mindful of the fact that their place was that of a “welcome guest in Swaziland,” but that maintaining that place would require that the people of Swaziland be taken into “full confidence” and trained for “their future responsibilities.” At the same time, he stressed that the “new government which is still feeling its way and learning the intricacies of running a modern state” needed to fulfill its

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obligations to provide adequate healthcare for its people by financially supporting medical work of all kinds in the country. Hynd felt that, with the proper data, a convincing case could be made regarding the financial needs of all facets of the medical mission work, including the Mbuluzi Leprosy Hospital, and that the mission could reasonably expect a “sympathetic hearing” in its pleas for greater support.\textsuperscript{6}

The reduction in patient population, which corresponded generally with the time period in which Hynd was writing his manifesto, was likely tied to the experience of financial hardships and the mission’s expectation that these were likely to continue.\textsuperscript{7} At Mbuluzi, the financial difficulties seem to have led to the conclusion that it was time to say farewell to some cases who may have lingered at the hospital longer than was absolutely necessary. When Stark wrote to the Leprosy Mission in March of 1970, he noted among those discharged were “a number who had been several years in residence. It was with mingled feelings that they left their happy home and said ‘Good-bye’ to their friends.”\textsuperscript{8} The progress of leprosy treatment was, at this time, certainly an adequately

\textsuperscript{6} Ibid. On its own, the coming of independence in 1968 does not seem to have had any terribly significant effects at Mbuluzi. About the only sign of difficulty was that in 1972, the government’s Chief Medical Officer, Dr. Jack Klopper, had to inform the Department of Public Works that they were, in fact, responsible for the maintenance and renovation of buildings at Mbuluzi per the original 1948 Memorandum of Agreement. See J. Klopper to the Permanant Secretary, Ministry of Works, Power and Communication, 28 February, 1972, Correspondence File #22, RFMH Archives.

\textsuperscript{7} This expectation did not prove to be ill-founded. For example, in 1974, there was a period of time in which the government subventions ceased entirely, leaving the RFMH with a deficit in excess of R9000. When Hynd wrote to the Ministry of Health complaining that their failure to pay left the RFMH “financially embarrassed,” the government did come up with the money to cover the missed payments. See Wayne Bauder to Samuel Hynd, 25 October, 1974; Samuel Hynd to the Permanent Secretary, Ministry of Health, 6 November, 1974; and Z.H. Shabangu to Samuel Hynd, 25 November, 1974, Correspondence File 23c, RFMH Archives.

\textsuperscript{8} Kenneth Stark to the Leprosy Mission, March 11, 1970, Correspondence File #22, RFMH Archives.
uneven thing to justify the continued residence of patients whose signs of active leprosy may have receded some time before, especially if they were willing to remain. And, under the circumstances outlined in the previous chapter, in which Mbuluzi’s patients could feel assured of a reasonable supply of social and material resources, it was only logical that a significant number of patients would be willing. Now, however, the hard financial realities seem to have mandated that some of these patients be encouraged, perhaps even compelled, to return to their homes.

Despite reduced numbers, the work at Mbuluzi continued for more than a decade beyond the crisis of 1969, however haltingly it may have done so. There was a growing sense among many who were involved in leprosy work that the steady diminution of numbers at Mbuluzi did not necessarily mean that eradication was right around the corner. Indeed, by the 1970s, many were coming face to face with the naiveté of the scientific optimism characteristic of the generation that constructed Mbuluzi and hoped its presence would quickly bring the end of leprosy. Samuel Hynd captured a sliver of that sentiment in a letter to the General Secretary for the European Federation of Anti-Leprosy Associations (E.L.E.P.): “Our experience appears to be much the same as other parts of the world where we thought that by this time leprosy would be practically wiped out but in spite of the new drugs available and better conditions throughout the country, we are still finding new cases from areas where we have known leprosy to be endemic but even from new areas from which we have not previously seen cases of leprosy.”

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9 Samuel Hynd to P. Van den Wingaert, 26 April, 1974, Correspondence File #23c, “Leprosy Hospital (L6), 1973-1974,” RFMH Archives.
Hynd and his colleagues could legitimately claim to have gained control of leprosy; the model of disease control that Mbuluzi represented had proven adequate to cut the prevalence rate of leprosy more than in half, and there certainly did not appear to be any danger of the disease becoming resurgent. However, there was still a gap between this achievement and the hopes of David Hynd, Sowden and others that an institution like Mbuluzi would be the key to eradicating leprosy. The sense that Mbuluzi may have come to the outer limits of its usefulness as a tool for combating leprosy without entirely wiping out the disease left two distinct but intertwined questions to be addressed: what should be done about the remaining cases of leprosy in Swaziland? And what should be done with the facilities at Mbuluzi?

As I highlighted in chapter three, the question of the future of the facility was nearly as old as the institution itself, since J.C. Callanan had envisioned it growing into a facility for tuberculosis patients. The Nazarene mission had demonstrated a clear preference for keeping the focus at Mbuluzi on leprosy work, but over time they did attempt some minor modifications to the operation of the facilities. In the mid-1960s, during the time when David Hynd was living there after his retirement from the RFMH, they had opened an outpatient clinic that operated from the colony’s gatehouse building. The important thing to recognize about the clinic work was that it was always understood as a supplement or an appendage to the leprosy work, rather than a direct extension of it. In fact, it could probably be better conceived of as an extension of the RFMH, which continued to operate a network of these outpatient clinics throughout the country. The

10 David Hynd to Margaret Fraser, 9 May, 1964, David Hynd Collection, NA.
positioning of the clinic in the building closest to the entry gate was part of an intentional strategy to keep people off the grounds of the colony itself and minimize any potential mixing of the patient populations. The fortunes of this outpatient venture tended to vary considerably depending on the ability of the Nazarene mission to provide staffing, and by 1975, it was more or less on its last legs as an expansion of the Mbuluzi endeavor.11

Wider visions for what the institution could become, as had always been the case, typically came from outside sources and especially from the government. Since those earliest days, the British administration, beginning at Callanan’s urging, had harbored visions of creating a combined leprosy/tuberculosis treatment center at Mbuluzi. Although the Nazarene missionaries certainly never attempted to initiate any such change, David Hynd had at least briefly revisited the issue in 1962 on behalf of Dr. J.B. Whitworth, who became Swaziland’s Director of Medical Services upon Callanan’s retirement in October of 1957. Hynd’s report came in response to a 1957/58 World Health Organization survey which estimated that 1% of Swaziland’s population was suffering from tuberculosis (meaning roughly 2,400 people), with only sixty beds in all mission and government hospitals available for these patients.12 Whitworth himself had grown increasingly insistent that something needed to be done rather urgently to address Swaziland’s tuberculosis case load, annually referring to it in his Medical & Sanitary Reports after 1959 as the chief health problem facing Swaziland. A joint UNICEF/WHO


12 David Hynd, “Conversion of Mbuluzi Leper Settlement to a Tuberculosis Settlement,” 19 March, 1962, David Hynd Collection, NA.
project finally got underway in 1963 after numerous bureaucratic delays, which had clearly frustrated Whitworth enormously, and his appeal for Hynd to reconsider a merger of leprosy and tuberculosis treatment at Mbuluzi seems to have been chiefly motivated by his desire to find some sort of avenue for progress in this area. Hynd’s report concluded that it would be possible to house approximately 100 tuberculosis patients at Mbuluzi with just a few additions to the existing facilities, but once the UNICEF/WHO project got underway in Manzini, nothing further ever came of the idea.

A decade later, new ideas about the future use of the Mbuluzi settlement began to emerge, especially in light of another season in which patient numbers had noticeably dwindled. This time, the idea got as far as having the Ministry of Health approve the use of existing buildings to establish a workshop for people suffering from physical disabilities. This was an area that had been neglected in Swaziland, as suggested by the letter of Dr. Fanny Friedman, the Chief Medical Officer for the Ministry of Health, who acknowledged that caring for the disabled was “too big a problem to be tackled in Swaziland by a small voluntary group.”\textsuperscript{13} He was referring to the Swaziland Society for the Handicapped, an organization founded in 1970 and which had, from its beginning had connections with the Mbuluzi work, thanks chiefly to Mr. Cuthbert Pretious, a leader in Swaziland’s Red Cross Society and one of the more regular and fondly remembered of Mbuluzi’s pilgrims. The Catholic Church’s St. Joseph’s Mission, which lay just to the east of Manzini, had also been developing as a resource center for people with physical disabilities, especially those who were blind. One of the key figures there was Father

\textsuperscript{13} F. Friedman to Samuel Hynd, 20 November, 1973, Correspondence File #23c, RFMH Archives.
Angelo Ciccone, an Italian missionary in Swaziland who had himself been keenly interested in starting leprosy work in Swaziland under Catholic auspices before finding himself cut out of that work by the Nazarene success in securing it under their leadership.

Work with people suffering from disabilities offered some of the same spiritual rewards associated with leprosy work; after all, many of the miracles of Christ and the Apostles recorded in the Gospels involved the healing of people suffering from physical disabilities. And because nerve damage was one of the more common symptoms of leprosy, many of its victims needed the sorts of rehabilitation and occupational therapy that others with physical disabilities needed. This intersection of concerns produced natural synergy between the two areas of medical work and made it possible for the idea to gain traction with the Nazarene missionaries who had never had a lot of enthusiasm for combining tuberculosis and leprosy care.

It was likely not entirely coincidental that discussions about the future of the Mbuluzi Hospital structures began in earnest in late 1972, following the decision of Elizabeth Cole to retire. Cole was not an overt opponent of the idea of mixing the leprosy work at Mbuluzi with some other medical endeavors, but she never particularly warmed to the idea and apparently maintained an assumption to the end that it would be best for leprosy patients to have their own dedicated facility. When Cole retired at age 61, she left a small fund in the care of the Nazarene mission but stipulating its use in future leprosy work; she specifically envisioned the construction of a new hospital wing.
connected to the RFMH in Manzini. Her first concern, in other words, was with the question of what should be done with the leprosy patients and not so much with the future of the facility itself. Moreover, being near the end of her missionary career, she was not likely to drive new ideas forward. It would have been only natural that her retirement and the realization that others would have to follow in her footsteps likely helped spur new kinds of thinking about what Mbuluzi might become. Though the nurse matrons who followed in her steps at Mbuluzi were each called to missionary service in their own right, none of Cole’s immediate successors were publicly known to have a spiritual call to leprosy work specifically, the trait that had chiefly defined the public personality of Elizabeth Cole.

But once Cole had stepped aside, the pace of conversations quickened noticeably regarding Mbuluzi’s future. Some of the initiative came from the Swaziland Society for the Handicapped, whose management committee first proposed in October of 1972 that the Society investigate leasing some of the available space at Mbuluzi, which they thought would provide enough space for “a handicapped workshop and residential quarters, perhaps with a dozen adults of either sex.” An approach to Dr. Stark at the RFMH just prior to the October meeting and a follow up conversation with Sister Elizabeth Mishler, the new matron at Mbuluzi, suggested that both of them were on board. Getting a firm response from the Ministry of Health proved more difficult, but by

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14 Samuel Hynd to Glenda Hetrick, 13 July, 1973; Glenda Hetrick to Samuel Hynd, 14 July, 1973, Correspondence File #23c, RFMH Archives.

February of 1973, Dr. Friedman had at least agreed to investigate their request.\textsuperscript{16} By November, the Ministry of Health had formally approved the Society’s workshop proposal, but alongside the workshop, was also planning to have the Ministry of Agriculture assume control of Mbuluzi’s cattle herd with the goal of creating a dairy demonstration project.

Dr. Friedman described this as “a very good step in the demonstration of co-ordinated effort by different Ministries...” which would go “… a long way to integration of efforts which will be instrumental in assisting to remove the time old stigma attached to leprosy.”\textsuperscript{17} Friedman’s language and vision could, of course, have just as easily come from Callanan, Sowden, or other public health officers of a prior generation in Swaziland. The parallels between her ideas of leprosy as a stigmatized disease best treated as part of an integrated system of care and those of the World War II generation are quite striking. Transition to independence aside, relatively little had changed in the upper levels of Swaziland’s medical administration. Given the dearth of Swazi leadership prepared to step into roles like that of Friedman, it is perhaps little surprise that Swaziland’s administrators still subscribed to many of the modernizing visions that animated the administration immediately after World War II. And, as with that previous generation, much of fate of those visions depended upon forces not directly under the control of local decision makers.

\textsuperscript{16} Information regarding the course of these conversations can be found in the Minutes of the Management Committee for their meetings on November 20, 1972; January 22, 1973; and February 20, 1973. All of these are accessible in Correspondence File 319, RFMH Archives.

\textsuperscript{17} Friedman to Hynd, 20 November, 1973, RFMH Archives.
As it happened, the cooperative workshop for people with disabilities never came into existence. In yet another demonstration of the ways in which outside expertise swayed the course of developments in Swaziland, it was an outside consultant whose work in conducting “a survey of the handicapped in Swaziland, has found that the original plan will not work, and the scope of the project beyond the reach of the (Society for the Handicapped).”" The integration of the Ministry of Agriculture’s dairy farm project, however, survived this reassessment, but it soon became an entirely new nexus for conflict.

In many ways, the conflicts that emerged over the dairy project encapsulated many of the cultural clashes that had long existed between the missionary view of the leprosy hospital/colony as a work apart versus the government view that it was somehow a part of a larger structure representative of the benefits of modernity and progress. Just as David Hynd’s relationship with Callanan and Sowden had frayed over these differing expectations, so also would his son’s relationship to government be tested on these same philosophical grounds. As Dr. Friedman’s letter to Samuel Hynd had indicated, the government saw this as an opportunity to show how cooperative ventures and coordinated efforts by varying government agencies brought tangible benefits to a wide range of people. The missionaries, on the other hand, wanted to be sure that the interests of the leprosy work continued to receive preferential treatment.

The leprosy colony had long had a herd of dairy cows at its disposal and, at various times, had enjoyed a relative bounty of milk for its patients. But the new plan called for that herd to be turned over to the supervision of employees of the Ministry of Agriculture who would provide certain fixed quantities of milk to the hospital patients, as well as paying cash for access to the colony’s housing, land, and farm equipment. In late 1974, as Samuel Hynd was negotiating the exact terms of this new arrangement, he laid down some very clear provisions that protected the favored treatment of the colony and its residents, providing them with forty liters of milk daily (providing roughly one liter of milk for each of the colony’s adult inhabitants), the meat of one animal from the herd roughly every two months, and some oversight for the hospital in the disciplining of all personnel on site, regardless of assignment or responsibilities.

The problem, as Hynd soon discovered, was that the government was not really in the mood to negotiate. In truth, the missionaries had no leverage in the situation, as all of the Mbuluzi property was ultimately under government control. Having been content for the better part of two decades to leave the property largely at the disposal of the mission, the government was now in a more assertive mood and no longer perceived the leprosy work as a high priority work on its own terms. Hynd might have received a more sympathetic hearing from people working in the government’s medical offices, but it was

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19 See, for example, the correspondence between Elizabeth Cole and David Hynd in December of 1953 and April of 1954 regarding the use of Mbuluzi’s surplus milk to supply the needs of patients and staff at the Raleigh Fitkin Memorial Hospital in Box 2499, “Unprocessed Correspondence,” David Hynd Collection, NA.

20 Samuel Hynd to the Permanent Secretary, Ministry of Agriculture, 20 December, 1974, Correspondence File #23b, RFMH Archives.
undoubtedly difficult for the Ministry of Agriculture to see where the needs of a few
dozen leprosy patients at most could supersede its visions. The reply from the Ministry
negated or modified most of Hynd’s terms: halving the milk supply, promising meat only
at the discretion of the farm manager, and insisting that only the Ministry retained
disciplinary oversight of farm personnel.21

The tension was, in one sense, merely a question of perspective. Was the dairy
farm a sidelight to the leprosy colony whose interests and practices should have priority?
Or was it an equal partner, perhaps even an autonomous unit, free to pursue its own
objectives and policies? The failure to bring all parties into alignment on these questions
produced seven years of on and off clashes that exposed the different priorities of the two
parties. In May of 1976, for example, Nita Clegg learned from the Peace Corps volunteer
who was living at Mbuluзи and supervising the dairy farm that, after consultations with
his superiors at the Ministry of Agriculture, they had decided to stop supplying free meat
to the hospital because they wanted the farm to begin turning a profit. Clegg could
understand the desire for profitability, but from her perspective, this was a direct threat to
patient well being. The only viable option was for the Ministry of Health to increase the
subsidy it paid the Nazarene mission, but this probably seemed a little too much to hope
for.22

The frequency and intensity of these clashes continued to build slowly and
steadily over the years. Provision of staff housing and the collection of rental payments

21 N.T. Gumede to Samuel Hynd, 10 March, 1975, Correspondence File #23b, RFMH Archives.

22 E.M. Clegg to Samuel Hynd, 5 May, 1976, Correspondence File #23a, “Leprosy Hospital (L6),
for the use of facilities and equipment constantly arose. From the missionary perspective, as they struggled to remain connected to an older vision of Mbuluzi as a place of Christian harmony, these were not mere nuisances but fundamental distractions from the higher aims of leprosy work and the transformation of patient lives. It was, for example, the man appointed by the Ministry of Agriculture to take charge of the dairy project about whom Nita Clegg wrote the letter, cited in the previous chapter, regarding “his spirit” not being a good one right from the beginning. She fervently hoped that his transfer to service in another area of Ministry work would come about, but in the end, he outlasted Clegg who departed Swaziland in 1978.

The situation had deteriorated still further by 1981, but by this time, there had been one significant personnel change that directly affected both parties. In 1978, Samuel Hynd parted with the Nazarene mission and had taken up a new post as Swaziland’s Minister of Health. In the meantime, Clegg had been replaced at Mbuluzi first by Jane Brewington and then by Claudia Stevenson, another American missionary nurse and one who had experienced a clear and specific calling to leprosy work in the form of a vision, much as Elizabeth Cole had back in the 1930s.23 The existing correspondence leaves some gaps to explain exactly what took place, but by September of 1981, Hynd was implementing a new Leprosy Control Agreement for Swaziland, not with the Nazarene mission but with the Leprosy Mission in Southern Africa. In so doing, Hynd began asserting a more active government role in supervising the affairs at Mbuluzi. In a letter to the leadership of the Nazarene mission, he rather harshly critiqued his successors at the

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23 Interview with Claudia Stevenson, 16 July, 2008.
RFMH for having left Stevenson to “fight a lone battle against extreme odds,” resulting in “the present sad situation” as a consequence of the “inability or unwillingness on the part of her missionary and hospital authorities to investigate her cries for help.” Although the mission was now taking steps to aid Stevenson, Hynd was also initiating “a more active role by my Ministry officials” in making a “definite demarcation of responsibility and area of operation between Leprosy Hospital and Dairy Demonstration Farm more clear.”24

The details of the sequence of events and the precise details of what took place are not at all clear; however, those details are of lesser significance than the ways in which all of these pieces pointed towards the new realities of Mbuluzi and the end of its operation. Though some of the old practices persisted, the Christmas pageant for example, the site had lost much of its sacred veneer, as a consequence of both the reduction in the patient load and the movement of key personnel. In addition, other kinds of evidence began to emerge which suggested that Mbuluzi was simply no longer effective in fulfilling its purpose.

Much of this new information came about as a consequence of a resurgence in external interventions, largely stimulated by the investment of the Leprosy Mission. In 1978-79, the Leprosy Mission had organized a leprosy survey, which was carried out by a

24 Samuel Hynd to Richard Zanner, 18 September, 1981, Hospital Affiliates File #68, “Leprosy Control Programme, 1981-1985,” RFMH Archives. Although Claudia Stevenson could undoubtedly have clarified these events, she passed away before I was able to conduct a follow up interview, and I uncovered this correspondence well after my original interview with her. Samuel Hynd, whose departure from the Nazarene mission was under somewhat cloudy circumstances, preferred to gloss over this era in my interviews.
leprosy specialist from Ethiopia, with significantly more fruitful results than its ill-fated predecessor of the 1940s. The new survey turned up as many as eighty new cases of leprosy in the country, roughly three times the patient population housed at Mbuluzi at that time. On the one hand, this pointed to a breakdown within the country in leprosy surveillance, and in the two years following the survey, the Leprosy Mission organized training workshops for doctors and nurses by members of their international staff, including one by Dr. Stanley Browne who was the Leprosy Mission’s medical consultant and one of the chief voices on leprosy care in the world at the time. On the other hand, the results of the leprosy survey only confirmed the general feeling globally that long term residential care was not to be preferred from any perspective over the possibility of outpatient care. Thus, when in 1979, consultants from Denmark (usually referred to as the “Dangroup”) recommended, as part of a health study conducted on behalf of the African Development Bank, that Mbuluzi be closed as the country’s treatment center and that a new centralized referral unit be opened at the RFMH in Manzini, it was only a matter of time before the doors closed for good.25

The formal decision to close Mbuluzi came on March 4, 1982 at a meeting assembled at the office of the Ministry of Health in Mbabane.26

25 Information regarding the Dangroup recommendations and the decision to close down Mbuluzi can be found in nearly all the files in the RFMH Archives relating to leprosy. However, see especially H.W. Wheate, “Leprosy in Swaziland and its Control,” 1982, and Samuel Hynd to Richard Zanner, 10 February, 1982, Hospital Affiliates File #68.

26 Most of the following information in the following paragraphs is from the archival collection in development at the Raleigh Fitkin Memorial Hospital, Manzini, Swaziland. In particular, see the Minutes of the meeting of the Sub-committee of the Management Committee of the Leprosy Control Programme, Thursday, March 4, 1982, at the Ministry of Health, Mbabane, Hospital Affiliates File #68, “Leprosy Control Programme, 1981-1985.”
were representatives of the Ministry of Health, the Leprosy Mission, and the Raleigh Fitkin Memorial Hospital. The chair of the meeting was none other than Dr. Samuel Hynd, in his capacity as the country’s Minister of Health. Along with Dr. Z.M. Dlamini, the country’s Director of Medical Services, they represented a renewed investment by the government of Swaziland in leprosy work, something that had generally been absent since 1956. The other key players in the conversation were Walter Maasch, R.S.W. Ford’s successor as the Secretary for the Leprosy Mission in Southern Africa, and Peter Laubscher, the organization’s field secretary for Swaziland. Just six months out from the signing of the new agreement, Maasch and Laubscher were primary agents in setting a new course for Swaziland’s Leprosy Control Programme. It was perhaps the great irony of the situation that Hynd, as a former missionary of the denomination that had negotiated so long and so delicately with the British administration of Swaziland, was now making the decisions that relegated the same mission to a clearly secondary position.

Dr. Wardlaw, the chief medical officer at RFMH, and Mr. Mdluli, the hospital’s administrator, had a notable role to play in this meeting, but at many subsequent meetings of the Management Committee of the Leprosy Control Programme, representatives of RFMH had very little to do with the proceedings.

The Nazarene mission had not been cut entirely out of the picture, however, as the new home base for Swaziland’s leprosy treatment was to be RFMH. In fact, a few of the remaining patients from Mbuluzi had already been transferred to the Manzini hospital and had been admitted to the general wards. All of this might suggest an actual increase in Nazarene involvement with leprosy treatment in Swaziland, but in fact, the
circumstances were quite different. The Leprosy Control Programme, under the direction of the Leprosy Mission reporting to the Ministry of Health, was a tenant at the RFMH and operated with a high level of autonomy. Though they made use of RFMH laboratory facilities, relied upon Nazarene missionary doctors to sign orders, and admitted the few patients who needed hospital care to the RFMH’s wards, they did the lion’s share of their administrative work and outpatient care in a space that they rented from the hospital, located in an outlying wing of the 300-bed facility.

Perhaps unsurprisingly, given how persistent the issue had remained throughout the twentieth century, the decision to close Mbuluzi gave rise yet again to a conversation centered around stigma. Even at this late stage and with an accumulated mountain of evidence that there was little stigmatization of leprosy in Swaziland, much of the discussion at the decisive meeting revolved around the question of how well the leprosy patients would be received if they were admitted to ordinary hospital wards at RFMH. The documentary evidence suggests that there was by this time some difference of opinion even among the missionaries as to what they should expect in this regard. To take one example, in their year-end report to the Leprosy Mission for the year 1971, the Nazarenes had declared that there was very little social prejudice that would prevent patients from presenting themselves for treatment at Mbuluzi; however, the very next year, the report, in responding to the very same question, suggested that there was “still
some witchcraft association,” that they felt might constitute or create some degree of social prejudice.27

It is quite likely that at least part of the explanation for the discrepancies between these annual reports lay in their differing authorship. The 1971 report was the work of Dr. Kenneth Stark, a Nazarene doctor with more than twenty years of service in Swaziland by that time but also an American doctor and one who had always played a secondary role in matters related to leprosy. As Michelle Moran has demonstrated, the American medical establishment had had its own experience with leprosy as an imperial disease that posed a looming public health threat, but this was chiefly the product of an earlier period, at the turn of the nineteenth into the twentieth centuries. American leprosy treatment was also confined to the Carville institution in Louisiana and the Hawaiian islands, which meant that there was little opportunity for medical students to be exposed to it. And certainly, by the 1970s, doctors such as Stark, who had trained as a physician before the advent of sulphone therapies, if they heard anything about leprosy treatment from American medical sources would chiefly have heard about the triumph of new scientific developments for which Carville became a major research center.28

The 1972 report, on the other hand, was the work of Samuel Hynd, whose work at RFMH had begun one year after Stark but whose experience of Swaziland was much


deeper and whose views of Swazis and of leprosy had been profoundly shaped by his father’s work there. As a consequence of his experience in leprosy work and the ways in which his life had been shaped by his father’s work, Samuel Hynd consistently held that there was evidence of stigmatization among Swazis, writing in 1974, for example, that “There is a natural fear still amongst the Swazis of Leprosy and it needs someone with a dedication which goes beyond the normal limit for someone to take this work on.”

This idea seems to have continued to have a hold right through the 1982 meeting. The minutes of the meeting do not identify by name the people who held particular concerns, summarizing the general conversation without identifying particular speakers, but, given that he was running the meeting in his role as Minister of Health, it may very well have been Hynd who anticipated the possibility of stigmatization as a problem for patients at RFMH. When I spoke to him nearly thirty years later, he certainly still remembered surprise as being his chief reaction to the smooth transition and acknowledged that he had anticipated having considerably greater difficulties in transitioning patients out of Mbuluzi and into general hospital wards.

But, as events happened, the stigma issue once again proved to be a non-story. Relatively few patients even came to Manzini; the majority were discharged from Mbuluzi directly to their homes. By the time of the next Management Committee meeting in May, only one elderly woman remained at Mbuluzi, likely as a result of her physical disabilities, and responsibility for her care was being handed over to social

29 Samuel Hynd to Peter Piazza, 18 February, 1974, Correspondence File #23c, “Leprosy Hospital (L6), 1973-1974,” RFMH Archives.
workers from the Ministry of Home Affairs. The patients who did receive a transfer to the RFMH had experienced no problems in the transition. As often as possible, the staff assigned them to separated rooms rather than the general wards, but there had been no sign of problems in any cases.

The only exception was that some nurses had expressed fears of infection, a continuation of a pattern with which the missionaries had had some previous experience in which Swazis who worked closely with them had adopted at least mildly stigmatized views of leprosy patients and their illness. As recently as 1976, a Swazi member of the hospital administration had expressed resistance to leprosy patients receiving treatment at RFHM; Sister Clegg chalked the man’s resistance up to his ignorance of the reduced medical capabilities of the Mbuluzi facility as well as his personal fear of the disease. In 1982, with the nurses expressing fear of leprosy infection, Sister Claudia Stevenson, the last nurse matron at Mbuluzi who had now been seconded by the Nazarene mission to the Leprosy Mission to continue doing leprosy work, was asked to do some educational work with them in order to dispel the anxieties of nurses and to ensure that those anxieties were not transferred to the patient population as a whole. In the end, this seems to have been adequate to address the concerns. However, this repeated dynamic in the Swaziland context demonstrates quite clearly the reality that stigmatizing behavior is learned and not

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30 E.M. Clegg to Samuel Hynd, Aug. 2, 1976, Correspondence File #23a, Leprosy Hospital (L6), 1975-76, RFMH Archives.

even all that subconsciously, but often through relatively overt processes of training and education.

Once Mbuluzi closed its doors for good, the Leprosy Control Programme was briefly revitalized in Swaziland by the investment of the Leprosy Mission staffers who had energy and resources for the task at hand. In some senses, little changed in the transition to Leprosy Mission direction. Although not identified with any particular Christian denomination, the Leprosy Mission was a consciously Christian organization, and chiefly evangelical Protestant in its orientation. Thus, for example, they articulated their philosophy of recruitment for local workers in language similar to that of earlier Nazarene missionaries: “It is important to us that such workers should be dedicated Christians, since our ministry to leprosy patients and their dependants will be a compassionate and spiritual one as well as a medical and social one.”

Given that there would be no great likelihood of finding people with practical experience of leprosy work in Swaziland, they planned to recruit people from Swaziland’s evangelical churches and to pay for the necessary seminars to bring those recruits up to par in terms of job-related skills. Just as David Hynd had insisted from the very beginning, the work of leprosy care in Swaziland would still prioritize a concern for the spiritual, as well as the physical. But rather unlike the agreement negotiated between the Nazarenes and the British

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32 Walter O. Maasch to Samuel Hynd, 11 February, 1981, David Hynd Collection, NA. The Leprosy Mission’s predisposition to Protestantism was also suggested in a letter from David Hynd to Walter Maasch shortly after Hynd, in his honorary role as a Vice-President of the organization, had reviewed a draft of the new Leprosy Mission Constitution. Hynd, who had shown his own suspicions regarding Catholics over the years, pointed out that it might not be wise for the Leprosy Mission to include language that suggested that the Leprosy Mission only wanted to cooperate with institutions that were run by Protestant churches, as the drafted language apparently did. See David Hynd to Walter Maasch, 11 June, 1980, David Hynd Collection, NA.
administration back in 1948, the Ministry of Health under Samuel Hynd’s leadership raised no concerns about this as a facet of leprosy control. Hynd’s influence, as well as the growing numbers of Christian churches in Swaziland, helped ensure that the clashes of the past between British colonial and evangelical holiness cultures were not a significant factor in the decision-making process. The new agreement secured for the Leprosy Mission “freedom in Christian worship and witness within Swaziland, subject to respect for public order and morality.” The only caveat was that such activity “by patients or staff will be entirely voluntary and without constraint.”

The twenty-three years following the closure of Mbuluzi saw some remarkable progress in leprosy control in Swaziland. With multi-drug therapy, the long-promised eradication of the illness was finally on its way to becoming reality. In October of 1991, it was my own father who declared at a meeting of the Management Committee that he did not believe Swaziland had leprosy anymore. This was not precisely true; the minutes of subsequent quarterly meetings usually made note of one or two individual new cases that had been identified since the last meeting. But the number of cases now fell well below the threshold of 1 in 10,000 that the World Health Organization identified as the benchmark for disease elimination. And some of these new cases were not Swazis but Mozambican refugees, seeking asylum from the civil war which had torn apart their own

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34 Minutes of the Meeting of the Management Committee of the Swaziland Leprosy Control Programme, held at the Ministry of Health, Mbabane, October 4, 1991, RFMH Archive.
country in the previous 16 years. The main task of the two to three staffers employed by the Leprosy Mission in the country was to oversee the long term care of patients like Gogo Shiba who needed access to medication, thereby sustaining at least partially the moral bonds created by their earlier encounters at Mbuluzi. But dwindling patient numbers, the shifting attention of the global health community to other issues, and the finite resources of a financially strapped Swazi government inevitably meant a diminished place for leprosy patients.

In 2005, the government of Swaziland officially took control of the Leprosy Control Programme. A Ministry of Health employee was designated to continue the programme and sent to Ethiopia for a course of study on “Leprosy/TB and HIV/AIDS.” The very fact that his course of preparation combined leprosy with the two dominant public health issues in Swaziland at the time probably was an indication of just how little attention leprosy would receive upon his return, and indeed, none of the former patients that I met could recall a visit from this man beyond the first time when he was introduced at their homes by his Leprosy Mission predecessor. When I visited the Leprosy Control Programme offices at the RFMH in 2009 and 2010, I found files badly neglected, filled with mouse droppings, and furniture covered in dust. It was evident that no one had carried on any active work with the leprosy program in quite some time, and the people I spoke to confirmed that no one from the government was ever seen visiting the offices or making use of those files. The whole picture was as clear a visual representation as one


might think to look for in trying to understand why leprosy is now classified by the WHO as one of seventeen neglected tropical diseases.\textsuperscript{37} It was, furthermore, a telling symbol of the transformation of leprosy care in Swaziland from its prominence in earlier decades to irrelevance. This is, of course, in some ways a happy ending to the story, as leprosy is no longer the kind of public health threat that demands attention in Swaziland. But, as I have argued throughout this dissertation, that was in some senses always the case. Yet, for the reasons identified here, there was a period of time in which the disease received considerable resources, and the optimistic colonial-era promises of the benefits of modernity suggested that there would be resources for the future as well. For former patients like Gogo Shiba, the final severing of those moral bonds of relational dependence and the resulting sense of dislocation and abjection, heard in her assertion that ‘no one cares for us now,’ has surely been dramatic.

\textsuperscript{37} On Neglected Tropical Diseases, see the WHO’s website: http://www.who.int/neglected_diseases/en/.
Conclusion
Shifting Circumstances, Adaptive Living

When I first wrote the prospectus outlining my research plans for this dissertation, I confidently asserted that there was a very simple but interesting story that needed to be told. Leprosy, I claimed, was a disease stigmatized in more or less equal proportions by both Swazis and Westerners of all stripes. As such, it presented an interesting contrast to the standard narrative of Western colonizing cultures oppressing, coercing, and otherwise attempting to remake African cultures into their own image. Here, I thought, was a place where European bureaucrats, American missionaries, and Swazi commoners all shared the same natural fear of a much misunderstood disease. The interesting piece of the story would be to learn how these various groups responded over the course of the twentieth century to the dramatically shifting medical understanding of the disease that I described in the opening paragraphs of this dissertation. What similarities and differences would mark their movements along these roughly similar trajectories? Even now, it strikes me as an interesting story to tell, if only there were anything accurate about the basic assumptions that underpinned that prospectus.

I think it is likely a good thing that my prospectus, as for so many of my graduate school predecessors, was essentially a dead document after only a very short time in the field. It did not, however, necessarily feel that way when I first began to realize that the stigmas I had anticipated uncovering were nowhere near as common as I had expected. Indeed, for a time, it appeared to me that I would have no alternative but to simply recite the multitude of ways in which Westerners had followed their erroneous assumptions
about both leprosy and Swazi culture into creating unnecessarily oppressive institutions that exerted their power over Swazis who would, in the lingo of so many of the books I read during my graduate training, demonstrate their agency by displays of resistance against hegemonic regimes. At best, I thought the dissertation would become another cautionary tale about the misfortunes of inattentive philanthropy, encapsulated in contemporary images of rusted out tractors donated by development agencies and abandoned once outside funding ran out on unsustainable projects. And, in some sense, these are themes of this dissertation. It is clear that missionaries and British administrators often did misunderstand their local context or were confused about what exactly Swazis thought about leprosy, and it was not unusual for them to outright ignore Swazi input when it suited them to do so. And, of course, the patients who sneaked away from Mbuluzi to purchase alcohol or who grew dagga to supplement their incomes were resisting an imposed order whose legitimacy they did not fully acknowledge.

Ultimately, however, I find this bifurcated mode of analysis unhelpful or, at best, extremely limited. The events I have described are much more helpfully analyzed in terms of adaptability and negotiation, and they help us see a great deal more about the limits of Western power and influence in the colonial context than they do about its hegemonic aspirations. Furthermore, it seems to me to do little good in this case to try casting aspersions on the character of Western missionaries and administrators as the agents of oppression. To do so is clearly to create a straw man that badly caricatures the realities of the situation. Did they believe in the superiority of their culture and its modes of knowing the world? Yes. Were they often frustrated when Swazis did not conform to
their expectations? Of course. Did they have large egos that made it difficult for them to cooperate well even among themselves or lay aside their prior assumptions? Quite often, yes. But they were also, by and large, deeply committed to their work as motivated by their various religious and humanitarian concerns. And for all the misunderstandings that can be seen clearly in retrospect, they also did ultimately eradicate leprosy in Swaziland (at least, by the statistical measures used by the World Health Organization), an achievement that should not be simply brushed aside.

The story on the Swazi side of this equation is, in my view, even more fascinating and the one that certainly bears further investigation. If my claims in this dissertation regarding the Swazi role in the story of leprosy care in Swaziland have been relatively more modest than those I have made regarding Westerners and their role, it is chiefly because of my keen awareness of the limits of my own research process and understanding. Some of the obstacles that hindered my field research were well outside of my control. The offices of the Leprosy Control Programme, for example, were in a building that happened to be undergoing a major renovation project while I was in Swaziland and therefore unavailable. Those offices contain files that provide data on the experiences of every individual patient treated for leprosy in Swaziland since the opening of the Mbuluzi Leprosy Hospital in 1948, and my inability to access them was all the more frustrating since I had to walk by the building that housed them virtually every day as I headed out to conduct other elements of my research.

Other obstacles might be considered a consequence of my inability to better forecast the future. In a perfect world, I would have achieved fluency in siSwati prior to
arriving in the field (a regret that, as a missionary child living in Swaziland, I somehow never imagined would have the significance that it does to me now), which would have considerably eased the interview process with my informants. With more complete knowledge of the situation, I would also have chosen a different place of residence for my fieldwork, which might have allowed for more extended or at least more numerous points of contact with at least some of my informants. Of course, hindsight is 20/20 in such matters, and no research is ever conducted under ideal field circumstances.

Despite these limitations, I hope that this dissertation has managed to uncover some fascinating and significant elements of Swazi thinking about leprosy, as well as about the ways in which they demonstrated a dynamic adaptability that helped them turn the experience of leprosy into something fruitful. Understanding the reasons why and under what circumstances some Swazis learned to stigmatize leprosy as well as why so many Swazis were apparently quite ready to live under the stigmatized gaze of outsiders hints at the crucial processes by which peoples of different cultures adapt themselves to shifting circumstances. This is not to say that Swazis simply abandoned their own cultural ideas in favor of those of more powerful outsiders; I have tried to show that the actions and adaptations enacted by Swazis were coherent from within their own particular cultural perspectives and are rightly understood only as evolutions of their own ideas.

Trying to understand as carefully as possible the evolution of all the ideas and perspectives at play in this dissertation and how those ideas motivated the actions of all parties seems to me to be a very worthwhile goal in the twenty-first century. Conversations about disease control and eradication are every bit as live today as they
were in Swaziland in the 1940s. The diseases have changed; leprosy has been replaced by HIV/AIDS, malaria, and now ebola. But many of the central dynamics of the leprosy story have not changed very much. Western governments and philanthropic organizations still command vast resources that they often wield relatively carelessly in the developing world, however admirable the causes may be. The Swaziland leprosy experience is an appropriate reminder that a touch of humility in the face of local knowledge and a fair amount of attentive listening are likely to go a long way in determining the long term fruitfulness of those endeavors.
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CURRICULUM VITAE
William K. McCoy

EDUCATION

BA: Point Loma Nazarene University, History, 2000

MA: Boston University, African History, May, 2004

PhD: Boston University, African History, May 2015

ACADEMIC EXPERIENCE


2012,3 American Historical Association & International Leprosy Congress paper presented, “We are thrown away”: The Language of Leprosy and the Founding of the Ncabaneni Leprosy Settlement

2012,3 Book review essays in *Fides et Historia*

2010 Research seminars presented to the University of Swaziland Faculty of History (September) and Faculty of Health Sciences (November)


2009 Participant in workshop on “Public Theology: The South African Experience,” sponsored by The Nagel Institute for the Study of World Christianity


2000 3 months as instructor for the Church of the Nazarene in Rwanda and Democratic Republic of Congo; taught Ethics in a credentialing program for church leaders.

TEACHING EXPERIENCE

2009- Assistant Professor of History at Eastern Nazarene College, teaching courses in African studies, Western Civilizations, European History, and World History

2005-9 Instructor in History at Eastern Nazarene College, courses in African studies and Western Heritage

2007,8 Course instructor, “Themes in African History,” Emmanuel College

2007-8 Course instructor, “History of Sub-Saharan Africa,” University of Rhode Island, Alan Shawn Feinstein Campus

LANGUAGE COMPETENCIES

Reading and Speaking: Swahili (4 semesters completed)
isiZulu/siSwati (2 semesters completed, 2 months tutorials)
Spanish (3 years high school, 2 semesters undergraduate)

Reading: Portuguese (passed graduate level reading course)