MEDICAL HISTORY AND AFRIKANER SOCIETY AT THE END OF THE NINETEENTH CENTURY

Birth, death and disease are fundamental to human society and have been widely explored in the history of other countries.[1] In South Africa, however, such studies remain relatively undeveloped except where they touch on political issues.[2] The emergence of HIV/AIDS as a national crisis, however, has drawn attention to the way in which health issues can permeate national life and social identity and makes a strong case for the need to understand the relationship between disease and society. Boer use of traditional remedies has been one strand in the making of Afrikaner identity but it has been little examined historically. It could also be argued that health issues have played a larger part in the making of Afrikaner culture and society than is generally acknowledged.

This assertion is made somewhat hesitantly since little has been written on this aspect of Afrikaner identity. The recent work, *The Afrikaners*, by Hermann Giliomee, for instance, contains no references in the index to health, medicine or doctors. Nor is demography or population mentioned, despite that fact that Afrikaners have undergone two major demographic disasters since 1900, in the concentration camps of the South African War and in the 1918 influenza epidemic. Yet the way in which Afrikaners in the past coped with illness or physical disaster is a thin thread which runs through the writing of early Boer society.[3] For much of their history, isolated from professional medical care, the home has been the focus of health care. Perhaps for this reason, health care was not a public issue in the Boer republics where public health legislation was fairly rudimentary. After Union a department of public health and public health legislation were only put in place after the 1918 'flu epidemic. In the years that followed, however, Afrikaners increasingly embraced modern medical practice. Nursing became a significant occupation for young Afrikaans women, a means of social upliftment and work which did not conflict with conservative views on the role of women in society.[4] From the 1930s at least, debates about medical training centred on the need for an Afrikaans medical school, where Afrikaans doctors could be educated in their own language.[5] Chris Barnard's first heart transplant was as much a proud achievement of Afrikaners, as it was for South African medicine as a whole; a clear statement of Afrikaner right to be seen as equal to the developed nations of the West.

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[1] For example, the English population studies based on the parish registers, and the wide range of work published in *Social History of Medicine*, to name only two examples.

[2] Shula Marks, particularly, has done pioneering work in the political economy of health, with influence far beyond this area. The University of Cape Town has been a centre for the social history of medicine for many years, some of this work culminating in a work currently in press, H. Deacon, et al, *The Cape Doctor* (Radopi,, 2004). The University of Natal in Durban, under Cathy Burns is another focus for research, while the Medical School at University of the Witwatersrand has also promoted interest in the area.

[3] B. Spoelstra, *Ons Volkslewe* (Pretoria, 1922); G.S. Preller (ed), *Die Dagboek van Louis Trichardt (1836-1838)* (Cape Town, 1938); Paul Kruger and his thumb etc.

[4] S. Marks, *Divided Sisterhood. Race, Class and Gender in the South African Nursing Profession* (London, 1994).

[5] UG 25-1939, *Report of the Committee on Medical Training in South Africa*, 31, 49; E. van Heyningen, 'UCT Medical School. A background'. Unpublished paper to be incorporated in a work produced by the Health Sciences Faculty, University of Cape Town.

Mortality in the Boer republics before 1899

Because this is such an under-researched area myths abound. It is usually accepted that the Boers of the eighteenth and nineteenth centuries were a healthy and fertile people[6]. In one sense this fits with our modern understanding of the aetiology of disease. Small and isolated populations, lacking the vectors to sustain infection, are less prone to the devastating epidemics that ravaged the early industrial cities. It is probably true therefore, that, apart from the early smallpox epidemics, the Boers were little affected by the worst infectious diseases – smallpox, measles, typhoid, typhus, and tuberculosis, to name a few. Cholera, the scourge of nineteenth century Europe, only reached South Africa in the late twentieth century, while plague, the Black Death of mediaeval Europe, came to South Africa only in February 1901 and the Cape Town epidemic was less severe even than Australia's during the same pandemic.[7] It was a number of years before the disease reached the Rand and it never became a major health risk.

On the other hand, pre-industrial populations were rarely healthy or long-lived. The usual pre-industrial profile is one of a high birth-rate, a high infant mortality rate [imr], and a relatively short lifespan. There are occasional exceptions – the early New England settlements in North America appear to have been one – but these are rare. To cite one example, the Maoris of the first hundred years of settlement in New Zealand, when nourishing food in the form of the moa and such animals, was abundant and when land was there for the taking, rarely reached their forties. Even in 1900 the life expectancy in Australia was 51 for men and 54 for men, compared with 45 for white men and 48 for white women at the Cape.[8] One must ask then, were the Boers any different? If so, why?

Answers are not easy. Prior to 1894 there was no formal registration of births and deaths in South Africa; even then it was confined to the Cape. In the Boer republics there were few censuses – two in the Orange Free State in 1880 and 1890, and one in the Transvaal in 1890.[9] Modern tools for demographic measurement, therefore, do not exist. There may be other ways of approaching the problem. There has been no investigation of church registers in the way in which the English parish registers have been analysed. But this is an expensive project and the huge destruction of records during the South African war may be an obstacle. Moreover, the deaths of very young babies, unbaptised between *nagmale*, would be excluded. A more fruitful approach might be through the vast accumulation of genealogical data, which is at its richest amongst Afrikaner families; moreover an experienced body of researchers already exists in some numbers, if they could be drawn into such an undertaking.[10] At present, however, other tactics are necessary.

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[6] E.H. Burrows, for instance, asserts that the Voortrekkers seem to have been a remarkably healthy people. *A History of Medicine in South Africa up to the End of the Nineteenth Century* (Cape Town, Balkema, 1958), 190.

[7] E. van Heyningen, 'Cape Town and the plague of 1901' *Studies in the History of Cape Town*, 4, 198?.

[8] C Simkins and E. van Heyningen, 'Fertility, mortality, and migration in the Cape Colony, 1891-1904' *The International Journal of African Historical Studies*, 22:1, (1989), 89.

[9] I am not concerned here with the Johannesburg census of c.1898.

[10] Anyone who has spent time in South African archival depots will be aware of the numbers of people researching their family genealogies.

The background to this paper is a three-year project on the medical history of the concentration camps of the South African War, in which Dr Iain Smith of the University of Warwick and I, are engaged. If we are to put the mortality of the camps into any kind of historical perspective, we need to know the death rates of the Orange Free State and Transvaal before the war. The British at the time were well aware of this problem; medical officers of the camps sometimes compared camp death rates with those of England, at least in early 1901 before mortality rose so catastrophically.[11] In the blue books the authorities compared the camp rates with those in the Cape, some of which were extremely high.[12] Kimberley at any time was an unhealthy town; during the siege the imr reached that of the worst of the camps, particularly amongst black children. Other Cape towns, however, were also fatal places to live. Worst of all was Cape Town where the average life expectancy at the turn of the century amongst blacks was about twenty-nine to thirty years.[13] The British could legitimately claim, therefore, that South African mortality was extremely high, even in peacetime. The difference, of course, was racial – it was blacks rather than whites who died in such numbers in the Cape.

Ultimately such arguments are unsatisfying anyway. The British authorities were self-serving and it can fairly be argued that conditions of life in the Boer communities of the republics were different from those of blacks in the Cape Colony. One approach, used here, has been to look at the age of population in the census data of 1890; the Free State and Transvaal each produced one in that year. It is known that these censuses were unreliable. The 1904 Transvaal census suggested an undercount of 10% for the 1890 census[14]. For these purposes this doesn't matter if the count is consistent. Probably it was not entirely; it is likely that those living in more thinly populated areas may have remained uncounted as, for instance, in the Soutpansberg. Nevertheless, the results are interesting, if sometimes puzzling.

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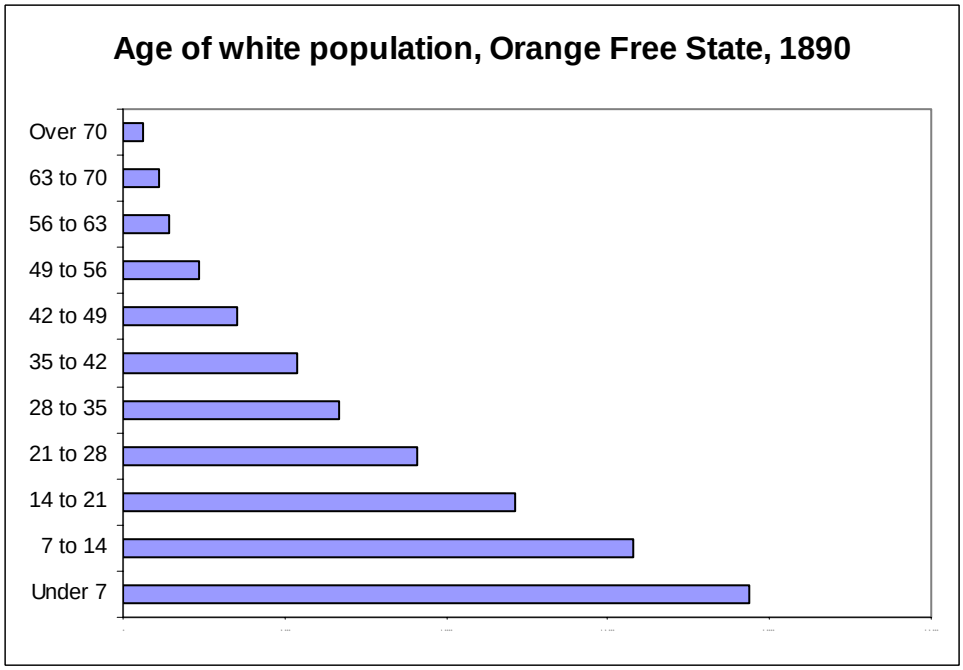
[11] For example, Free State Archives, SRC 5, RC1163, Report on public health and sanitation of refugeee camps, Aliwal North, April 1901.

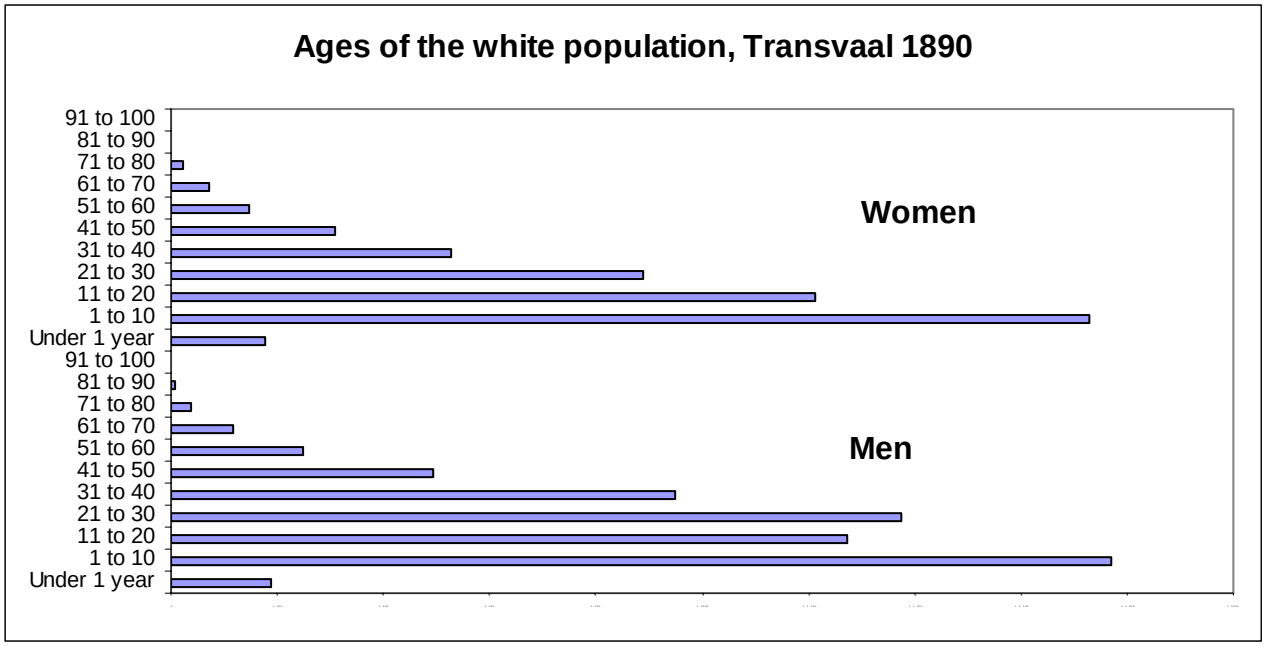
[12] Cd 902, *Further Papers relating to the Working of the Refugee Camps in the Transvaal, Orange River Colony, Cape Colony, and Natal* , A.J. Gregory's comments; See also E Hobhouse, *The Brunt of the War and Where It Fell*, 147, citing *The Times*, 16 September 1901, 19 October 1901.

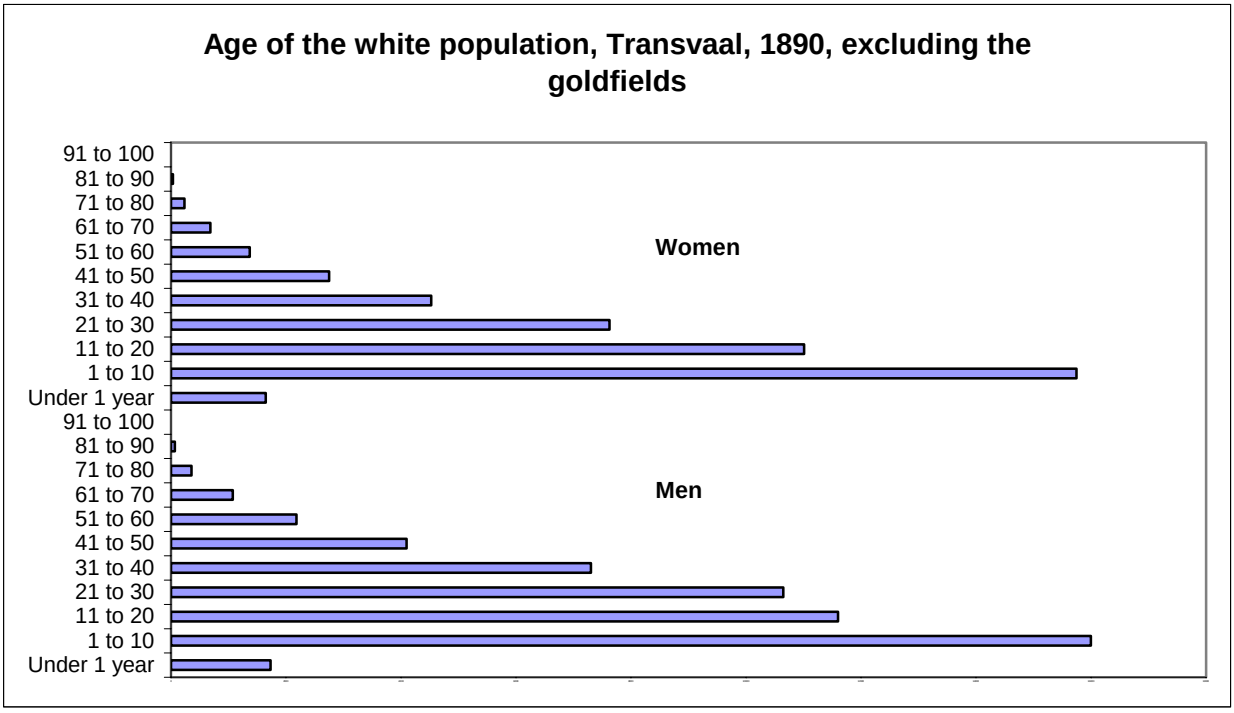
[13] Simkins and van Heyningen, 'Fertility, mortality and migration in the Cape Colony', 90, 92.

[14] Transvaal, *Results of a Census of the Transvaal Colony and Swaziland* (London, Waterlow, 1906), vi.



The Free State 1890 census did not distinguish between men and women. This is an almost classic pre-industrial age profile, showing a high birth rate and a fairly high imr. The most unusual feature, perhaps, is the relatively large number of people living to 70 and beyond. Our work is not sufficiently advanced to translate this profile into any estimate of the imr, but it does suggest that the death of babies was not uncommon in the republican Free State.





The 1890 Transvaal census presents far more problems. For one thing, the discovery of gold dramatically increased the number of young men, black and white, attracted to the republic. There is, therefore, a disproportionate number of men, and a disproportion between men and women, in the age group 21 to 30. Even if the figures for the goldfields are removed, however, problems remain. Consistently, throughout the republic, the mortality of women appears to have been higher than that of men. This suggests that childbirth and the diseases of women took a high toll, perhaps on account of the high fertility rate. More problematic still is the small number of young children in 1890, a pattern which appears consistently across all the districts and wards of the SAR.

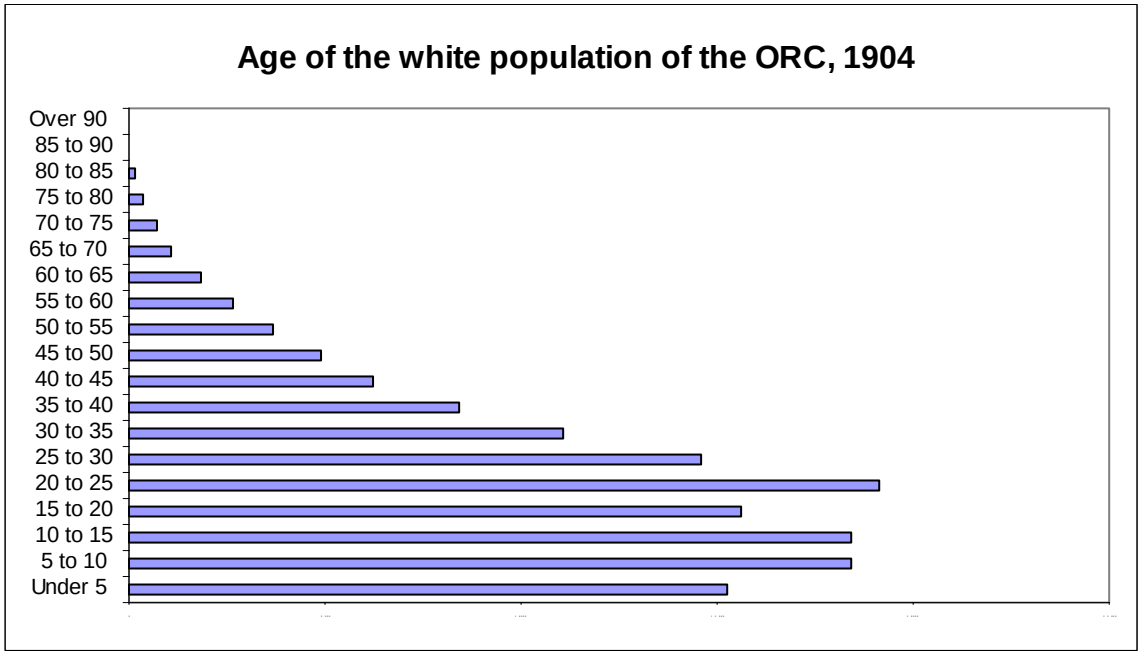
Although the small number of infants is an anomaly for which we cannot at present account, [15] a conclusion which does seem acceptable, is that the Boers of the two republics did not differ significantly from the pre-industrial societies of Europe. If fertility was high, so was mortality. A few, especially men, lived to a considerable age, but the majority died relatively young.

These age profiles also demonstrate strikingly the extent of the demographic disaster of the concentration camps. Again, the pattern presented by the Orange River Colony in 1904 is less complex than that of the Transvaal. These censuses, conducted under British rule, were probably reasonably reliable. In the ORC the heavy toll of infants is particularly marked, but the numbers are aberrant for all those under twenty. The impact on the elderly is less clear but the curve does seem to be somewhat steeper than in 1890.

[15] The reason for this may lie in the way in which the census data was collected; most of the infants may have been recorded in the age group '1 to 10' rather than 'Under 1 year'; '1 to 10' is also a very long period – there is often a distinction made between children under and over 5 years.

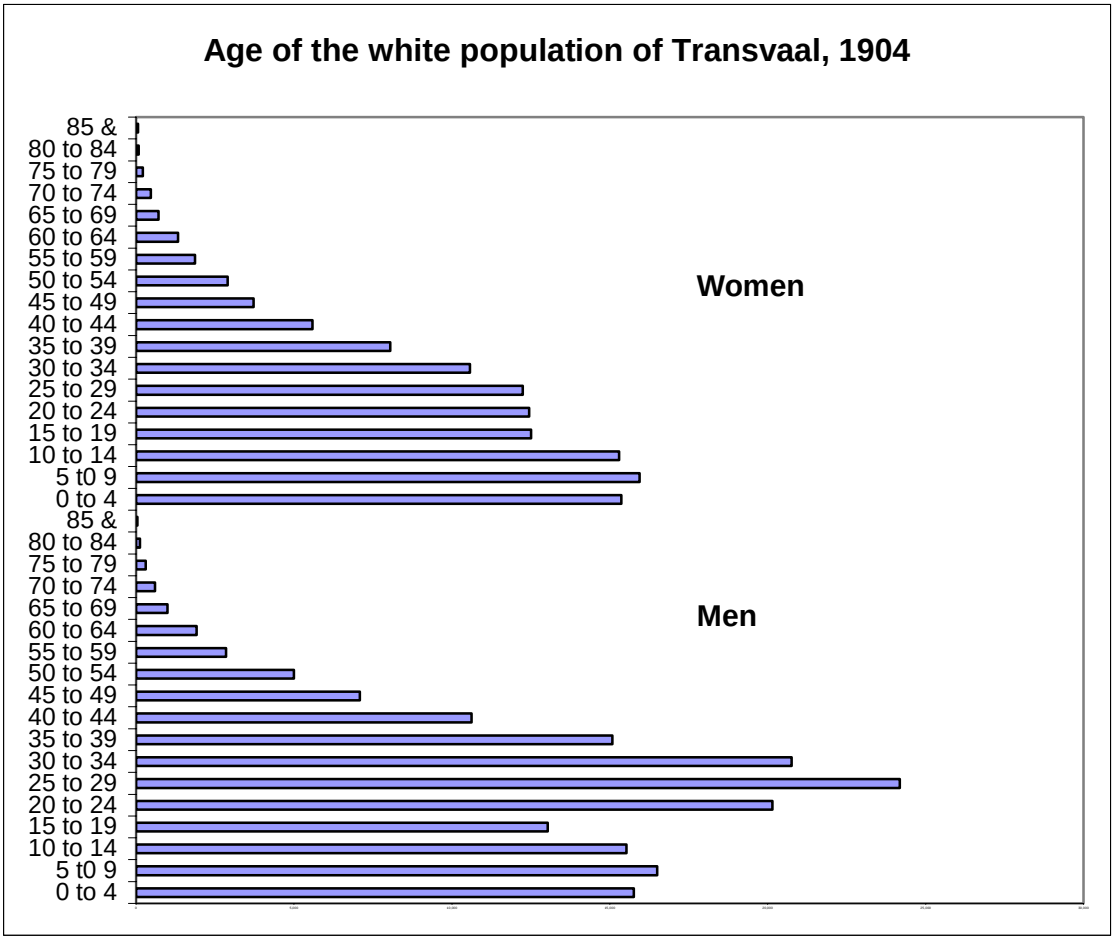
The profiles for the Transvaal include the goldfields. Again, for both men and women the toll of young people is striking. So is the impact of young male immigrants, skewing the ratio of men to women even more than had been the case in 1890. If we are to understand the nature of gender relations in Afrikaans society, some account should be taken of this numerical predominance of men.[16]

What has been demonstrated here is a simple and limited means of examining mortality and life expectancy in the Orange Free State and South African Republic. Nevertheless, it does suggest that Boer society was somewhat less healthy than has been realised. This is impressionistically borne out by the testimonies of women during the war. Over and over again they mention that, when the British arrived on their farms, they themselves were ailing, or the children were sick, or other relatives were ill.[17] This may well have been a device to emphasise their vulnerability and the brutality of the military, but it does imply that ill health was not uncommon.



[16] According to the 1904 census, to a large extent this holds true of black societies in the Transvaal as well.

[17] E Neethling, *Mag Ons Vergeet?* [3rd edn] (Cape Town, Nasionale Pers, 1942), 6; EH Hobhouse, *War Without Glamour* (Bloemfontein, Nasionale Pers 1924), 18, 25; Hobhouse, *The Brunt of the War and Where It Fell* (London, Methuen, 1902), 11, 258.



If Boers were dying in fairly large numbers before the war, and they were not dying in epidemics of infectious diseases, what was the cause of mortality? Without adequate statistics, one can only speculate but there are some indications of what was occurring. Class must be taken into consideration. After the mineral revolution, considerable changes occurred in the agricultural highveld. On the one hand new markets opened up, making the production of crops, rather than pastoralism, more viable. Considerable wealth flowed into the hands of some farmers. On the other hand, speculators bought up increasing amounts of land, particularly in the Transvaal and northern Free State, and in the Harrismith district of the Free State. Where landless Boers had survived adequately before, pressure on land, competition from African farmers and the advent of the railway, which reduced the opportunities for lucrative transport riding, all contributed to the impoverishment of the bywoners.[18]

Those farmers with newly acquired wealth invested some of their money in land and in equipment. But the women's testimonies of the South African War also suggest that a revolution was occurring in the home, something like the changes occurring in the English countryside in the early nineteenth century. Henry Taylor, working amongst the Boers in the Ficksburg district in the 1880s, described the Boer houses of the time as 'drab' and 'comfortless in the extreme', with bare rafters, and no paper on

[18] T Keegan, 'The transformation of agrarian society and economy in industrialising South Africa: the Orange Free State grain belt in the early twentieth century ' (PhD thesis, University of London, 1981), 56-73.

the walls or pictures to relieve the 'dull mud colour'. There was no literature apart from the Bible, furniture was simple and there were no carpets on the floors. In some houses the only partitions between rooms were blankets or print curtains hung across the room on a string.[19]

In the last decade of the century it would seem that larger houses were built. Musical instruments were certainly acquired – almost every home which could afford one, seems to have possessed a piano or harmonium.[20] Many of the accounts of farm burning mention the destruction of books, sometimes in considerable numbers. Furniture, carpets, silver, porcelain and clothes were all destroyed by the war. There was at least some outlay on education. The numbers of schools increased and some wealthier farmers employed governesses to educate their daughters – at least one mentions the presence of an English governess at the start of the war.[21] The number of written testimonies, letters, diaries and memoirs which have survived the war are also witness to a broadening reach of education which was by no means confined to the towns.

Along with education, such families almost certainly acquired some understanding of modern notions of hygiene and public health. Afrikaners were never slow to use doctors in times of war;[22] in times of peace it was probably these wealthier families who called on the few doctors available to them. Henry Taylor in Ficksburg seems to have had no difficulty in charging high fees – he records being paid £200 on one occasion for an operation.[23] Prosperity, education, good nutrition and modern standards of sanitation probably all ensured that such families were relatively healthy. However, women were still subject to the dangers of childbirth; the fact that the fertility transition had barely touched South Africa meant that families were still large, increasing the problems of women's health. Obesity, a high fat diet and large quantities of red meat would all have contributed to heart ailments.[24] Farming, hunting and riding accidents were all regular hazards of life. It is probable that the average life expectancy for the more affluent classes was not much more than fifty, in keeping with that of countries like Britain or the United States with more advanced medical standards.

For the poor the position would have been rather different. Although there is little information about bywoner life before the war, investigations into the 'poor white' problem after the war throw some light on the subject. The Transvaal Indigency Commission of 1908 described a life in which poor accommodation and malnutrition were the norm for some families.

> The whole existence of the backward Boer farmer is arranged on a hand-to-mouth basis. His dwellinghouse is generally of poor quality, his outhouse accommodation ramshackle and inadequate;

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[19] H Taylor, *Doctor to Bantu, Boer and Briton, 1877-1906* (Cape Town, David Philip, 1972), 122-3.

[20] LM Phillipps, *With Rimington* (London, Arnold, 1901), 131-2, 209; Hobhouse, *The Brunt of the War*, 97; Neethling, *Mag Ons Vergeet?* [1st edn, 1938], 39.

[21] Hobhouse, *War Without Glamour*, 49. Admittedly, this was probably an English-speaking family, but many young Boer women were fluent in English.

[22] Burrows, *A History of Medicine in South Africa*,

[23] Taylor, *Doctor to Bantu, Boer and Briton*, 37.

[24] See, for instance, Neethling, *Mag Ons Vergeet?*, [1st edn], 39. It is known that some Afrikaans families are particularly prone to high cholesterol-related disorders.

> his garden, if he has one at all, untidy and unkempt. There are no plantations of trees to shelter the homestead and supply fuel or fencing wood. When he has money it is often spent in tinned provisions inferior to the food which he might grow himself. Mealie porridge is cooked in large quantities on one or two days in the week and left in a bowl on the table, and the children come in and take a piece when they feel hungry without even sitting down to a proper meal. The clothing is usually old and dirty, except in the case of the young girls who are often dressed in cheap finery.[25]

Some districts appear to have particularly unhealthy, notably the malarial areas of the lowveld. Dr Dunn, the district surgeon of Piet Retief, who had been practising in the Transvaal since 1891,[26] commented on the 'poor, ill-chosen and monotonous diet' of poorer families, and the extent to which malaria had impaired the physique and energy of the children.[27]

The question of health was specifically addressed by the Carnegie Commission some thirty years later. Although these investigations were conducted a generation after the war, and many of their inquiries were related to the Cape, the commissioners themselves believed that the conditions they found in the 1930s were not necessarily radically different from the pre-war position, given the conservative nature of rural life amongst the poor. One cannot exclude the fact that the position of many people may have deteriorated considerably as a result of the war, but there is evidence to suggest the drought, rinderpest and economic change had made their impact before 1899.

Drawing on his impressions of rural poverty at the turn of the century in the Karroo, Murray, the author of the health volume of the Carnegie Commission, remarked on the isolation in which these families had lived for generations, which had resulted in 'total ignorance of many simple rules of hygiene and of the dangers consequent upon their insanitary habits and surroundings'. Food, water and milk were all polluted by 'flies, dust and faecal sources'. Flies, especially, were a major source of contamination. Manure from stables and kraals were removed infrequently, if ever, and sanitary conveniences, where they existed at all, were used only by the women. Fleas and body lice were also common in such homes.[28]

The result, he claimed, was that localised epidemics of such diseases as typhoid were common; only the isolation prevented more widespread infection. Many children suffered from tapeworm. Enteritis was common amongst infants, contributing to a high imr, although older children acquired an immunity to faecal infections.[29] Confinements were primitive and unhygienic, conducted with the assistance of inexperienced and untrained female relatives 'and even native women'. (This was a particular obsession of doctors; while there was undoubtedly some truth in their claims, it should also be remembered that they lost valuable business through such

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[25] *Transvaal Indigency Commission*, 1908, 61, cited in WA Murray, *Health Factors in the Poor White Problem* (Stellenbosch, Carnegie Commission Vol.4, 1932), 3.

[26] *Staats Almanak*, 1899, 87.

[27] *Transvaal Indigency Commission*, 1908, 57, cited in Murray, *Health Factors in the Poor White Problem*, 2.

[28] Murray, *Health Factors in the Poor White Problem*, 8.

[29] Ibid., 7, 71

practices.)[30] Babies were often fed artificially from a very tender age, most unscientifically.[31] Such families, Murray argued, were also seriously malnourished.

> The great majority of the rural population live mostly upon farinaceous food, chiefly bread and porridge (mealie pap or 'tiger' oats); eat meat once a day or less often, and use a little milk, but little else of flesh-forming food; cultivate a small amount of vegetables, chiefly pumpkins and sweet potatoes, and eat fruit when locally grown. In short their fare is seriously lacking in variety and in the protective and body-building elements which play an important part in an adequate diet.'[32]

It is immediately obvious that there are problems in interpreting this data – to modern nutritionists Murray's inadequate diet would look a good deal better than that of wealthier counterparts eating red meat several times a day. Indeed, he comments repeatedly, and with surprise, on the fact that the people were so healthy. Nevertheless, other evidence which he cites suggests that there were serious nutritional problems. Vitamins in vegetables were destroyed by the practice of long cooking; tomatoes and lettuce were rarely grown and still more rarely eaten; fruit in the dryer areas was unobtainable although prickly pears were sometimes substituted; milk was not available in winter since the growing of winter fodder for the cows was uncommon. The result, often, was that 'sub-acute' scurvy was widespread, with 'spongy gums, subcutaneous tender swellings tending to break down to form freely bleeding ulcers, general weakness'.[33] C. Louis Leipoldt's investigations into the health of school children in the lowveld in the 1920s also convinced him that poor nutrition was widespread and damaged the health of society.[34]

All these factors suggest a society in which infants were vulnerable, especially to gastro-enteritis, women bearing a large number of children had a heightened mortality rate and adult men were subject particularly to heart ailments or the accidents of an outdoor life. This is a society which might overtly appear to be healthy, but in which life expectancy was not lengthy by today's standards. Inadequate nutrition, poor accommodation and, in some areas, exposure to endemic diseases like malaria or bilharzias, probably shortened the lives of the poor even more.

Boer medical practice

Because the governments of the Boer republics placed a low priority on public health reform it would be a mistake to argue that the Boers were hostile to modern medicine. On the contrary, the evidence suggests that, where professional medical care was available, they made ready use of it. Certainly Henry Taylor, practising in Ficksburg, attending both to black and white patients, found that he had as much work as he could cope with.[35] Probably Boers used a mix of therapies, picking and choosing what they found most useful. The reasons for the lack of public health reform, are not hard to find. The Cape with a history of several major epidemics to trigger reform, had only begun to put a medical infrastructure in place from the 1880s. Initially lack of resources was one reason for republican neglect; a small and somewhat embattled

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[30] See also Taylor, *Doctor to Bantu, Boer and Briton*, 131.

[31] Murray, *Health Factors in the Poor White Problem*, 7.

[32] Ibid., 31.

[33] Ibid., 33-5.

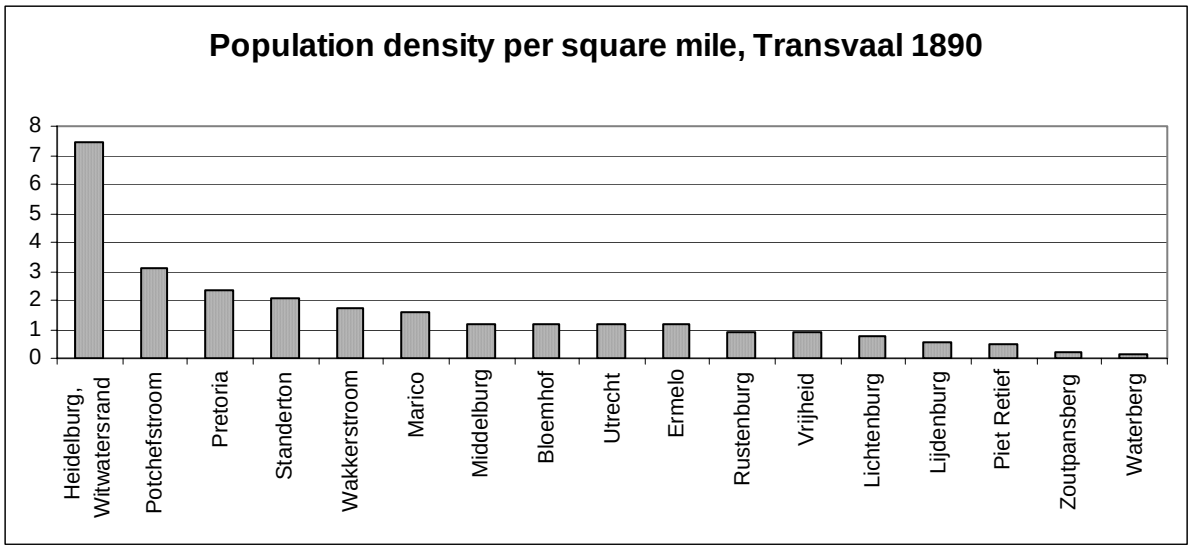
[34] Ibid., 47, 90-1.

[35] Taylor, *Doctor to Bantu, Boer and Briton*, 36, 132-3.

medical profession was a second; a public and government which was relatively uneducated in an understanding of modern public health was a third.

To a large extent the two Boer republics had lacked the stimuli which had driven medical reform forward in the Cape.[36] There had been no major epidemics to decimate the Boer or the black populations, so the belief that the Boers were a healthy and hardy people persisted; black disease and mortality was of little interest to most whites unless it threatened their own health or interests. In the 1890s this applied only to mine labour and even here investigations into health on the mines was in its infancy and quite separate from general public health issues.

In the Cape an organised medical profession had been vital in promoting reform. In the Boer republics the numbers were too small, and their organisation too weak, to give them a voice in government. Even after the mineral revolution, when there was a considerable influx of doctors, they were concentrated almost entirely in the mining centres where they could make viable livings. Just how thinly-scattered the rural population of the Transvaal was, can also be demonstrated from the 1890 census. Even in the Heidelberg-Witwatersrand area the population density was estimated at fewer than 8 people per square mile. Even after the discovery of gold, only a handful of centres offered the possibility of making a medical living, in an age when doctors made house calls, and did so on horseback.



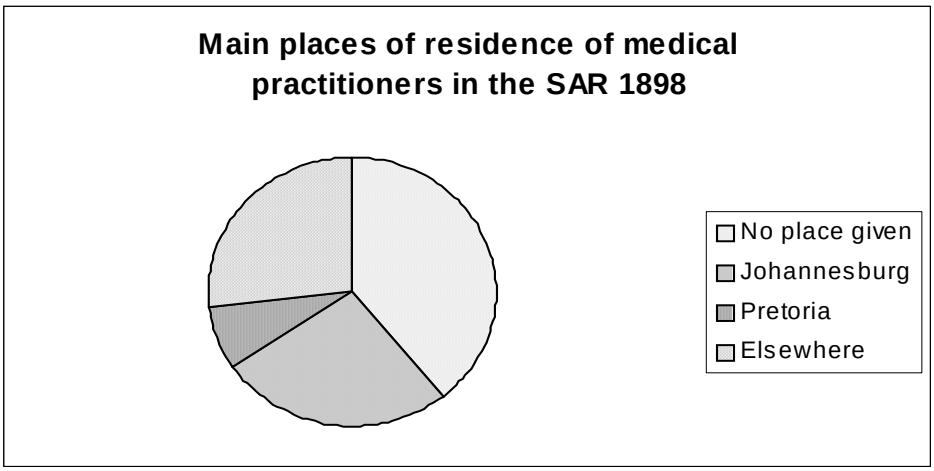
In the South African Republic, in 1886, legislation was passed which provided for the registration of medical practitioners, replacing the more casual laws which had existed before[37]. A list of registered practitioners was published in the *Staats Almanak.* As the Cape had discovered, however, unless registration was carefully monitored, the lists rapidly became out of date, still including doctors who had moved away, died, or left

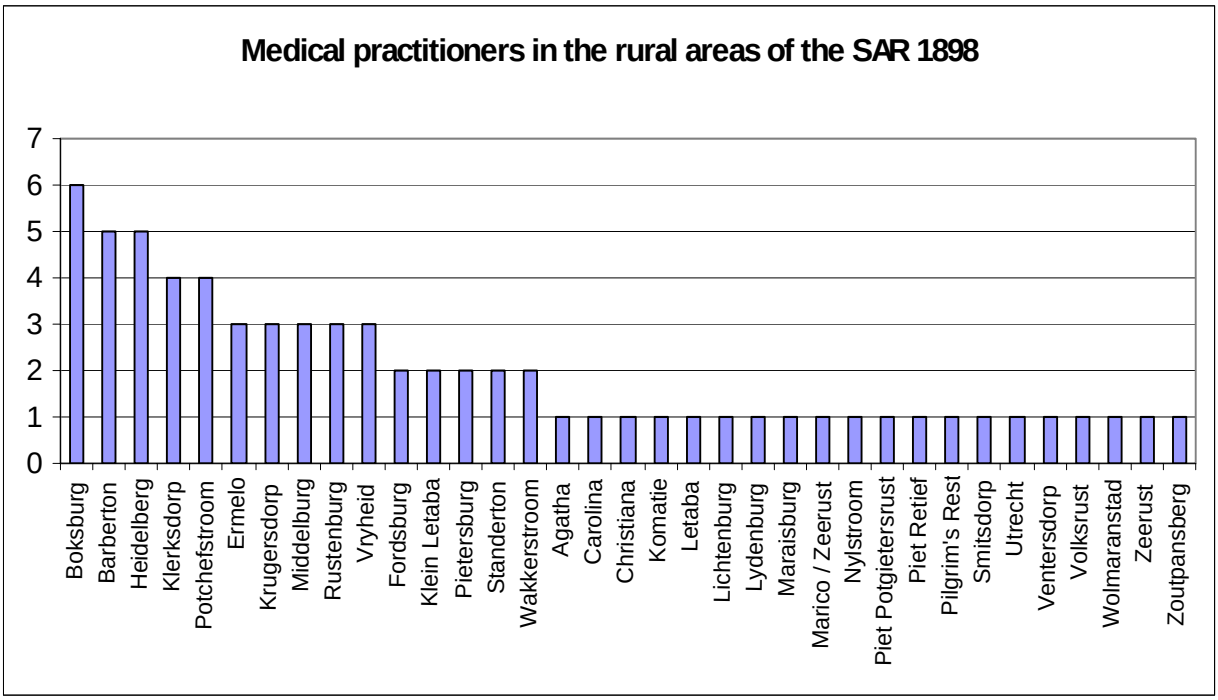
[36] E. van Heyningen, 'Agents of Empire: the medical profession of the Cape Colony, 1880-1910' *Medical History*, 33 (1989), 450-71; for a more extended discussion of the Cape medical professions see Deacon et al, *The Cape Doctor*.

[37] Burrows, *A Medical History of South Africa*, 284-5.

the country. This would appear to be the case in the SAR since no less than three of the district surgeons in 1898 did not appear on the list of registered practitioners. Nevertheless, a brief analysis of the list indicates some interesting features in comparison with the Cape.

In 1898 there were 271 doctors listed in the *Staats Almanak*, including those who were listed in various places but not on the registered list. Their distribution was hugely skewed. No less than 106 of the 271 gave no place of residence. Of the remaining, there were 71 in Johannesburg and 20 in Pretoria. The rest were scattered thinly across the country.

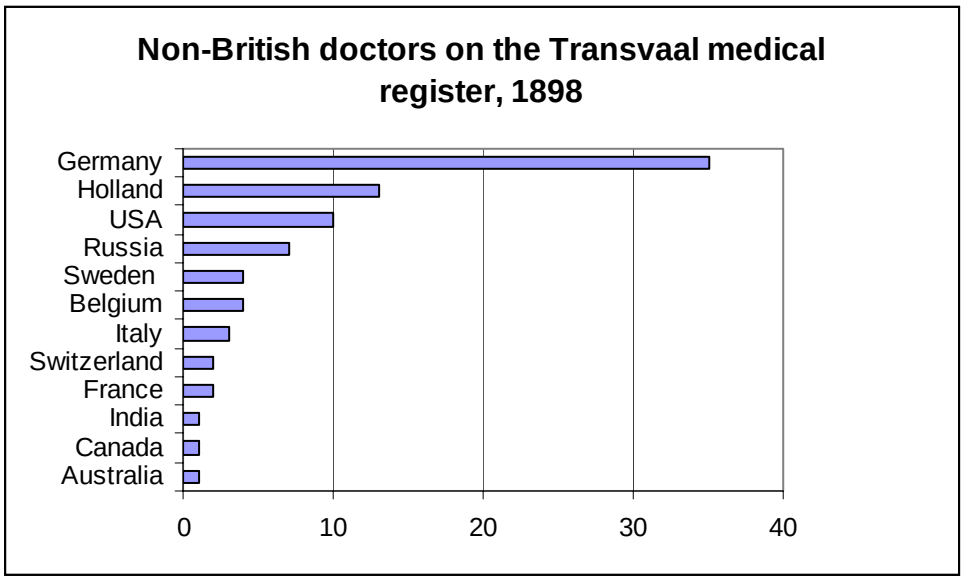




As in the Cape, the majority of doctors in the rural areas survived because of their government appointments as district surgeons. Both republics had adopted this unique South African institution, dating back to Company days. The main function of district surgeons was to vaccinate against smallpox, provide basic medical care in prisons and other government institutions, and to do post mortems in doubtful cases of death. In the Cape they were constantly at odds with the government over inadequate pay but

they came to provide a vital force to promote health reform.[38] In many respects their position was probably not very different in the Free State and Transvaal.

In one way, however, the medical practitioners of the Transvaal, and probably those of the Free State, differed from those of the Cape. Cape medical institutions were strongly influenced by the British example. One consequence was that doctors with medical qualifications which were not recognised by British medical legislation were largely excluded from the Cape as well. This meant that there were few continental doctors and almost none from the United States on the Cape register[39]. The South African Republic was far less restrictive. It is true that the majority of doctors, 161 of the 244 whose qualifications are listed, were British, holding British qualifications, or South Africans who had trained in Britain.[40] Nevertheless, considerably more continental doctors appeared on the Transvaal register, a handful of Americans, and even an Australian. Although Burrows suggests that the Transvaal was a 'quacks' paradise',[41] most of these doctors were well qualified. A handful held only the L.S.A. (Lond.), the lowest British qualification, but the majority held the normal range of L.R.C.S. and L.R.C.P of the Scottish universities or M.R.C.S. and L.R.C.P. of England, while a substantial number held M.D.s indicating a university education.[42] Most of the continental-trained practitioners also held reputable qualifications, while the Americans, far from being the fly-by-nights feared by the British, included one from Harvard and two from Yale. The Bombay-trained doctor had a British training as well.



The Orange Free State did not publish their list of registered practitioners but, by 1899, 250 were recorded in the smaller republic. There were, Burrows states, 150

[38] Van Heyningen, 'Agents of Empire', 468.

[39] Ibid., 452-3.

[40] There were no facilities for medical training in South Africa until after Union.

[41] Burrows, *A History of Medicine in South Africa*, 284

[42] There was a considerable range of British qualifications of which the above were only a few.

British, twelve who were Cape-born, fifty-two German, twenty Dutch and eight Jewish (presumably Russian) doctors.[43] Since the Free State had a far smaller population than the Transvaal, and a much smaller area, this suggests that far more Free Staters had access to professional medical attention than the Boers of the Transvaal.

If the use of traditional remedies was widespread, then, it was at least partly the result of isolation, lack of access to alternative health care, and the high cost of professional practitioners, even when they were available. Taylor routinely charged between £1 10s to £2 2s per hour to visit a patient, when a ride out to a farm could take several house. Medicines were £1 a bottle, also well beyond the pockets of those who earned a few shillings a day.[44]

Boer medical practice is the subject of considerable myth-making. In the first place, it is usually not clear what elements of medical care are involved in the notion of Boer remedies, – the use of the *Huis Apotheek*, the use of indigenous herbs, or, less commonly perhaps, the use of animal parts and excreta.[45] The growth of interest in alternative medicine and black indigenous medicine sometimes places a priority on 'natural' medicines as opposed to the products of Western scientific research, and gives Boer traditional practices an additional mystique. This is not to suggest that there was not value in some Boer remedies. The point, however, was that these practices were a complex mix of knowledge from seventeenth century Europe, information gained from interaction with the indigenous people of Africa whom they encountered, and experience. Herbal remedies had a long and respectable lineage and remain the aspect of traditional medicines which are the most widely discussed.[46]

The Boer tradition of healing was partly derived from an earlier European system. Even before they left the Western Cape magical practices, carried over from Europe, were also probably incorporated into their healing system. Moreover, over 150 years medical practice had been modified by the South African environment, by some limited access to European medicines, and by contact with the healing practices of the indigenous people. In seventeenth-century Europe the humoral philosophy of medicine, derived from the Greeks, although questioned by some scientists, had by no means been discarded. Central to this system was the belief that the body and the environment formed a whole, and that health or disease was a product of the relationship between the two. The body consisted of four parts or 'humors', blood, phlegm, yellow bile and black bile, each of which was associated with a particular part of the body and a specific season of the year and consisted of two fundamental qualities; so, for instance, blood was hot and moist, and was associated with the liver and with spring. Rosenberg notes that by the eighteenth-century the fundamental principles were rarely articulated, but given the lack of diagnostic tools, treatment was still primarily concerned with bringing these humors into balance through a management of the excretions and secretions of the body. Bleeding and purging were favoured nostrums but it was the result by which this balance was obtained, rather

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[43] Burrows, *A History of Medicine in South Africa*, 295.

[44] Taylor, *Doctor to Bantu, Boer and Briton*, 37. Only the prosperous could afford such fees.

[45] For a brief description of these remedies see Burrows, *A History of Medicine in South Africa*, 190-4.

[46] For a list of herbs commonly used by the Voortrekkers see Burrows, *History of Medicine in South Africa*, 192-3; the interchange between Khoi, Afrikaner and western practitioners has been explored in Deacon et al, *The Cape Doctor*, ch.2.

than the means, which was of significance.[47] Medical practice was concerned, not with the diagnosis of a specific disease, since individual pathogens were not recognised, but with the identification of the cause of the imbalance and with restoring that balance. The notion of sweating out a fever was one of the most straightforward examples of the humoral system of healing, and was a long-established practice amongst the Boers. Louis Trigardt, one of the first of the Voortrekkers, had promoted sweating to break the fever of his son, using herbs, vinegar and aloe.[48]

Isolation may have meant that the Boers were relatively free of infectious disease - childbirth, snakebite and wounds from misfired guns or animal attacks were the most common hazards they encountered.[49] Survival from wounds inflicted by lions was often recounted with pride.[50] Sometimes the injured victim was nursed at home. Jacobus Bota was saved by his wife who used herbs boiled in water to dress the wound.[51] More often victims used brutal surgery on themselves, as did a farmer who dragged himself home, cut off his lacerated hand with an axe and dressed the stump with cow-dung, tied a bladder over it, and healed his other wounds with a salve made of a decoction of 'odoriferous herbs', lard and wax.[52] The salve may well have included the European sow-thistle or deadly nightshade, both, C.P. Thunberg noted, found growing wild near every farmhouse.[53]

Faith and 'magic' were often essential components of treatment and remained features of rural medicine until late in the nineteenth century. The treatment of snake bite included mixture of European practice dating back to Pliny, and local methods:

> His hand had been scarified immediately, and a cupping-glass applied, in order to extract the poison from it. After this it was steeped in a solution of vitriol, which was said to have been rendered quite black by it. An onion was next applied, and afterwards tortoise blood. This latter, when laid on the wound in a dry state, was said to dissolve and turn to a fluid blood, that exhibited signs of effervescence; as the poison of serpents has a stronger attraction for tortoise blood than for human blood, so as to attract the poison to itself. [54]

Patent medicines had been widely employed by the Boers at least since the eighteenth century. The original Halle medicines had been produced and distributed by an orphanage in Halle in Germany and were in use at the Cape until the early nineteenth century. The opening paragraphs of the diary of Louis Trigardt were devoted to an explanation of the value of these medicines, especially 'Essentia dulcis'.[55] By 1900

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[47] C. Rosenberg, *The Care of Strangers. The Rise of America's Hospital System* (Baltimore, 1987),71-5; K.F. Kiple, *The Cambridge World History of Human Disease* (Cambridge, 1993), 11.

[48] A.W. Sloan, *English Medicine in the Seventeenth Century* (Durham, 1996), 62-3; Preller, *Die Dagboek van Louis Trichardt*, 45.

[49] It should be noted, however, that almost nothing is known of Boer mortality rates, although a belief in the healthiness and fertility of the eighteenth- and nineteenth-century Boer families became an ingredient of Afrikaner ethnic identity.

[50] The lion attack on Paul Kruger is probably the best-known example, passing into folk memory.

[51] Thunberg, *Travels*, p.207.

[52] Ibid., p.296.

[53] Ibid., p. 66.

[54] Ibid., pp.301-2. See also pp.43, 104-5. On the use of 'snakestone' see ch. 2.

[55] Ibid., 3.

the Halle medicines had been largely replaced by the *Huis Apotheek*, a similar product which came in a box together with instructions for the use of the various items although, it had been noted, few could read them and the family relied on the appearance of the bottles and their places in the box in order to identify them.[56] Old people, it has been observed, 'het presies geweet wanneer Groen Amara of Wit Vometief die aangewese middel was, wat die werking van Rooi Veventel of Balsem Sulphuris moet wees op 'n siekte'.[57] Dutch medicines were probably as reputable as the patent medicines which were widely available in Britain at the same time and continue to be used today.[58]

An aspect of Boer medical practice which is largely ignored now was the use of animal parts, blood or dung. Burrows notes suggestively that 'The intestinal contents of different animals or their excreta were believed to possess almost magical healing qualities'.[59] The use of animal parts as a form of therapy had a long tradition in Europe and they appeared even in some of the early editions of Culpeper's pharmocopoeia.[60] Animal excreta were removed from the London Pharmacopoeia in 1788[61] but the Boers continued to make use of such items into the twentieth century. Best known was '*dassiepis*' [dassie urine] or *Hyraceum*, taken from the shelters of dassies (*Hyrax*).[62] The sceptical F.R. Davel, in his unpublished memoirs written in the late nineteenth century, made relatively little reference to herbal remedies; most were animal in origin, ranging from '*koraan maag*' [guinea fowl stomach] to blood or urine of various kinds. Boers used these medicines, he explained, because they were so far from doctors, because the roads were so bad or because the doctors were sometimes so incompetent that jackal liver or crow soup (for rheumatic fever) were preferable.[63]At the same time it is possible that this was a therapy that had been assimilated from or reinforced by the African healers, for dung was widely used at least in Xhosa healing practices.[64]

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[56] J.F. Juritz and Co., *List of Halle Medicines* (Cape Town, 1870), 'Pharmaceutical Notes from the Cape Colony' in *The Chemist and Druggist* 27, (15.10.1885), 600, both cited in M. Ryan, *A History of Organised Pharmacy in South Africa 1885-1950* (Cape Town, 1978), 3; Burrows, *History of Medicine*, 190-1. Today these products are manufactured by Lennons of Port Elizabeth and are widely available in pharmacies as a form of alternative medicine.

[57] Spoelstra, Ons Volkslewe, p.124.

[58] Opium was widely used in patent medicines in Britain, particularly in the popular children's medicine, 'Godfrey's Cordial'. Despite some legislative restrictions Smith believes that its use continued to be widespread until 1914. F.B. Smith, *The People's Health 1830-1910* (London, 1979), 95-7.

[59] Burrows, *History of Medicine*, 192.

[60] Sloan, *English Medicine in the Seventeenth Century*, 61.

[61] P.W.Laidler and M.Gelfand, *South Africa. Its Medical History 1652-1898* (Cape Town, 1971), p.71.

[62] C.P. Thunberg *Travels at the Cape of Good Hope 1772-1775*, ed by V.S. Forbes, (Cape Town, 1986), p.73.

[63] Unpublished memoir of F.R. Davel in private possession.

[64] J.W. Appleyard, *The War of the Axe and the Xosa bible. The Journal of the Rev. J.W. Appleyard*, ed by J. Frye (Cape Town, 1971), p.11; J.P. FitzGerald at the Grey Hospital in King William's Town refers this practice on a number of occasions, for instance, Kaffrarian Museum, J.P. FitzGerald Letterbook, I, J.P. FitzGerald to the Chief Commissioner, Fort Murray, 6.12.1856.

It is difficult to know who used which remedies, why and how. The evidence at present is largely impressionistic. It is probable that most people adopted the remedies which seemed most appropriate in their circumstances, attending a doctor if they could afford it but falling back on familiar techniques for familiar ailments.

Conclusion

This paper has done no more than indicate that the relationship between health care and Boer society was more varied than is sometimes supposed. A number of questions have barely been touched – the role of the woman as healer, the impetus behind medical legislation in the republics, the status of health in individual communities; these are only a few of the topics which deserve further exploration. What is clear, however, is that Boer society was probably no healthier than whites elsewhere in South Africa and that they were prepared to use modern medical technology readily when it suited them. It is probably true that the concentration camps left a legacy of fear of hospitals and suspicion of doctors but, on the other hand, they introduced a considerable number of young women to nursing, an experience which was not necessarily negative and may have led them to encourage their daughters to become nurses in the next decades.

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