

THE MEDICAL LIFE OF WILLIAM ANDERSON SOGA IN LATE NINETEENTH-CENTURY BRITAIN AND SOUTH AFRICA

by

SURYAKANTHIE CHETTY*

*Department of Historical and Heritage Studies, University of Pretoria, Pretoria
0002, South Africa*

William Anderson Soga is considered the first indigenous Western-educated medical doctor in the region that would become South Africa. As a medical missionary he epitomized the union of medicine and religion to promote ‘civilization’. This paper explores the world inhabited by the Sogas which comprised the ‘traditional’ and the ‘modern’, progress, conflict and conquest. It seeks to contextualize the figure of William Anderson Soga in late nineteenth-century South Africa and uses as a case study Soga’s thesis on the Bomvana as a means of understanding his own position as a figure of mixed heritage during a period when Western ‘civilization’ was unequivocally harnessed to the narrative of progress. Soga’s analysis of the health and indigenous healing practices of the Bomvana spanned the fields of medicine and ethnography, with a focus on the role of the environment, an environment that was rapidly changing owing to modernization. While Soga explicitly advocated Western medical practices, his thesis was nevertheless an attempt to record aspects of indigenous culture as they were being eroded by the pervasive influence of Western knowledge systems. Finally, this paper addresses the intellectual influences that underpinned Soga’s analysis, demonstrating the ambiguous legacy of modernity.

Keywords: William Anderson Soga; South Africa; Xhosa; medicine; Bomvana; civilizing mission

INTRODUCTION

William Anderson Soga was of Xhosa and Scottish extraction, a medical doctor and a missionary. He spent his career on the frontier of White settlement in late nineteenth-century South Africa, healing both Black and White people. His life and his work are an illustration of the convergence between colonialism and medicine, the Western and the indigenous and borders—geographical and ideological—both fixed and transgressed.

The historiography of colonial medicine has expanded tremendously in depth and scope over the last three decades. From very early first-person accounts of the experiences of medical professionals, writing of the colonial context was less about medical breakthroughs—which tended to be the prerogative of the metropole—than it was about the

* chetty_s@yahoo.co.uk; chetty.s@up.ac.za

supplantation of ‘savagery and superstition’ by the ‘civilizing’ influence of medicine, particularly in the guise of public medicine. Since the latter part of the twentieth century, however, the study of colonial medicine as a distinct field has come into its own, with increasing consideration of the relationship between medicine, power and ideology within the colonial context. Its distinctive nature notwithstanding, there is simultaneously an acknowledgement of the porous nature of the boundary between the metropole and the colony, with Shula Marks posing the question, ‘what is ... colonial about colonial medicine?’ This can be answered by considering ‘imperial medicine’ to be the practice of Western biomedicine in those areas of the globe that fell under European colonization. Yet, consideration too has to be given to the ways in which Western medical knowledge was perceived, received and shaped by those who were its recipients—the indigenous people of Africa and Asia—and how this knowledge was contextualized and transformed by the colonial encounter.¹

Related to the last, using the lens of tropical medicine, Mark Harrison addresses the shifting attitudes of European medical practitioners in colonial India towards indigenous medicine. In the early nineteenth century, under the ambit of the East India Company and inspired by Enlightenment values, there was a marked tolerance for and appreciation of indigenous medicine. Despite this, the Orientalist framework in which this occurred was predicated on European superiority and the degeneration of Indian society. During a time when Europeans succumbed readily, Indian habits and remedies were given serious credence in the treatment and prevention of tropical disease, and the locally acquired knowledge and expertise of these Indian-based British doctors rendered them authorities in tropical medicine in the metropole. From the 1820s, however, there was an increasing dismissal of indigenous knowledge in favour of Western science and medicine. Indians were no longer consulted for solutions to tropical disease; it was those very habits and customs that were associated instead with the spread of disease, posing a threat to public health—and to colonial order. Harrison therefore demonstrates the evolving nature of medical knowledge as it is intertwined with the changing nature of colonialism, finally creating a dichotomy between indigenous and Western knowledge systems and the ultimate marginalization and dismissal of the former.² By the time of Soga’s writing and the establishment of his practice in the Eastern Cape, then, this marginalization of indigenous knowledge was all but complete, and silenced even more effectively by the animosity of White settlers.

The relationship between disease, healing and colonialism is therefore what Roy Porter describes as ‘many-faceted’. The international spread of colonialism brought the global transmission of disease, with smallpox, for instance, having a devastating effect on the Khoekhoe at the Cape from the seventeenth century. Europeans, too, succumbed to diseases in the ‘tropics’. The perceived superiority of Western medicine did little to offset the double-edged sword of ‘progress’—crowded and unsanitary living conditions, poor nutrition, occupational disease. Western medical practitioners challenged the authority of indigenous healers, harnessing Western medicine and science to the colonial project.³ As

1 Shula Marks, ‘What is colonial about colonial medicine? And what has happened to imperialism and health?’, *Social Hist. Med.* **10**, 205–219 (1997) (<https://doi.org/10.1093/shm/10.2.205>).

2 Mark Harrison, ‘Tropical medicine in nineteenth-century India’, *Br. J. Hist. Sci.* **25**, 299–318 (1992) (<https://doi.org/10.1017/S0007087400029137>), at pp. 301, 303, 307, 309–310.

3 Roy Porter, *The greatest benefit to mankind: a medical history of humanity from antiquity to the present* (Fontana Press, London, 1999), p. 482.

Pratik Chakrabarti argues, the rise of ‘modern’ medicine was concomitant with imperialism, and the history of the two are intimately linked. The development of natural history, the professionalization of surgeons, the use of drugs and the growing emphasis on public health—all features of modern European medicine—were as evident in the colonies, each shaping and, in turn, being shaped by the other.⁴ Within the South African context, as Anne Digby points out, ‘Southern Africa was a settler society with medical as well as religious and political colonisers’.⁵

Marks reiterates this deep-seated relationship between colonialism and Western biomedicine. Both imperial expansion and medicine were the twin products of Western technology with the parallel assumption of European intellectual and cultural superiority—and dominance. Medicine was the means by which European bodies could endure and ultimately subordinate the ‘tropics’. It created biological norms while simultaneously emphasizing distinction—and hierarchy—based on ideological assumptions regarding race and gender. The role of medicine in the colonial context thus presents the ideal opportunity to assess the colonial encounter, considering not just the power exerted on the indigenous but the ways in which the latter sought to understand, assimilate, adapt and resist. It situates the ideology of medicine within the local and regional characteristics of the colony. In addition, as Marks reminds us, there is the history of illness and disease as it relates particularly to the colonial context. In South Africa in the late nineteenth century, this was marked by the transition wrought by a changing economy, the move to commercial agriculture and mining. Demands for labour, restrictions on land occupation and ownership, and the mass movement of people to the burgeoning urban centres brought to the fore the diseases linked with poverty and a society in dramatic transition.⁶ And it is in this world of transition that we can place William Anderson Soga, who reflects the ambiguities of an exemplar of Western medicine even as he was part of a people defeated and dispossessed.

From the mid nineteenth century, there was a proliferation of medical health professionals in the Cape Colony, the great majority of whom were White, male and British. Yet Western medicine co-existed—often uneasily—with existing systems of healing. These included that used by rural Boers, which was a combination of folk and herbal remedies as well as indigenous systems of healing.⁷ As Harriet Deacon argues, however, by 1807 Western-trained medical professionals had positioned themselves as the sole ‘legal’ sources of medical treatment with government-sanctioned approval, thereby marginalizing alternative forms of healing. The latter, however, remained a dominant form of healing in southern Africa,⁸ thus existing in tension with Western medicine, which also took on an ideological cast; like agriculture, education, industrialization and waged labour, it was part of the ethos of British ‘civilization’. The last two decades of the nineteenth century were therefore significant in the development of the medical profession at the Cape Colony, marking not just the formalization of the profession but its ideological role—particularly in public health.

There were two kinds of doctors practising at the Cape: the secular medical professional and the medical missionary. For the latter, as in the case of the principal of

4 Pratik Chakrabarti, *Medicine and Empire, 1600–1960* (Palgrave Macmillan, Basingstoke, 2014), p. xv.

5 Anne Digby, *Diversity and division in medicine: health care in South Africa from the 1800s* (Peter Lang, Bern, 2006), p. 27.

6 Marks, *op. cit.* (note 1), pp. 208, 210, 215.

7 William Beinart and Saul Dubow, *The scientific imagination in South Africa: 1700 to the present* (Cambridge University Press, 2021), p. 148.

8 Harriet Deacon, ‘The Cape doctor in the nineteenth century’, in *The Cape doctor in the nineteenth century: a social history* (ed. Harriet Deacon, Howard Phillips and Elizabeth van Heyningen), pp. 17–43 (Rodopi, Amsterdam and New York, 2004), p. 19.

Lovedale College, James Stewart, medicine was not just the means of alleviating suffering but Western medicine could counter the ‘“malignant influence” of indigenous healing practices’. For Cape Governor George Grey, medicine was seen as little different—the means by which ‘witch doctors’ would be exorcized and the Xhosa incorporated into the British fold with the complicity of African doctors trained in Western medicine.⁹ As reports of the Glasgow Missionary Society in the 1830s indicate, the methods of traditional healers were seen as being at odds with the conventions of Western medicine, where herbal remedies were prescribed for symptoms rather than underlying causes and there was much opportunity for charlatans.¹⁰ The role of the medical missionary, then, was one that combined the secular nature of Western medicine with an evangelizing mission. Through the use of medicine and scientific methods of healing, the medical missionary could demonstrate concretely the ‘benevolence’ of Western influence to an indigenous population wary of proselytizing.¹¹

Western medicine was also the means by which early policies of domination and segregation could be implemented. The Public Health Act No. 23 (1897) was a public health initiative that placed the region on par with similar British legislation. It was simultaneously used to exclude ‘undesirable’ groups deemed a public health hazard from the Cape such as Indians, uphold the racial stereotypes regarding the sanitary habits of Eastern European Jewish immigrants and, with the outbreak of plague, was implemented to remove Africans from the city owing to the apparent threat they posed to public health. Public health concerns were linked to the ideology of segregation.¹² Western medicine was therefore an ambiguous feature of late nineteenth- and early twentieth-century South Africa—it was used to ‘civilize’, to exclude and ultimately to resist. All these features would be evident to varying degrees in Soga’s work.

As David Killingray points out, there are significant challenges for the historian writing about Black South Africans in the period before 1912, the most important of which is a dearth of primary material. It is often the most prominent Black political and intellectual leaders whose voices are to an extent preserved in the archive—Tiyo Soga is one such figure, with a biography published of him as early as 1878; however, his son, William Anderson, is not.¹³ The latter’s life was less documented than that of his father or his brothers, and the writings that exist tend to privilege his work as a missionary rather than a medical doctor. An exception, however, is his thesis written in 1894.¹⁴ Through an understanding of colonial attitudes to indigenous medicine and, concurrent with this, the envisaged role of Western medicine as well as William Anderson Soga’s own analysis of indigenous healing, as evident in his writings, it is possible to gain some understanding of

9 E. B. van Heyningen, ‘Agents of empire: the medical profession in the Cape colony, 1880–1910’, *Med. Hist.* **33**, 450–471 (1989), at pp. 466–467.

10 Robert H. W. Shepherd, *Lovedale South Africa: the story of a century, 1841–1941* (Lovedale Press, Lovedale, 1942), pp. 51–54.

11 Cairns Craig, ‘Empire of intellect: the Scottish Enlightenment and Scotland’s intellectual migrants’, in *Scotland and the British Empire* (ed. John M. MacKenzie and T. M. Devine), 84–117 (Oxford University Press, 2016), at p. 96.

12 Van Heyningen, *op. cit.* (note 9), pp. 469–470.

13 David Killingray, ‘Significant Black South Africans in Britain before 1912: Pan-African organisations and the emergence of South Africa’s first Black lawyers’, *S. Afr. Hist. J.* **64**, 393–417 (2012), at pp. 393–394.

14 Natasha Erlank, ‘The history of the Soga family, race and identity in South Africa in the late 19th and early 20th centuries’, in *Oxford research encyclopedias, African history* (Oxford University Press, 2021), <https://doi.org/10.1093/acrefore/9780190277734.013.776>.

the medical and ideological world inhabited by the man hailed as the first Black doctor in the region that would become South Africa.

ANTECEDENTS

Through the course of a tumultuous nineteenth century, marked by industrialization (and imperialism), science and medicine were unequivocally associated with progress. As Porter notes, dramatic technological change, bringing with it both economic and social upheaval, suggested the power of human agency to transform the natural world, and scientific medicine was part of a new way of understanding, interacting with and ultimately controlling the natural. New technologies such as the stethoscope were invented and diagnosis took on a scientific bent, with post-mortem investigations used to determine the physical effects of disease. A focus was on respiratory illness, with new understanding of tuberculosis and its physical manifestation in the lungs. In Germany, the emphasis was on the laboratory and the chemical changes in the human body. Organic chemistry demonstrated the ways in which the digestive system broke down food into its chemical components, necessary to understand nutrition. Another significant area affected by the new scientific medicine was pharmacology, with chemical experiments performed to determine the action and efficacy of existing drugs and develop new medicines. Related to this was the accurate determination of dosage. Scientific study ultimately provided a norm of measurement against which deviations could be determined and medicine used to correct.¹⁵

Inseparable from the rise of scientific medicine in the nineteenth century were the illness and disease associated with industrialization. In Europe's growing cities, the working classes lived in overcrowded and unsanitary conditions compounded by growing environmental pollution. Inadequate diet and unremitting labour created low life expectancy, and disease was rampant. Especially prevalent in Britain's industrial heartland was tuberculosis, accounting for approximately 25% of all deaths among the poor. Outbreaks of typhus and global epidemics such as cholera heightened the misery of the working classes. Yet it was not just the poor that were affected. Epidemics presented a threat to political stability; they represented 'disorder and danger'. In the nineteenth century, then, scientific medicine took on an ideological cast, becoming inseparable from public health and, with it, Christian morality and the intervention of the state and medical professionals for the greater good and the maintenance of order.¹⁶ This mission of modern medicine would be transported to the colonies.

In 1836 Andrew Geddes Bain—later to become a key figure in the Cape as a civil engineer and geologist—was stationed on the eastern frontier in the region that would become South Africa and tasked with preserving the border between the Xhosa and the British settlers and preventing stock theft. In his journal, Captain Bain noted his role in helping a Xhosa chief who approached him for assistance in using the Tyumie River for irrigation. While in the vicinity of the Tyumie Mission Station, Bain also came across a Xhosa man named Soga who was attempting to plough the land. The going was difficult but Bain saw this as a sign of the civilizing and modernizing influence of settler occupation. He

¹⁵ Porter, *op. cit.* (note 3), pp. 305–311, 322–323, 333–334, 345.

¹⁶ *Ibid.*, pp. 398–399, 401–405.

would subsequently provide assistance in enabling Soga to develop the skills necessary to use the plough effectively.¹⁷

Old Soga—as he was known—proved a quick study, becoming the first known member of the Xhosa to make use of modern irrigation techniques and a plough to produce crops for the market. His agricultural and entrepreneurial skills were such that he attracted the attention of the Cape government, which provided him with a plough and the instructions in its use.¹⁸ In an almost lyrical and evocative description of the landscape inhabited by the Bomvana some seven decades later, Old Soga's grandson, William Anderson, indicated the agricultural concerns that had partly underpinned the notion of progress on the mission stations and that had been so successfully adapted by his grandfather. The landscape was described in relation to its productivity—cattle herding, the cultivation of fruit and vegetables and crops for the market such as grains and tobacco. Also considered was the availability of water and the suitability of the land for irrigation.¹⁹ Old Soga, then, was one of the first of the Xhosa to actively engage with the forces of progress as exemplified by the mission station and the ideology of the 'civilising mission'. His descendants, too, would embrace the new opportunities afforded them, straddling the boundaries between the 'traditional' and the 'modern'.

Old Soga's son—and William Anderson's father—was Tiyo Soga, who was born in 1829 and educated first at the Tyumie mission school and then Lovedale.²⁰ Envisioned as an exemplar of progress, the Lovedale missionaries focused on the translation of the Bible into Xhosa but were also cognisant of the existence of the secular world and, as at Tyumie, training was provided in modern agricultural methods and inhabitants were encouraged to '[adopt] the dress as well as the thoughts and feelings of civilised life'.²¹ With the inauguration of the Lovedale Institute in 1841, Reverend James Laing articulated the proposed role of Lovedale as that of:

allowing and enabling the educated Native to drink at the English fountains of literature, science and practical godliness; and afterwards to employ himself dispersing abroad these very fountains through the medium of his mother tongue.²²

In contrast to much of the racial prejudice and violence that characterized the eastern frontier in the nineteenth century, Lovedale was an integrated school with Black and White pupils being taught in the same classroom with an ethos based on an understanding that indigenous Africans were deserving of 'the rights of British subjects' and, ultimately, of citizenship—for which a Western education would prepare them.²³ Yet for many Xhosa during this period of violence and conquest, a Western education was seen as a further attempt to erode their traditions, and Tiyo himself—who studied at Glasgow University,

17 Andrew Geddes Bain, 'Military journal at Fort Thomson, 1836', in *Journals of Andrew Geddes Bain* (Van Riebeeck Society, Cape Town, 1949), pp. 163–190.

18 Donovan Williams, *Umfundisi: a biography of Tiyo Soga, 1829–1871* (Lovedale Press, Press, 1978), pp. 8–9.

19 William Anderson Soga, *The ethnology of the Bomvanas of Bomvanaland, an aboriginal tribe of South East Africa: with observations upon the climate and diseases of the country, and the methods of treatment in use among the people*, MD thesis, University of Glasgow (1894), pp. 1, 2, <https://theses.gla.ac.uk/73985/1/1894SogaMD.pdf> (accessed 14 November 2021).

20 Shepherd, *op. cit.* (note 10), pp. 2, 64.

21 *Ibid.*, pp. 65–67.

22 *Ibid.*, p. 96.

23 *Ibid.*, pp. 98–99.

was ordained as a minister of the United Presbyterian Church and married a Scottish woman, Janet Burnside— incurred a particular aversion as ‘a renegade’, tainted by Western influence.²⁴

Tiyo Soga was a man of two worlds. Although more recently claimed as a proto-African nationalist, Vivian Bickford-Smith has discussed the complex and perhaps contradictory elements that constituted the man shaped by the colonial encounter in all its forms.²⁵ It was a complexity reflected in his eldest son. Born in 1858 and the first of seven surviving children, William Anderson was named for the Presbyterian minister who spoke at Tiyo’s ordination in 1856, a prayer that consisted both of a valorization of the Xhosa chief Sandile and a simultaneous denouncement of British actions in the Eastern Cape.²⁶ His words reflected Tiyo’s own ambivalence regarding the civilizing mission—his strong conviction that British rule and, with it, science, education and religion was instrumental to progress. Tiyo was, however, just as cognisant of the racial discrimination, violence and dispossession that accompanied the civilizing mission. As Bickford-Smith argues, British loyalism was one facet of an identity that was also drawn from his Xhosa heritage.²⁷ Tiyo’s own father, ‘Old Soga’, had also demonstrated this shifting identity, serving as an advisor to the Xhosa chiefs but later embracing modernization by turning to commercial farming.²⁸ William Anderson Soga would do no less in a career that brought together Western medicine, an understanding of indigenous healing and an acknowledgement of a way of life that was irretrievably subsumed by the relentless march of progress.

RELIGION, MEDICINE AND CIVILIZATION

Twelve-year-old William Anderson—along with his two younger brothers—was sent to the Dollar Academy in Scotland for their education. Tiyo’s belief was that, while education opportunities were available for Black children in the Cape Colony, he had reservations as to whether a sufficiently high quality of education would be afforded them even if they came from ‘respectable’ backgrounds. While Lovedale was the exception, Tiyo did not want his sons to be confined to this one institution in the event that it might affect ‘the natural bent or inclination of their minds with reference to the future’.²⁹ Despite acknowledging the importance of the education and other accoutrements that resulted from the colonial encounter, Tiyo was nonetheless aware of the racially based limitations that applied at the Cape, where aspirations to ‘civilization’ and political equality sat uneasily with the maintenance of White supremacy.

His eldest son enrolled for a bachelor’s degree in medicine at Glasgow University. As Matthew Eddy shows, Glasgow University had a long history of training Black doctors, including James McCune Smith, the first African American doctor to graduate from the medical school in 1837, almost five decades before William Anderson. It was a regimen of medical training that combined both the practical and the theoretical.³⁰ In 1880, his

24 Williams, *op. cit.* (note 18), pp. 19–26.

25 Vivian Bickford-Smith, ‘African nationalist or British loyalist? The complicated case of Tiyo Soga’, *Hist. Workshop J.* 71, 74–97 (2011).

26 *Ibid.*, pp. 78–79.

27 *Ibid.*, p. 89.

28 *Ibid.*, p. 78.

29 Williams, *op. cit.* (note 18), pp. 88–89.

first year of study, William Anderson's subjects included chemistry, botany and natural history. This was followed by a more medical focus in subsequent years: anatomy, regional anatomy, physiology, surgery, clinical surgery, midwifery, forensic medicine, pathology, materia medica, and pharmacy and therapeutics. He passed most of his subjects with admittedly average marks, with the exception of forensic medicine, where he clearly excelled, achieving 80% in his fourth professional examination in 1883.³¹ He also demonstrated an aptitude for materia medica and therapeutics and was awarded a second class certificate in the subject in 1880–1881 and a first class certificate for materia medica and practical pharmacy in 1881.³²

Soga's subjects were a reflection of the regulation of medical training that had been a hallmark of the university from the preceding century, yet which had necessarily been adapted to changing environments, bringing with them new diseases. During Soga's period of study at the university, the chair of medicine was William Tennant Gairdner, a position he had held since 1862.³³ Gairdner was born in 1824 and studied at the University of Edinburgh. While lecturing in pathology, he developed an early interest in public health, with research into pulmonary diseases as well as cholera. One of his major works, *Public health in relation to air and water*, was published in 1862, the same year he was appointed to the chair of medicine at Glasgow University.³⁴ In the monograph, Gairdner addressed some of the features of public health that would to varying degrees be apparent in Soga's dissertation—the quality of air and water, the living conditions and housing of the working classes, and the spread of tuberculosis. In his introduction, Gairdner described public health as a 'modern science'; its associations with the challenges of modernity were unequivocal. Simultaneously, Gairdner considered public health to be a religious imperative—the physical purity of the body was associated with morality and spirituality.³⁵

Soga's dissertation would also reflect his interest in materia medica. The year 1880 saw not just his first year of study at Glasgow University but the installation of the new chair of materia medica and therapeutics, Matthew Charteris.³⁶ Materia medica had its origins in the ancient world, but it was in the eighteenth century that systematic investigation was conducted into the use of drugs, ushering in the new science of pharmacology, which would grow exponentially in the nineteenth century. Concurrent with the development of pharmacology was that of homeopathy, the alternative to modern medicine that stressed a lesser degree of medical intervention in the curing of disease.³⁷ It is indicative of the tension between the modern and the indigenous as reflected in Soga's own experiences. While largely recognized for the *Practice of medicine*, which was first published in 1888 and ran to several editions, Charteris was also absorbed by the relationship between climate and health,

30 Matthew Daniel Eddy, 'James McCune Smith: new discovery reveals how first African American doctor fought for women's rights in Glasgow', *Conversation*, 8 October 2021, <https://theconversation.com/james-mccune-smith-new-discovery-reveals-how-first-african-american-doctor-fought-for-womens-rights-in-glasgow-166233> (accessed 24 September 2023).

31 Graduate Schedule (MED5/2/5), Library archives and special collections, University of Glasgow.

32 Degree and Prize List (SEN10/23 p. 202 and SEN10/24 p. 215), Library archives and special collections, University of Glasgow.

33 James Coutts, *A history of the University of Glasgow from its foundation in 1451 to 1909* (James Maclehose and Sons, Glasgow, 1909), pp. 511, 657.

34 George Alexander Gibson, *Life of Sir William Tennant Gairdner, KCB, MD, LLD, FRS* (James Maclehose and Sons, Glasgow, 1912), pp. 11, 18, 53, 55, 79.

35 W. T. Gairdner, *Public health in relation to air and water* (Edmonston and Douglas, Edinburgh, 1862), pp. 4–5.

36 Coutts, *op. cit.* (note 33), p. 650.

37 Linette A. Parker, 1915 'A brief history of materia medica', *Am. J. Nurs.* **15**, 830 (1915).

making a study of the various health resorts in Britain and Europe in terms of altitude and more temperate conditions, the mineral composition of their water and its perceived effects on health. Also considered is air quality and the benefits of fresh air, good ventilation and exercise outdoors.³⁸ Charteris's work is an articulation of contemporary medical thinking and would also be evident in Soga's discussion of the lifestyle of the Bomvana.

William Anderson Soga obtained his bachelor's degree in medicine from Glasgow University in 1883. In the MD Graduation Album, there are five signatories for April 1894 indicating their acknowledgement of their MD: three from Scotland, one from England, and William Anderson, who indicated his origins as 'Kaffraria'.³⁹ British Kaffraria had been created in the wake of the Seventh Frontier War between the British and the Xhosa in 1846. Occupying the territory between the Kei and Keiskamma rivers, it was reserved for the defeated Xhosa and administered by British High Commissioner Sir Harry Smith. The land was subdivided, with the divisions given the name of English counties, and it was surveyed preparatory to the implementation of taxation policies. Smith was unequivocal in his desire to foster the civilizing mission of British imperialism: 'You shall all learn to speak English at the schools which I shall establish for you ... You may no longer be naked and wicked barbarians, which you will ever be unless you labour and become industrious. You shall be taught to plough ...'⁴⁰ The first medical professionals in British Kaffraria were the military doctors who had used medicine to foster this civilizing mission, encouraging the conquered Xhosa to make use of 'European physicians'. They would also collaborate with missionaries such as those on the Tyumie Mission Station to provide their medical expertise.⁴¹ Old Soga had taken up the plough, even as he had taken up arms against the British in an earlier conflict. His grandson, William Anderson, would be a firm advocate of this civilizing mission yet nevertheless display a profound ambivalence towards the loss of Xhosa independence and the effects of modernization.

Considered the first South African Black doctor, Soga was followed a decade later by Abdullah Abdurahman, prominent politician and activist who rose to lead the African Political Organisation and was one of the pioneering Black political activists to seek political alliances across racial lines.⁴² The ideological role of Western-trained doctors at the Cape had been a feature for much of the nineteenth century—medicine was part and parcel of the civilizing mission of Empire. This was given impetus by the preponderance of British and British-trained doctors. There were no medical schools in southern Africa and prospective doctors were compelled to study abroad, either in continental Europe or in Great Britain and, in particular, Scotland.⁴³ As a founding member of the African National Congress, Pixley ka Seme proclaimed in 1906 that those who studied abroad understood the value of knowledge and education, with a mission 'to drive darkness from the land'.⁴⁴ For

38 M. Charteris, *Health-resorts at home and abroad* (J. & A. Churchill, London, 1885).

39 MD Graduation Album (R1/5/4), Library archives and special collections, University of Glasgow.

40 Jeff Peires, *The house of Phalo: a history of the Xhosa people in the days of their independence* (Jonathan Ball Publishers, Johannesburg and Cape Town, 1981), pp. 188–189.

41 Van Heyningen, 'Medical practice in the Eastern Cape', in *The Cape doctor in the nineteenth century: a social history* (ed. Harriet Deacon, Howard Phillips and Elizabeth van Heyningen), pp. 169–194 (Rodopi, Amsterdam and New York, 2004), at pp. 177–178.

42 B. M. Mayosi, 'The first Black doctors and their influence in South Africa', *S. Afr. Med. J.* **105**, 635–636 (2015).

43 Van Heyningen, *op. cit.* (note 9), p. 454.

44 Killingray, *op. cit.* (note 13), p. 395.

William Anderson Soga, that ‘darkness’ consisted of both colonial racism and indigenous practices that were at odds with science and Christianity.

After qualifying as a fully fledged medical doctor, William Anderson followed in the footsteps of his father, undertaking to serve as a missionary in the Eastern Cape under the auspices of the United Presbyterian Church in 1885. His mission work, however, would be supplemented, and at times supplanted, by his medical work owing to the lack of medical professionals in the region. Like his father, too, William Anderson married a Scotswoman, Mary Agnes Meikle, prior to his return to South Africa.⁴⁵

On Soga’s return to South Africa, he and his wife were based at the Miller Mission in the Eastern Cape. While writing some years later, John Henderson Soga’s account of the work of the Miller Mission would have borne some similarity to the evangelizing mission under his brother’s leadership. ‘Aggressive Christian work’ had been a feature of the mission station, and the expansion of Christianity was gradual. With the establishment of a mission station, inroads were made into ‘traditional’ groups, with missionaries visiting the kraals of those who seemed most inclined towards the ‘Word of Life’. Prayer meetings were held on Wednesdays and women’s meetings on Tuesdays and Thursdays. Women played a significant role in the spread of Christianity, with Soga’s belief that they were essential to the evangelizing mission. They therefore formed a cohort that travelled ‘to the heathen kraals’ in order to propagate the religion.⁴⁶

In addition to her medical and proselytizing duties, Mary Agnes is believed to have been responsible for the education of young children on the mission station. She also gave lectures at the Women’s Zenana Mission.⁴⁷ The Ladies Association for the Support of Zenana Work and Bible Women in India had been formed in 1867 and would be renamed the Baptist Zenana Mission in 1897. It had been formed by British women to convert Zenana women—those of a higher caste—who were believed to require the ‘freedom’ of Christianity. As access to these women by men outside the family circle was forbidden, there was the opportunity for British women to play more overt and prominent roles as missionaries—which, as Karen Smith argues, empowered British female missionaries as well.⁴⁸ Mary Agnes’s work can be contextualized by the changing recognition afforded to the wives of missionaries as well as the growing accommodation of unmarried female missionaries. In the early nineteenth century, missionary wives bore children, assumed domestic responsibility and assisted their husbands while exemplifying the vision of the ideal Christian housewife and mother—their work was arduous, unremitting and unacknowledged. They were also key to the provision of nursing and medical care. In many cases, their homes became the site of medical care and these women also dispensed medicines. By the late nineteenth century, missionary societies increasingly acknowledged the invaluable work of these women and made provision for women to take on missionary roles as individuals.⁴⁹ Mary Agnes’s work as teacher, her lectures to the Zenana Mission and the prominent role she played in William Anderson’s—and later, their son Alexander’s—

45 Erlank, *op. cit.* (note 14).

46 J. H. Soga, ‘Miller Mission Station’, in *The education of a South African tribe* (ed. P. A. W. Cook), (Juta Publishers, Cape Town and Johannesburg, 1934), p. 44.

47 Erlank, *op. cit.* (note 14).

48 Please refer to Karen E. Smith, ‘Women in cultural captivity: British women and the Zenana mission: in a little pamphlet outlining the work of two British Baptist women, Marianne Lewis and Elizabeth Sale: pioneers of missionary work among women, (1) Ernest Payne remarked that 1792 was a key year for two publications’, *Baptist Herit.* **41**, (2006).

49 Digby, *op. cit.* (note 5), pp. 117–119.

medical practice are suggestive of not only a changing context but also a sense of independence that was in part predicated on her role as a healer.

While his priority was his evangelizing mission, William Anderson's services as a doctor were necessary and he also established his private medical practice.⁵⁰ Owing to the rural location of his practice, it is likely that most of his patients were drawn from the Xhosa, yet, owing to the dearth of medical professionals, Soga treated both White and Black patients.⁵¹ Key was the need for medical treatment. Owing to their proximity to indigenous people, and given the import of portraying a beneficent colonialism, missionaries had to varying extents over the course of the nineteenth century been involved in healing the sick. Very few of them received formal medical training but carried with them 'medical chests' as well as texts to consult when treating their families and followers. The former contained a variety of remedies to address anything from the bronchial to the dermatological. Realizing the potential significance of offering medical treatment in addition to proselytization, there were increasing initiatives to provide more formal medical training for missionaries by British missionary societies. Tiyo Soga studied both medicine and theology. Early medical missionaries included Johannes van der Kemp and David Livingstone, sent by the London Missionary Society.⁵² The moral and scientific authority of the medical missionary converged and was absolute, with the doctor described as the 'saviour of humanity'.⁵³ For the medical missionary, then, there was the salvation of the soul, which was concomitant with the saving of the body.

As Digby shows, from the mid nineteenth century, the provision of education and medical treatment was necessary to further the spread of Christianity in southern Africa—which was proceeding slowly. While Western medicine was seen as antithetical and its practitioners hostile to indigenous healing practices, indigenous people were syncretic, drawing upon the healing practices of both. Medical missionaries—and missionaries in general—were therefore inundated with requests for treatment, especially in areas where no other medical services were available. Missionaries—those with both formal medical training and those without—provided treatment for a variety of ailments.⁵⁴

While Western medicine was symbolic of colonial penetration, William Anderson was in an unenviable position. Later, John Henderson Soga would highlight the difficulties attendant in adapting the indigenous lifestyle of the Bomvana—the Xhosa group served by the Miller mission—to the demands of the modern world. They were not subject to conquest and had willingly agreed to the stewardship of the colonial state in the nineteenth century. This made them a 'protectorate tribe' that was permitted to retain aspects of 'tradition', making it a challenge for the implementation of Christian beliefs and values. This hampered the move towards modernity and, as John Henderson put it, 'the "old things", which should have passed away, still maintain a firm hold upon the people'.⁵⁵ Related to this was the power of the chiefs who were not kindly disposed to the inevitable social changes that would accompany Christianity, ultimately leading to a loss of traditional authority. As John

50 Erlank, *op. cit.* (note 14).

51 Elizabeth van Heyningen, 'Regularly licensed and properly educated practitioners', in *The Cape doctor in the nineteenth century: a social history* (ed. Harriet Deacon, Howard Phillips and Elizabeth van Heyningen), 195–222 (Rodopi, Amsterdam and New York, 2004), at p. 214.

52 Digby, *op. cit.* (note 5), pp. 104–106.

53 Porter, *op. cit.* (note 3), p. 427.

54 Digby, *op. cit.* (note 5), pp. 30, 33, 108–109.

55 J. H. Soga, *op. cit.* (note 46), pp. 43–44.

Henderson argued, chiefs and headmen played a disruptive role, using various means to force converts to return to the fold and, when all else failed, casting them out.⁵⁶

The combination of both missionary and medical duties proved onerous, and William Anderson suffered a breakdown in 1891. Once he had recuperated, he worked towards his MD.⁵⁷ His location also gave him the opportunity to observe the practices of the Bomvana and, almost a decade into his medical practice, William Anderson submitted his MD dissertation to the University of Glasgow entitled ‘The Ethnology of the Bomvanas of Bomvanaland, an aboriginal tribe of South East Africa: with observations upon the climate and diseases of the country, and the methods of treatment in use among the people’.⁵⁸

Soga’s thesis—running to 36 handwritten pages—relates specifically to medical anthropology, addressing language, culture and religion of the Bomvana and the relationship between health and environment. Just as significantly, however, it is a reflection of Soga’s own position in colonial and indigenous society and says as much about the writer as it does about the subject(s). As Rebekah Lee discusses, missionaries were the earliest repositories of ethnography in Africa—their proximity to indigenous groups and their understanding of indigenous languages accorded them the opportunity to observe practices related to illness and healing. As such, they were to an extent able to understand ‘African world-views’, although this did little to challenge their beliefs in the ultimate efficacy of Western medicine.⁵⁹ This relationship would be even more complex in the case of Soga.

From the outset, he demonstrated the ambiguity that was so evident in his father, Tiyo. His stated aim in undertaking the study was an effort to ‘preserve’ some aspect of indigenous culture through his writing even as he understood the inevitability of the loss of indigenous knowledge through the pervasiveness of Western systems. The thesis, however, was not simply an act of preservation but also presented the acknowledgement that there was something of worth in indigenous knowledge that could be absorbed into Western knowledge systems, even if it originated ‘from savage tribes’.⁵⁸ His assessment of the Bomvana is divided here into the themes of cultural adaptation, health and environment and healing.

CULTURAL ADAPTATION

Soga’s engagement with race and culture is one of the more significant aspects of the thesis. Anthropological understandings of race in the nineteenth century exceeded that of mere physical difference—they also related to aptitude, intellect and ‘civilization’; distinctions that were perceived to be immutable.⁶⁰ Yet Soga’s work was not uninfluenced by his own position as a person of ‘mixed race’, incorporating therefore the perceived elements of both that served to challenge the absolute nature of racial categorization. By the early twentieth century, two—not necessarily contradictory—perceptions of mixed race were held

⁵⁶ *Ibid.*, p. 45.

⁵⁷ Dr William Anderson Soga, S2A3 *Biographical database of Southern African science*, https://www.s2a3.org.za/bio/Biograph_final.php?serial=2648 (accessed 16 July 2024).

⁵⁸ Soga, *op. cit.* (note 19), p. 1. Please refer to Anne Digby, ‘On the notable MD thesis of William Anderson Soga, first Black doctor in South Africa’, *S. Afr. Med. J.* **97**, 345–346 (2007).

⁵⁹ Rebekah Lee, *Health, healing and illness in African history* (Bloomsbury Academic, London, 2021), p. 22.

⁶⁰ Charles King, *The reinvention of humanity: a story of race, sex, gender and the discovery of culture* (Bodley Head, London, 2019), p. 81.

at the Cape. Influenced by the work of German medical anthropologist Eugen Fischer in South West Africa (at the time, a German colony), ‘Basters’⁶¹ displayed both ‘physical and moral degeneration’ but could also represent ‘hybrid vigour’, particularly if miscegenation occurred between races that displayed like characteristics. It did little to challenge the notion of the racial superiority (and ‘purity’), as hybrid races were inevitably considered to be less than racially ‘pure’ types.⁶² These ideas of race and miscegenation therefore partially contextualize Soga’s description of the Xhosa, especially in terms of their adaptability—and hence ‘similarity’—to Western ‘civilization’.

While addressing the Bomvana specifically, Soga’s discussion moved between the ethnic group and the characteristics of the Bantu-speaking people as a whole, of which he was part. It thus became both an anthropological study and a valorization of a particular indigenous group. For Soga, the distant northern origins of the progenitors of South Africa’s Bantu-speaking population gave them a shared identity, despite the regional differences in language, as well as the various ethnic or ‘tribal’ affiliations, which included the Xhosa, the Tembu and the Zulu. Their ancestry further connected them to those beyond the borders of southern Africa. There is a sense of ethnic pride in Soga’s avowal of this shared identity with these disparate groups falling under the title ‘Bantu’ or ‘the people’ that is in stark contrast to the later employment of the term by the apartheid state to signify insurmountable difference and legal discrimination. Soga’s view was of a noble people described as ‘brave and warlike’, who were able to communicate across tribal affiliation.⁶³

In his discussion of language, which formed an important component of this shared identity, Soga demonstrated the prioritization of both the understanding of indigenous languages and the translation of religious material into indigenous languages that was a tenet of missionary activity in the Eastern Cape—with Tiyo Soga involved in translating the Bible into Xhosa. Indigenous languages—particularly those that fell into the Bantu language group—were described as inherently grammatical, lending themselves to oratory feats and, significantly, flexible enough to allow the incorporation of ‘foreign ideas’. This adaptability was also found in the people described as being of ‘remarkable intelligence’, ultimately giving them an inherent ability to both adapt to and prosper in the modern, colonial world. With the caveat that this was a ‘savage language’, Soga nevertheless advocated its compatibility with the ethos of progress. He went so far as to hypothesize that the language was the remnant ‘of a comparatively civilised people’, although acknowledging that there was no evidence for this in the historical record.⁶⁴ Interestingly, his argument, while making use of distinctions such as ‘civilized’ and ‘savage’, suggested assimilation and compatibility, an acknowledgement of indigenous worth, while nevertheless subordinating this to Western superiority.

Also evident was his attention to physical description. For Soga, the Bomvana had the physically aesthetically pleasing features of the ‘Bantu’: ‘well-formed, well developed bodies ... a very intelligent cast of countenance ... features being open and pleasant’.⁶⁵ Of particular note, however, and a feature on which Soga expended some time, was their lighter skin, which was attributed to a mixed heritage. He went on to relate the history of

61 Literally translated as ‘hybrids’.

62 Saul Dubow, *Scientific racism in modern South Africa* (Cambridge University Press, 1995), pp. 183–184.

63 Soga, *op. cit.* (note 19), p. 3.

64 *Ibid.*, p. 10.

65 *Ibid.*, p. 5.

the Bomvana's early European encounter a century before. A ship had been wrecked off the coast of Pondoland, where the Bomvana had initially lived, and a number of men survived and were incorporated into the tribe. In a manner reminiscent of Defoe's *Robinson Crusoe*, Soga described the sailors' construction of a house assembled from the wreckage of the ship 'to the great wonder of the natives'. The men were eventually assimilated as chiefs and adopted polygamy. When eventually found by Dutch hunters, four returned to 'civilization' while three elected to remain behind, becoming the 'progenitors of the ... White Clan'.⁶⁶

Soga also pointed out that the different skin tone of the descendants of the Dutch sailors was not the only distinguishing feature of the Bomvana. Their name itself referred to the 'reddish people', indicative of some 'distinctive peculiarity' in their distant history that had yet to be explained. The account is as revealing about Soga as it is about the Bomvana. It is not a challenge to contextualize Soga's fixation on physical characteristics in light of his personal history—a man considered to be of 'mixed race' who had himself married a White woman, during a period when perceived racial difference was the key determinant of 'civilization'. Writing of the response of African Americans in the nineteenth century to the prevailing views of racial inequality, Mia Bay demonstrates the ways in which these figures engaged with intellectual, ideological and religious beliefs that increasingly portrayed racial distinction and hierarchy as a universal truth. Black writers found themselves in the unenviable position of having to defend Black capability and adaptability in light of the 'civilized' values of White society.⁶⁷ Soga's analysis reflects this tension, demonstrating the porous yet pervasive nature of racial thinking.

Related to this was the ability to adapt to the social and environmental upheaval wrought by the colonial encounter, and here there were ethnic differences. Soga set clear distinctions between the 'Bantu' and the Khoesan, characteristics that went on beyond the physical to marking the two as being 'socially, intellectually and morally' distinct. His subsequent discussion of the characteristics of these people is therefore framed by their difference from the Khoesan. The noble warrior tradition of Bantu-speaking people was portrayed favourably and they were 'not treacherous nor [were] they cruel to their captives'. They were proudly independent and, even in defeat, would never permit their enslavement, a condition seen as demeaning. Important too, the 'Bantu' were portrayed as thriving numerically, with 'no tendency to disappear'.⁶⁸

Notions of African suitability and adaptability had a long theological and philosophical history in the West. From antiquity, accounts penned by Europeans considered the distant regions of the world—especially in Africa—as being inhabited by those considered not quite human. They became a dilemma for theologians: were they separate races and hence not descended from Adam, or were they the descendants of Adam who had degenerated? By the eighteenth century, climate had been added as a compelling reason for racial difference. Beginning with Enlightenment philosopher Montesquieu, climate was perceived as precipitating changes in the ways in which human physiology worked, leading to social, cultural and political differences. Colder climates (Europe) produced people who 'were more vigorous because the fibres in their cardiovascular systems contracted in cold air and stimulated faster flowing of blood', whereas residents of the tropics were subject to

66 *Ibid.*, pp. 5–7.

67 Mia Bay, *The White image in the Black mind: African-American ideas about White people, 1830–1925* (Oxford University Press, 2000), pp. 14–15, 21–22.

68 Soga, *op. cit.* (note 19), pp. 10–11.

the opposite, leading to torpor. In a pre-emption of polygenism, Scottish lawyer Henry Homes hypothesized that the races were specifically created for their particular climate. This would make them both geographically and biologically distinct, with no possibility of assimilation. Like Montesquieu before him, Homes also accorded climate—and thus the races associated with it—with morality, psychology and ability. By the mid nineteenth century, as Livingstone discusses, Louis Agassiz, drawing upon the pre-Adamite notion that supported different origins for human races, further emphasized the geographical and biological distinctiveness of races, arguing that any transgression of the boundaries of race ‘was both socially and morally repugnant’. Agassiz reserved a particular condescension for ‘African races’, believing them to be wholly incompatible with ‘civilised society’. Language was also a key feature of the debate over racial origins, with distinctions made between ‘a separate and superior adamic language’ and more ‘primitive’ tongues.⁶⁹

But there were also the counterarguments made for the common origins of humankind—even if gradations of difference remained. While holding to polygenesis, Charles Hamilton Smith believed that the ‘fusing’ of older races—the ‘tropical African’ and the Asian—with the ‘superior’ Caucasian would enable the former to achieve the elevation of the latter. For Catholics, an Adamite or common origin was the basis of the Church itself—although this did not preclude degeneration and inequality. Presbyterian minister Thomas Smyth took particular exception to polygenesis as it was only with common descent from Adam, and thus the incorporation of all, that proselytization was possible. Black theologians were in agreement, and by the late nineteenth century—just prior to Soga’s writing—arguments were put forth arguing for the descent of the ‘Negro’ from Adam from the line of Noah’s son, Ham, ‘The Negro is a man. He is of Adam. He is of Noah. The Negro is a brother’.⁷⁰ Soga’s discussion of language and capability reflects this notion of common origin.

Soga would also hardly have been unaware of the writings of the missionary described as a ‘heretic’ in his time by Jeff Guy: John William Colenso. Based in Natal in the nineteenth century, Bishop Colenso took issue with settler descriptions of African indolence and inherent dishonesty and condemned the British failure to adequately provide for the needs of the Zulu despite making demands for both taxation and labour. Like the Sogas, Colenso was cognizant of the importance of understanding vernacular languages and so clearly and unambiguously imparting the message of Christianity in a manner designed to incorporate rather than alienate. He also believed that the true and ‘noble’ calling of the missionary was ‘not to save a few individual souls from everlasting burnings, but to raise a whole race to the true dignity of man ... a being endowed with intellectual, moral and spiritual faculties’. With the challenges to orthodoxy presented by scientific advances in geology (deep time) and evolution in the nineteenth century, Colenso sought to reconcile religion with science, unwilling to see a dichotomy between faith and reason. Through science, God’s wondrous creation could be revealed and progress underlaid both science and religion. Societies could be ranked according to their level of progress, but this did not preclude them from advancing to an eventual level of equality. All humankind shared spirituality, but progress could be acquired.⁷¹

69 David N. Livingstone, *Adam’s ancestors: race, religion and the politics of human origins* (Johns Hopkins University Press, Baltimore, 2008), pp. 12–13, 55, 57–58, 64, 95, 104.

70 *Ibid.*, pp. 97–99, 130–131, 180–181, 185.

71 Jeff Guy, *The heretic: a study of the life of John William Colenso, 1814–1883* (University of Natal Press, Pietermaritzburg, 1983), pp. 48–49, 76–77, 165–167.

It is thus within this intellectual ferment of ‘civilization’, progress, science and religion that Soga’s assessment of the Bomvana can be situated. Adhering to notions of difference in his description of the Bomvana and other indigenous groups, there is nevertheless a sense of assimilation that was informed by his own position as scientist, as missionary and as physical embodiment of the settler and the indigenous.

HEALTH AND ENVIRONMENT

Despite the physical and other strengths of the Bomvana as described by Soga, their health was affected by a number of factors and these factors were a result of their transition to modernity and, with it, the demands of industrialization, exposure to new occupational diseases and inadequate health care.

The first factor was that of climate, and the prevalence of tuberculosis was attributed to the humid coastal conditions. Prior to the development of an effective treatment for tuberculosis,⁷² which would come two decades after Soga’s writing, the emphasis was on prevention—and this was linked with environment. Soga’s recommendation was the more arid regions of the interior for those afflicted with the disease.⁷³ The interior brought its own challenges, significantly the respiratory ailments associated with mining. Climate, too, was related to temperament and was described as ‘relaxing ... [with a tendency to evoke] lethargy and inability to take exercise’. Despite these relative shortcomings, the climate was seen as suitable not just for indigenous groups but for Europeans as well.⁷⁴ Soga’s work here in some ways pre-empts early twentieth-century concerns regarding the tropical climate. Drawing upon the South African experience and White poverty in the early twentieth century, Ellsworth Huntington’s *Civilization and climate* attributed the amenability of the South African climate to presenting an insufficient challenge in fostering the ‘push and energy’ characteristic of their European and North American counterparts.⁷⁵

In addition to climate, the lifestyle of the Bomvana was a contributing factor to the prevalence of disease, and this was a lifestyle in a state of flux. Soga began by drawing attention to what he considered to be the surprising similarities between the types of disease found in ‘civilised countries’ and those prevalent in a ‘barbarous people— living in a simple state of life’. This was partly attributed to a lack of knowledge, with contaminated water supplies resulting in a high incidence of dysentery. Diet was also a factor: over-indulgence in ‘native beer’ had adverse effects on the liver and poorly cooked meat led to tapeworm infections. Evident, too, was leprosy, which was apparently termed ‘Hottentots Disease’, with the Bomvana confiding in him that it was due to contact with the Khoesan.⁷⁶ As Digby argues, there was a belief among the Xhosa in the late nineteenth century that leprosy ‘was emphatically not an African disease’ but was thought to have originated from White settlers and the ‘Hottentots’, and thus to be a recent affliction for the Xhosa. It was what Digby considers a ‘reversal’ of conventional colonial views of Africa as the source of disease and

72 Porter, *op. cit.* (note 3), p. 442.

73 Soga also published a pamphlet on the means of preventing tuberculosis in 1905. Please refer to ‘Dr William Anderson Soga’, *op. cit.* (note 57).

74 Soga, *op. cit.* (note 19), pp. 16–18.

75 Dubow, *op. cit.* (note 62), pp. 174–176.

76 Soga, *op. cit.* (note 19), pp. 18–21.

suggests African perceptions of the aetiology of disease that were also informed by the colonial encounter.⁷⁷

Heart disease was associated with progress, and, as such, Soga believed the relatively low mortality rate associated with it was due to a lifestyle that was 'simple and tranquil, without fret, worry or push'. Yet the adverse effects associated with modernity and industrialization were beginning to leave their mark, as was evident in the high incidence of tuberculosis, with a more detrimental effect on the Bomvana than on Whites and which was a major concern among groups 'in a transition state from heathenism to civilisation'. It was attributed readily to lifestyle—inadequate food, poorly constructed housing that allowed exposure to the elements and communal living—but the move from an indigenous to a more Western lifestyle was also a major factor. People wearing Western dress could not afford more than a single set of clothes and so clothing was washed and worn while still wet. A change in diet with 'new wants and new cravings' promoted malnourishment for those 'unused to this'.⁷⁸

In the late nineteenth and early twentieth centuries in England, tuberculosis was both a source of public concern and an intervention, acquiring a moral connotation. This was particularly the case for the poor who were afflicted with the disease. Containing the spread of tuberculosis necessitated confinement, and sanatoria were established that were administered under the Poor Law. Harsh regimens were maintained in these institutions, where movement was controlled, patients were not permitted to smoke or drink alcohol, and an emphasis was placed on a healthy climate with 'exposure to the elements' and manual labour outdoors as 'Labour would build moral fibre'. The treatment was the discipline of the body and the mind in order to address the disease—and it ultimately failed, with sanatoria serving as little more than a means of isolating patients from the rest of the general population. It was argued that the poor would have been better served through improving their living conditions and thereby limiting the spread of disease.⁷⁹ Soga's analysis of the illness within the Bomvana population reflects a combination of both views: illness was due to their position in a changing world with a complex mix of lack of indigenous understanding, adverse external influence and the almost necessary growing pains of a people making the transition to a modern, yet still alien, lifestyle. The Bomvana were at a crossroads—caught between a precolonial past and Western 'civilization and progress', with tuberculosis the symptom of the transition.

INDIGENOUS HEALING

The Bomvana, of course, made use of their own healing methods, practising medicine that was very different from Western medicine, and the remaining third of Soga's dissertation pays particular attention to this. The first was the widespread use of indigenous plants in healing. The potentially fatal effects of eating infected meat, for instance, were ameliorated by the consumption of an infusion of tree roots from a particular tree. Similarly, the prevalence of poisonous snakes in the region coupled with people walking barefoot resulted in numerous snakebites and, again, indigenous plants were employed in order to make a

77 Digby, *op. cit.* (note 5), p. 174.

78 Soga, *op. cit.* (note 19), pp. 21–24.

79 Porter, *op. cit.* (note 3), pp. 422–423.

largely effective antidote, so much so that very few of those treated succumbed. Soga, however, lauded the treatment used by Western medical practitioners such as himself—‘liquor ammonia’—preferring this to the herbal potions used by the Bomvana.⁸⁰ Soga’s treatment for snakebite emulated that which was used in another British colony, Australia, from the mid nineteenth century. Along with efforts by settlers and indigenous groups to treat snakebite by attempting to halt the spread of venom through restricting blood flow or ‘sucking’ out the venom from the wound, ammonia was used in two ways. The first was an injection of ammonia to offset the effects of the venom by improving circulation and heart rate. The second was the application of ammonia directly onto the wound to ‘neutralize’ the venom. While the evidence for the success of ammonia is less than convincing, it remained in use as a preferred treatment by Western-trained medical practitioners. It was only towards the end of the nineteenth century—just after Soga’s writing—that there was the growing use of antivenom as an efficacious treatment, and it was well into the twentieth century when this became the ubiquitous treatment for snakebite.⁸¹ Soga’s use of ‘liquor ammonia’, then, was a ‘norm’ in treatment and a preferred alternative to methods employed by the Bomvana. It was, however, not necessarily a more effective form of treatment yet was considered to be superior owing to its use in Western medicine. Despite the legislative protection, nineteenth-century Western medicine in South Africa was a fairly conservative project, with little in the way of innovation in terms of the incorporation of indigenous plants and methods—and Soga’s treatment reflects this.⁸²

Whereas Soga was willing to countenance the efficacy of herbal remedies, even as he preferred Western methods of treatment, he was scathing in his description of ‘witch doctors’, who exemplified the ‘superstitious’ attitude towards medicine and healing that Soga and his contemporaries found difficult to counter. While the ‘witch doctor’—who could also be considered a ‘shaman’ or ‘medicine man’—was a key figure in healing in indigenous societies, witch doctors’ association with superstition and with paganism placed them at odds both with the scientific bent of Western medicine from the eighteenth century and with Christianity. Their influence, however, was pervasive, and evoked a vehement response from Soga. Illness was inevitably attributed by the Bomvana to the malign influence of witchcraft, rendering Western medicine—a product of the secular and the scientific—wholly inadequate when dealing with the supernatural. The cure therefore depended on the ability of a ‘witch doctor’ to determine the cause of illness as well as the individual responsible for causing it. Soga gave an extremely detailed account of what he believed to be the manipulative methods of the ‘witch doctor’, described as taking advantage of a hapless, gullible and impressionable people.⁸³

Of key importance are the different methodologies employed by ‘witch doctors’ and medical professionals such as Soga in relation to diagnosis. In the case of the latter, an in-depth consultation was required with a detailed description of symptoms. This, however, obviated the omnipotence of the ‘witch doctor’, who was expected to already know this information. He used guile to cultivate an air of magic and mystery by drawing together the friends of the sick person and asking them a series of leading questions designed to

80 Soga, *op. cit.* (note 19), pp. 24–27.

81 Peter Hobbins, ‘Hisstory: how the science of snake bite treatments has changed’, *Conversation*, 5 February 2017, <https://theconversation.com/hisstory-how-the-science-of-snake-bite-treatments-has-changed-71408> (accessed 12 September 2023).

82 Deacon, *op. cit.* (note 8), p. 21.

83 Soga, *op. cit.* (note 19), p. 30.

narrow down both the illness and the identity of the potential harm-doer. Soga described the encounter in significant detail, devoting at least four pages to the methods employed by the 'witch doctor' against people who 'are perfectly oblivious of the fact that they in their ignorance are supplying him with all the information he wants'. Once the guilty party was determined, their removal by being tortured and killed or forced to flee should ideally have led to a full recovery on the part of the afflicted. A necessary part of the role of the 'witch doctor', then, was the accusation of witchcraft, and for Soga this created a society based on fear owing to the capricious nature of a system where anyone could potentially be accused with little means of defence.⁸⁴ The machinations of 'witch doctors' and Soga's belief that they were holding people hostage to superstition was therefore a significant obstacle to his work, both as a missionary and as a doctor.

The 'witch doctor' was also involved in other related methods of healing that only seemed to emphasize Soga's view of their charlatanism. A method described as 'treatment by suction' entailed the sucking out of the 'evil substance' from the afflicted part of the anatomy. This substance was then manifest as a piece of vegetation or powder and, often upon its removal, the sufferer claimed to be healed. However, in cases where healing did not take place, successive healers were brought in to administer the treatment until they eventually admitted defeat by the more powerful 'evil influence'. The power of witchcraft was also evident in the administering of herbal concoctions. Unlike more widespread remedies, these were proprietary secrets, passed down within a family over successive generations. Each healer could claim expertise in treating a particular kind of ailment, a form of specialization. However, there existed no scientific method of administering doses and no account was taken of the individual's physiology. This could then result in inadvertently poisoning the patient. Should the treatment prove to be fatal, however, the healer could simply claim the power of 'the increase of the disease'. Through these methods, traditional healers could distance themselves from responsibility for any negative outcomes while taking credit for successes.⁸⁵

Despite Soga's scepticism, he was confronted with the strength of belief in indigenous medicine that undermined his own attempts at treating the Bomvana. There were areas in which Western medicine could potentially play an important role. Indigenous healers did not perform surgery of any kind, and there was a very strong resistance on the part of the Bomvana towards undergoing surgical procedures as well as to the use of chloroform. However, interventions such as the use of catheters to address bladder ailments were potentially lifesaving, as were interventions during childbirth, where a high rate of mortality was attributed to a 'retained placenta'. Through these and other measures, then, Soga remained optimistic that the efficacy of Western medicine would ultimately be proven, 'By showing them new methods of treatment, in a rational way, we are dealing a deadly blow at superstition and witchcraft.'⁸⁶ A year after his thesis was written, Witchcraft Act No. 20 was passed, which made illegal the killing of those deemed to be 'witches', believed to be responsible for causing illness. Through legislative means, then, the power of the 'witch doctor' was curtailed, marking a triumph for 'reason' over capricious 'superstition'.⁸⁷

84 *Ibid.*, pp. 30–33.

85 *Ibid.*, pp. 34–35.

86 *Ibid.*, pp. 35–36.

87 van Heyningen, *op. cit.* (note 41), p. 173.

The interaction between indigenous healing and Western medicine was, however, a complex one and not simply based on either the growing dominance of the Western model or, as Soga described it, the implacable hostility to Western medicine. The presence of medical missionaries such as Soga necessarily affected the balance of power. Healers lost a significant part of their status within indigenous communities as their potions and methods were supplanted by Western medicine—although, owing to the relative paucity of Western medical care, this process was uneven. With the availability of Western medicines, however, indigenous healers demonstrated a level of flexibility by incorporating these new medicines within existing modes of treatment, thus ensuring their continued relevance.⁸⁸

Simultaneously, indigenous healers distinguished between illnesses that could be treated by Western medicine and those that only they could address. A major change in Western medicine, as discussed earlier, was the adaptation of scientific and hence physical explanations for illness. The focus was on the body, which was distinguished from the non-tangible spirit. This distinction, however, was not evident in African societies, where the body could still be subject to the actions of ‘ancestors, witches or sorcerers’. As Digby explains, the treatment afforded by Western medical practitioners such as Soga addressed ‘disease’ while that of the Xhosa counterparts focused on ‘dis-ease’, illnesses that may be considered psychological on the part of Western doctors and which, for the Xhosa and other indigenous African groups, manifested as ‘fits, dreams or nightmares [and] spirit possession’.⁸⁹ As anthropologist Harriet Ngubane would write later, these were seen as uniquely African diseases affecting indigenous Africans only (regardless of ethnic affiliation) and thus requiring the intervention of indigenous healers.⁹⁰ This clear distinction between different forms of illness meant that particular uses were envisaged for both Western and indigenous medical practices, and patients could believe simultaneously in the efficacy of both. These nuanced distinctions, however, were not necessarily acknowledged by Soga.

CONCLUSION

In her history of mental illness, Julie Parle begins with the statement that ‘the only way to make sense of South Africa’s past is to speak of madness’—whether that ‘madness’ could be attributed to colonialism or to the policies of the apartheid state.⁹¹ The colonial encounter was marked by a profound disruption in the lives of indigenous Africans and none more so than the Bomvana, caught between the old and the new. The same can be said for Soga himself. Underlying his analysis of the Bomvana was the notion of both mental resilience and the psychological strain of colonial influence and conquest. This is evident in understanding of the ability to assimilate, the challenges presented by climate and a rapidly changing environment, and, in particular, the tenacious hold of indigenous healers whose

88 Digby, *op. cit.* (note 5), pp. 295–296.

89 *Ibid.*, pp. 286–287.

90 Harriet Ngubane, *Body and mind in Zulu medicine: an ethnography of health and disease in Nyuswa-Zulu thought and practice* (Academic Press, London, 1977), pp. 23–25. It is important to note that the literature on traditional medicine and healing in South Africa demonstrates significant continuities and similarities across indigenous groups in their perception of the role of indigenous healers, even as adaptations were made to account for changing contexts.

91 Julie Parle, *States of mind: searching for mental health in Natal and Zululand, 1868–1918* (University of Natal Press, Scottsville, 2007), p. 1.

methods crossed the mind–body and science–magic divides in a manner antithetical to the practise of Western medicine in the nineteenth century.

Forty years after Soga completed his thesis on the Bomvana, another study was made of the group by Peter Cook. The study had a focus on education but incorporated ethnographic and sociological material, including the family and political structure, economic and cultural activities and governance.⁹² The intervening four decades, however, had resulted in a society irrevocably altered by colonialism and the formalization of settler rule in the Union of South Africa formed in 1910. The imposition of taxes—to be paid in cash—and the desire to purchase commodities had been detrimental to Bomvana ‘self-sufficiency’, drawing them into the broader South African economy. The accumulation of cattle had had a damaging effect on the environment, reducing the availability of grazing land. The economic and social disruption had also had an adverse effect on what Cook termed ‘tribal education’. This form of education served as a means of assimilating an individual into the economic, social and cultural life of the group, but the changes wrought by the colonial encounter and modernization had rendered this form of education superfluous and ill-equipped to deal with the challenges of twentieth-century South Africa. As Cook put it, ‘the pristine glory of the tribe had gone’, the end point of a process to which Soga had alluded years earlier.⁹³ Yet, while Soga had had an ultimately optimistic view of progress, Cook’s study revealed that the increasingly discriminatory racial policies of the South African state had undermined the civilizing mission of the medical missionary.

In 1904 Soga left Miller Station in order to devote himself exclusively to the practise of medicine, and in 1913 his son, Alexander (also a product of Glasgow University), joined his medical practice. His son’s involvement allowed Soga the time and scope to return to his work as a missionary, which he continued until his death in 1916.⁹⁴

As both a medical practitioner and a missionary, William Anderson Soga represented the civilizing mission of British imperialism. As a Soga he was also part of a family that had engaged with the notions of Western progress, religion and civilization during a time when colonialism had altered indelibly the lives of the indigenous people of southern Africa while simultaneously excluding them from a society predicated on social, economic and political inequality. As a person of mixed heritage during a period when racial distinctions were clearly articulated, Soga’s identity straddled the boundaries of race and class. These tensions are reflected in his study of the Bomvana—their physical characteristics, language and, in particular, their healing practices and engagement with Western medicine. Soga’s work thus not only drew upon contemporary thinking about progress and civilization, but demonstrates the complex manner in which ideology was adapted to late nineteenth-century South Africa in the guise of medicine.

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⁹² Please refer to P. A. W. Cook, *The education of a South African Tribe* (Juta Publishers, Cape Town and Johannesburg, 1934).

⁹³ *Ibid.*, pp. 3, 17.

⁹⁴ ‘Dr William Anderson Soga’, *op. cit.* (note 57).

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DATA ACCESSIBILITY

This article has no additional data.

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