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Maternal and Child Welfare at the Raleigh Fitkin Memorial Hospital and the Swazi Women's Response, 1933-1945

Shokahle R. Dlamini*

Abstract

Maternal and Child Welfare (MCW) was introduced to Swazis in 1933 by the Raleigh Fitkin Memorial (RFM) Hospital of the Church of the Nazarene (CON). Literature on its introduction shows how European doctors in colonial spaces used their knowledge of medicine to further imperial expansion and control, legitimise and maintain colonial power and undermine local belief systems. Literature on the African response to its introduction is still scanty. Drawing from archives and oral informants, this article advances the standard assumption in medical historiography of Africa which states that African people were not passive recipients of biomedical services by demonstrating that Swazi women contested and sometimes rejected some of the MCW services. The article explores overlapping interests in health care provision between the CON missionaries and the colonial government and explains why pregnancy and childbirth were shifted from the private to the public domain. Further, it investigates Swazi women's contestation of some missionary maternal health practices, which forced CON missionaries to negotiate their uptake.

Keywords: Antenatal clinic; Church of the Nazarene; resistance; institutionalised birthing; indigenous medicine; maternal and child welfare; Raleigh Fitkin Memorial Hospital; syphilis.

Opsomming

Moeder- en Kinderwelsyn (MCW) is in 1933 aan die Swazi's bekendgestel by die Raleigh Fitkin Memorial (RFM) Hospital of the Church of the Nazarene (CON). Geskrifte oor die bekendstelling daarvan wys hoe Europese dokters in koloniale ruimtes hul mediese kennis gebruik het om imperiale uitbreiding en beheer te

* Shokahle R. Dlamini is a senior lecturer in the Department of History, University of Eswatini, and a senior research associate in the Faculty of Humanities of the University of Johannesburg. Her research interests have been on nursing, church and medical histories. She is now more interested in conducting research on gender and reproductive health.

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bevorder, imperiale mag gelegitimeer en in stand gehou het, en plaaslike stelsels van kennis en geloof ondermyn het. Geskrifte oor Afrikane se reaksie daarop is egter skraps. Deur middel van argiewe en mondelinge getuies voer hierdie artikel aan dat Afrikane nie bloot passiewe ontvangers van biomediese dienste was nie, deur te wys hoe Swazi vroue weerstand daarteen gebied het, en sommige van die MCW se dienste ronduit verwerp het. Die artikel stel ondersoek in na die CON-sendelinge en koloniale regering se oorvleuelende belange wat betref gesondheidsdienste, en verduidelik waarom swangerskap en geboorte verskuif is vanuit die private na die openbare sfeer. Verder stel dit ondersoek in na Swazi vroue se weerstand teen sommige van die sendelinge se gesondheidsdienste aan swanger vroue en moeders, wat die CON-sendelinge genoop het om oor die gebruik daarvan te onderhandel.

Sleutelwoorde: voorgeboorte kliniek, Church of the Nazarene, weerstand, geïnstitusionaliseerde geboorte, inheemse medisyne, moeder- en kinderwelsyn, Raleigh Fitkin Memorial Hospital, sifilis.

Introduction

Swaziland,[1] a British protectorate from 1903 to 1968, witnessed the arrival of the first British colonial medical officer, Dr R.C. Perkins, in 1904.[2] First and foremost, he established a Medical Department in Mbabane to provide healthcare for colonial officials and their families. But later, medical services were extended to the local population. The locals later enjoyed these services as secondary beneficiaries of the introduction of biomedicine. The extension of health services to the local people was also meant to ensnare a healthy and productive African labour force for the colonial economy.

The Church of the Nazarene (CON) later joined forces with the colonial government in July 1927 to expand medical services to serve the eastern and the central regions of Swaziland through the establishment of the Raleigh Fitkin Memorial (RFM) Hospital in Bremersdorp (now Manzini). Provision of health services such as maternity care, infant health care, nutrition and food preparation demonstrations, the provision of antenatal and childrearing advice and general public health education by the CON were primarily intended to attract potential converts. The facility was a centre for Christian evangelism[3] and healing. To this end, biomedicine was used as a means to obliterate indigenous knowledge and replace

1. In April 2018, the king of Swaziland, His Majesty King Mswati III changed the name of the country from Swaziland to Eswatini. However, for historical reasons, the earlier name will be used in this article.
2. D. Davis, *Nursing in Swaziland* (Florida: Nazarene Publishing House, 1975), 11.
3. For more information on this, see S.R. Dlamini, 'Medical Missions and Proselytisation: The Case of the Church of the Nazarene Medical Missions Proselytisation Activities in Swaziland, 1925–1968', *African Historical Review*, 53, 1/2 (2022), 20-42.

African indigenous medicines with those used in the West. However, Walima Kalusa argues that missionaries were not successful in this endeavour and 'scholarship that depicts Africans as little more than passive patients on whom all-powerful European doctors unproblematically inscribed Christian versions of disease and medicine obscure the cultural negotiations and exchange that attended the encounter between the two parties.'[4]

Most Swazi women contested the institutionalisation of birthing using three strategies. Firstly, instead of pregnant women presenting themselves for confinements, most of them continued to utilise indigenous birth attendants in the comfort of their homes and only brought new-born babies to the RFM hospital for examination during their early months of life. Secondly, others stayed at home and called midwives from the RFM Hospital or CON neighbouring clinics to come and assist with their delivery. Lastly, the Swazi women's choice to continue using *timbita* (indigenous concoctions) and to take their new-born babies to indigenous healers for protection and strengthening (kubacinisa) a few weeks after birth, despite discouragement by medical missionaries and colonial officials, was another form of Swazi women's resistance against colonial control. These strategies demonstrate that Swazi women were not passive recipients of colonial obstetric and paediatric services. Instead, they contested and sometimes rejected some of these services.

The RFM Hospital confined women before and after birth. Confinement served two purposes: firstly it served a medical purpose in that it was intended to promote the healing of the babies' navels using biomedical means. As Eva Lukhele, a graduate from the CON nurses' training school in the 1940s recalled, they (nurses trained at the RFM Hospital) had been advised by their Maternal and Child Welfare (MCW) tutors not to discharge babies before the navel was fully healed, to try to prevent local women turning to traditional healers to help it heal.[5] This was a form of attempted social and medical control over Swazi women, a control most women resisted and rejected by not availing themselves for confinements. Secondly, it served an evangelical purpose in that during this period the mothers were exposed to inexorable evangelisation. Shokahle Dlamini demonstrates this when she argues that some women were converted during the 10-day confinement period in some CON clinics.[6]

Medical knowledge and health measures were used by missionaries to justify and endorse European colonial projects in Africa in the period up to the end of World War II (WWII) in order to consolidate and legitimise colonial control.[7] The British

4. W.T. Kalusa, 'Missionaries, African Patients, and Negotiating Missionary Medicine at Kalene Hospital, Zambia, 1906–1935', *Journal of Southern African Studies*, 40, 2 (2014), 284.
5. Interview conducted by the author with Eva Lukhele, Croydon, 14 September 2013.
6. Dlamini, 'Medical Missions and Proselytisation', 20-42.
7. S.R. Dlamini, 'The Colonial State and the Church of the Nazarene in Medical

believed that it was 'their Christian duty to civilize the African. The civilization to be introduced was that of Victorian England, with its firm belief in the superior virtues of a way of life rooted in Christianity [and] a profit-seeking economy.'[8] One area where medical knowledge was used for this purpose in Swaziland, as in other colonies, was MCW. Endeavouring to transform the sexual and reproductive knowledge and behaviours of Swazi women, the RFM Hospital ventured into MCW service provision in 1933. The commencement of MCW services in Swaziland in the 1930s was, to a large extent, influenced by global trends. At the turn of the 20th century, there was a significantly high infant mortality in Europe making the protection of infant life a matter of vital importance. According to Ulrike Lindner, concerns about plummeting birth rates and the so-called national degeneration led to the implementation of various measures in MCW across Europe at the beginning of the 20th century. Infant health was closely connected with the idea of European population as both a national and imperial resource. These ideas were extended to colonies after World War I.[9] Laws promulgated to improve the condition of MCW in Britain were usually transposed to the British Empire. Affirming this, Glen Ncube argues that broader imperial trends influenced the reforms of national healthcare systems occurring especially in British colonial Africa during the interwar period. These reforms, as Ncube points out, were motivated 'by changing notions of public health, and medical science and its various methods and imperatives of care.'[10] Furthermore, substantial research was conducted by public health workers in Europe on maternal and infant mortality whose recommendations were implemented to improve lives.[11]

The colonial government in Swaziland did not introduce any legislation to improve MCW until after World War II. However, there was a medical policy in the mid-1930s which will be discussed in the next section of this article. Dr David Hynd, the CON medical missionary who founded the RFM Hospital was influenced by a number of circumstances to introduce MCW in this hospital. In part, Hynd was influenced by the policies and legislations followed in Scotland, his home country, but his influence stemmed mainly from the high rate of maternal and infant mortality in

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Evangelization and the Consolidation of Colonial Presence in Swaziland, 1903–1968', *South African Historical Journal,* 70, 2 (2018), 370.

8. S. Burman, 'Fighting a Two-pronged Attack: The Changing Legal Status of Women in Cape-ruled Basutoland', in *Women and Gender in Southern Africa to 1945,* ed. C. Walker (Cape Town and London: David Philip and James Currey, 1990), 53.
9. U. Lindner, 'The Transfer of European Social Policy Concepts to Tropical Africa, 1900-1950: The Example of Maternal and Child Welfare', *Journal of Global History*, (2014), 208-231. Also see A. Davin, 'Imperialism and Motherhood', in *Tensions of Empire: Colonial Cultures in a Bourgeois World,* eds F. Cooper and A.L. Stoler (Berkley, Los Angeles and London: University of California Press, 1997).
10. G. Ncube, 'Robert A. Askins and Healthcare Reform in Interwar Colonial Zimbabwe: The Influence of British and Trans-Territorial Colonial Models', *Historia*, 63, 2, (2018), 62.
11. A. Davin, 'Imperialism and Motherhood', *History Workshop*, 5 (1978), 9-65.

Swaziland in the 1930s and the medical policy initiated by Sir Alan Pim's reports in 1932. Pim was a British colonial official tasked with investigating the socio-economic conditions in seven British African colonies between 1932 and 1938.[12] As a result of this influence, CON clinics in the colonial period offered all MCW services including the birthing service. After World War II, the focus in Britain shifted from maintaining colonial rule to providing social services to the colonised communities.[13] When this change occurred (by the end of World War II in 1945), MCW programmes were firmly established and well developed in most African colonies.

In the past three decades, extant literature has been written on the history of biomedicine in African colonies during the 19th and 20th centuries. One of the arguments in this literature is that the main reason for extending biomedical services to Africans was to prevent Europeans from contracting diseases from the local indigenous people.[14] Other reasons include economic and political motivations.[15] In this literature, the European superiority complex is apparent and was the reason why Europeans imposed their supposedly 'superior' cultures upon Africans with the hope that African cultures would crumble amidst the fast-spreading European cultures. According to Walima Kalusa, Foucauldian studies have shown how European doctors in colonial spaces used their knowledge of medicine to further imperial expansion, legitimise and maintain colonial power, undermine local belief systems, and to 'construct the colonised as the governable other.'[16]Furthermore, this literature does not conceal African agency which Europeans had miscalculated by thinking that Africans would be passive victims prepared to change to European cultural practices.[17] Scholarship on colonial efforts to commence obstetric and paediatric

12. R. Smyth, 'The Roots of Community Development in Colonial Office Policy and Practice in Africa', *Social Policy and Administration*, 38, 4 (2004), 421.
13. For more on this see N.A. Amponsah, 'Colonizing the Womb: Women, Midwifery, and the State in Colonial Ghana' (Ph.D thesis, University of Texas, 2011).
14. For more on this view, see D. Arnold, *Imperial Medicine and Indigenous Societies* (Manchester: Manchester University Press, 1988); E.B. van Heyningen, 'Agents of Empire: The Medical Profession in the Cape Colony, 1880–1910', *Medical History*, 33 (1989), 450.
15. R. Bollen, 'Why did Western Countries Attempt to Impose their Medicine on Indigenous Societies in the Ninetieth Century? What were the Results?', *New Zealand Medical Student Journal*, 14 (2011), 1-4; D. Gordon, 'A Sword of Empire? Medicine and Colonialism at King William's Town, Xhosaland, 1856–91', in *Medicine and Colonial Identity,* eds B. Andrews and M.P. Sutphen (London: Routledge, 2003), accessed on 10 December 2016 [ebook available from NetLibrary].
16. W.T. Kalusa, 'Language, Medical Auxiliaries, and the Re-interpretation of Missionary Medicine in Colonial Mwinilunga, Zambia, 1922–51', *Journal of Eastern African Studies,* 1, 1 (2007), 58. For more insight on this, see P.D. Curtin, 'Medical Knowledge and Urban Planning in Tropical Africa', *The American Historical Review,* 90, 3 (1985), 594-613; and. Arnold, 'Introduction: Disease, Medicine and Empire', in *Imperial Medicine and Indigenous Societie*s, 1-26.
17. J. Iliffe, *East African Doctors: A History of the Modern Profession* (Cambridge: Cambridge University Press, 1998).

services is scanty with most case studies drawn from northern, western, central and eastern Africa.[18] There isn't much scholarly attention devoted to the southern African region regarding maternal and child welfare.

While a great deal has been written on the histories of biomedicine in colonial Africa, it is still essential that research on this topic continue because as Motlatsi Thabane indicates, social contexts differed from one colonised society to another, and often forced adaptations in colonial policy. 'New research from contexts not currently covered in published literature has [the] potential to add … to [existing] knowledge…'[19] In this article, I demonstrate that MCW in colonial Swaziland (now Eswatini) illuminates the agency of Swazi women in dealing with cultural imposition. In other words, in addition to the rationale from Thabane for continuing research in biomedicine in colonial Africa, public health issues in Africa enable us to recognise that African women were not passive recipients of the services offered in public health facilities. Instead, they selected the biomedical practices that worked for them and integrated these into their own web of health practices. Furthermore, they resisted and even despised services such as confinement before and after childbirth because they felt that these shifted birthing to the public domain.

This article's unique contribution and significance to scholarship is its demonstration of the Swazi women's response to the introduction of MCW, a response that divulges the colonisers' failure in their attempts to eradicate the use of indigenous knowledge. In colonial Africa, MCW activities were perceived by colonial governments as 'paths of least resistance to social control, economic exploitation, and political domination.'[20] On the other hand, maternity and childbirth were and still are social events because they occur within a contiguous social system and are understood within a cultural value system.[21] This made pregnant women important

18. J.N. Lasker. 'The Role of Health Services in Colonial Rule: The Case of the Ivory Coast', *Culture, Medicine, and Psychiatry*, 1, 3 (1977), 277-297; N.R. Hunt, '"Le bebe en brousse": European Women, African Birth Spacing and Colonial Intervention in Breast Feeding in the Belgian Congo', *The International Journal of African Historical Studie*s, 21, 3 (1988); 401-432; C. Summers, 'Intimate Colonialism: The Imperial Production of Reproduction in Uganda, 1907-1925', *Signs: Journal of Women in Culture and Society*, 16, 4 (1991); 787-807; H. Bell, *Frontiers of Medicine in the Anglo-Egyptian Sudan, 1899-1940* (Oxford: Clarendon Press, 1999); J. Allman, S. Geiger and N. Musisi, 'Introduction', in *Women in African Colonial Histories,* eds J. Allman, S. Geiger and N. Musisi (Bloomington and Indianapolis: Indiana University Press. 2002), 1-15; M. Jennings, '"A Matter of Vital Importance": The Place of Medical Mission in Maternal and Child Healthcare in Tanganyika, 1919-39', in *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa*, ed. D. Hardiman (New York: Rodopi, 2006), 227-250.
19. M. Thabane, 'Public Health Care in Colonial Lesotho: Themes Emerging from Archival Material, 1918-1935', *History of Psychiatry*, 32, 2(2021), 146.
20. Amponsah, 'Colonizing the Womb' , 2.
21. A. Symonds and S.C. Hunt, *The Midwife and Society: Perspectives, Policies and Practice* (London: Macmillan, 1991), 1.

as units of the wider society and according to Anayet Hossain and Korban Ali, their actions and behaviour, including their thoughts and feelings were influenced by the social life which surrounded them.[22] This contradicts the belief that MCW was a weak link and it further implies that the Swazi women's resistance to institutionalised birthing embodies the Swazi society's attitude to this particular colonial practice. Hence, despite efforts by the CON medical missionaries to change the indigenous medicinal therapies and indigenous methods and practices used for maternal and child care, these practices have not been eliminated. Instead, Swazi women have devised strategies to challenge and resist medicalisation[23] and institutionalisation of childbirth and child welfare, thus forcing the CON missionaries to negotiate with them to take up maternity and child care services.

Using archival, oral and secondary sources, this article examines the introduction of MCW in the kingdom by demonstrating the link between the state and the CON and explaining their overlapping interests in biomedical care service provision. It explains how pregnancy and childbirth were shifted from the private to the public domain and discusses the different ways in which expectant mothers responded to and asserted their agency in MCW services. It shows their active participation and contribution in the making of African history by challenging the imposition of practices which fueled their cultural imperialism. While the focus in this article falls on the RFM Hospital, observation of the CON clinics in a few instances has helped to strengthen the analysis.

Overlapping interests between the colonial government and the Church of the Nazarene

According to Nana Amponsah, in the period from the last two decades of the 19th century to the end of WWII, the British colonial administration instituted a health care system which supported population growth in order to maintain an adequate supply of African labour.[24] To this end, with the assistance of Christian missionaries, colonial governments in British colonial Africa introduced biomedicine, public health services, nursing and midwifery. In most British colonies the governments did not initiate the introduction of public health services but left this task in the hands of missionaries. Christian missionaries were usually the first to build and run health facilities in remote parts of Africa. Where colonial governments initiated this, their medical establishments remained small and poorly funded.[25] In Swaziland, the RFM

22. F.M. Anayet Hossain, M. Korban Ali, 'Relations between Individual and Society', *Open Journal of Social Science*, 2, 8 (2014), 132.
23. Nancy Rose Hunt was the first historian to investigate the medicalisation of childbirth in Africa in her book: N.R. Hunt, *A Colonial Lexicon: Of Birth Ritual, Medicalization and Mobility in the Congo* (Durham: Duke University Press, 1999).
24. Amponsah, 'Colonizing the Womb', 23.
25. See, for example, M. Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford: Stanford University Press, 1991).

Hospital which became the first hospital, was built by the CON in 1927 at Bremersdorp.[26] This is where MCW services were first provided in 1933. This CON medical mission was instituted by an agreement concluded between the CON and the colonial state in 1925,[27] whereby:

> …the British government offered a grant of 35 acres of land in Bremersdorp to the CON; on condition a well-equipped hospital was going to be erected on the site and a qualified British physician was going to be stationed there; with qualified nurses who would attend to the medical needs of the whites while conducting missionary work among the natives.[28]

This agreement established a long-lasting collaboration between the two parties. It led to the creation of the RFM Hospital and the introduction of nurses' training in 1927, followed by MCW services six years later. In this agreement the colonial government provided free land and financial support. The funds were used to pay staff and supply medication at the RFM Hospital and in future clinics. The CON agreed to build the hospital and provide medical and nursing staff. This agreement set the precedent for their collaboration during the colonial and post-colonial periods.

Apart from the CON/state agreement, from the 1930s onwards, there was in Swaziland, a colonial medical policy which compelled the government to construct medical outstations in order to reduce infant and maternal mortality rates and to place in these medical outstations trained Swazi nurses to deal with the work among women and children.[29] This policy stemmed from one of the recommendations of Sir Alan Pim's Report in 1932. Pim proposed a variety of social as well as economic reforms.[30] This healthcare policy was also directed towards preventive care which included vaccination to prevent diseases such as malaria and smallpox, and it laid emphasis on sanitation. It should be noted though that despite the existence of a policy compelling the government to build more clinics from the 1930s onwards, and despite the fact that MCW services in Africa were considered essential for the success of the British Empire, in Swaziland, in the period under review, it was undertaken by missionaries. However, the colonial government remained faithful in supporting the CON medical mission with payment of salaries for its medical staff and sponsoring the training of Swazi nurses through regular and systematic grants-in-aid.

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26. Swaziland National Archives (hereafter SNA), Resident Commissioner for Swaziland (hereafter RCS) 319/27: Opening Ceremony for the Raleigh Fitkin Memorial Hospital, Bremersdorp, Extract from a speech delivered by Dr Hynd on 16 July, 1927.
27. SNA, RCS 36/34: Annual Report of work done at the Bremersdorp Hospital, 1933.
28. Wits University Historical Papers Collection (hereafter Wits), File, A1441/D: Church of the Nazarene World Missions Work and Missionaries' Information.
29. SNA, RCS 938/32: Application for Assistance under Colonial Development Fund for Medical Outpost, 1932.
30. Smyth, 'The Roots of Community Development in Colonial Office Policy and Practice in Africa', 421.

When Dr Hynd arrived in 1925,[31] there was no hospital and the whole country was served by two medical practitioners, one in Mbabane and the other at Hlatikhulu, in southern Swaziland,[32] and one medical dispenser.[33] Two years after his arrival, Hynd inaugurated nurse training at the RFM Hospital. Hence, as seen earlier, from the 1930s onwards, the government not only paid the salaries for the RFM Hospital staff, but also provided funding for nursing students. As was the case elsewhere in British colonial Africa, the British colonialists' over-emphasis on alarmist approaches to 'high rates' of morbidity and mortality among Africans was influenced by their metropolitan roots, whereby, as seen earlier, 20th century Britain became increasingly preoccupied with these issues and British colonialists transposed these interests into their colonies. Affirming the high infant mortality in Swaziland,[34] Hynd stated, ' …since starting medical work in your district in 1925 one of the most disturbing features affecting native health has been the serious infant and maternal mortality.'[35] As previously demonstrated, Britan's increasing interest on MCW issues was heightened by her growing interest in trusteeship doctrines after World War I. Hence, the high infant mortality Hynd alludes to could not be ignored in the 1930s to the 1940s, a time when the South African and the Swazi mining industries demanded a healthy and rapidly growing Swazi population to meet the internal and external labour requirements.[36]

In addition, Hynd's social and physical welfare approach led to the introduction of MCW in the kingdom. The extension of medical services to Swazis by the CON medical missionaries was aimed at drawing Swazis towards God while convincing them of the magnanimity of British rule.[37] In light of this, it could be argued that the CON used biomedicine to advance several imperial and CON programmes, one being

31. Hynd was a CON medical missionary from Scotland who arrived in Swaziland in June 1925 to start the medical mission at Bremersdorp.
32. These were Dr R. Jamison who was stationed in Mbabane and was running a dispensary with two wards, one for whites and the other one for Swazis. Dr Jamison was also the country's Principal Medical Officer. Dr G.O.N. Waddington was placed in Hlatikhulu to service southern Swaziland. This arrangement left the central and eastern Swaziland without a medical officer until 1925 when Dr Hynd arrived.
33. D. Hynd, 'A Doctor's Arrival in Swaziland, the 1925 Style', *Swaziland Teachers' Journal*, 53 (1966), 21.
34. Infant mortality and low population growth were the worst fears of colonial governments in Africa. See M. Jennings, '"A Matter of Vital Importance":The Place of the Medical Mission in Maternal and Child Healthcare in Tanganyika, 1919–39', in D. Hardiman, *Healing Bodies: Saving Souls Medical Missions in Asia and Africa* (Amsterdam: Rodopi, 2006), 228.
35. SNA, RCS. 252/35: Maternity and Child Welfare Centre, Extract from Dr. Hynd's letter to the Resident Commissioner in March 1935.
36. S.R. Dlamini, 'Colonialism and Race in Nursing Education at Ainsworth Dickson Nursing Training School, Swaziland, 1927-1980', *The UK Association for the History of Nursing Bulletin*, 9 (2021), 10-14.
37. Dlamini, 'The Colonial State and the Church of the Nazarene in Medical Evangelization', 379.

the accomplishment of social control over colonial subjects.[38] It is against this backdrop that one appreciates the history of the introduction of maternal and child care in Swaziland by the CON, a background which also demonstrates the origin of the collaboration between the CON and the colonial government and the extent of their overlapping interests.

The origin of maternity and child welfare in Swaziland

As previously explained, the 1920s witnessed a bourgeoning of services targeting maternal and child health in the British Empire. Concern for the health of mothers and children began relatively early in some British colonies than in others.[39] In Swaziland, this concern was first raised by Dr Hynd in the late 1920s due to a remarkably high disease burden which adversely affected Swazi women and children. The period from the 1920s through the 1930s witnessed a gradual increase in the prevalence of diseases among the Swazis. According to Hamilton Dyke, the Principal Medical Officer (PMO) of Bechuanaland (now Botswana), the increase in disease burden was one of the effects of land alienation which made people in the High Commission Territories (HCTs) of Bechuanaland, Lesotho and Swaziland unable to resist diseases.[40] Explaining the connection between land alienation and increased disease burden, Helen Sweet wrote:

> In rural areas, where the African population was concentrated in officially designated reserves, there was insufficient land to farm and high hut taxes to pay, so that men were forced to leave their families and work as migrant labourers in white-owned mines, industries and farms... often living in crowded single-sex hostels near their jobs and separated from their wives ... Sexually transmitted diseases and tuberculosis became commonplace among migrant workers, who also transmitted these diseases to their families on their occasional visits home to the rural 'reserves'.[41]

Amongst sexually transmitted Infections (STIs), syphilis began to spread relentlessly in Swaziland from the 1930s onwards due to increased labour migration. Its prevalence was unsettling because syphilis has crippling effects on societies, causing

> ... still births, congenital deformities and blindness of the baby. It is also known to cause rapid spread of morbidity which puts a lot of strain on the patient and on medical services as hospitalization and medication begins to be required...[42]

38. Dlamini, 'The Colonial State and the Church of the Nazarene in Medical Evangelization', 379.
39. Jennings, 'A Matter of Vital Importance', 231.
40. SNA, RCS. 940/32: Report by the Principal Medical Officer, Bechuanaland on a Conference held at Bloemfontein Regarding the Training of Native Nurses, June 1932.
41. H. Sweet, 'A Mission to Nurse: The Mission Hospital's Role in the Development of Nursing in South Africa, c. 1948–1975', in *Routledge Handbook of the Global History of Nursing*, eds P.D. Antonio, J.A. Fairman and J.C. Whelan (Routledge: New York, 2013), 201.
42. *Times of Swaziland,* 'The Diseases that Kill our Future', 6 July, 1977.

As a result, towards the end of the 1930s, syphilis-related morbidity increased patronisation of antenatal services by the RFM Hospital medical missionaries who supported, publicised and defended these services to increase their uptake by Swazi women.

The critical need for MCW services was statistically captured in the 1933 Medical and Sanitary Report. Out of 681 pregnancies recorded, only 354 babies lived to see adulthood: 72 were miscarried, 54 were stillbirths, 147 babies died during the first year of life, 38 died between the ages of one and three years, and 15 died between three and five years of age. This was a mortality rate of approximately 50 percent.[43] While laying emphasis on infant mortality might have been one of the medical missionaries' most effective ways of soliciting funding especially from Britain, as seen earlier, high infant mortality was a common trend throughout Africa in the early 20th century. In Tanganyika (now Tanzania), for instance, surveys conducted in 1921 in the northern and western parts of the colony revealed that of the 707 children born in 34 chiefdoms, only 405 lived up to two years old. In the Ufipa District, only 48.2 percent of children reached adulthood, while in Kirando, about 53 percent died before reaching the age of two years.[44]

Furthermore, colonial officers and missionaries believed that biomedical knowledge was essential in reshaping the cultures of the colonised and in facilitating social control. Using MCW services, their particular focus was teaching 'natives' about sanitary concepts and Western mores central to Victorian middle-class society.[45] Nana Amponsah rightly observes that by attempting to control areas Africans value the most such as pregnancy, childbirth, and child upbringing, colonisers wanted to achieve complete control of the vital lifeline of the entire African society.[46]

Maternal and child welfare provision at the Raleigh Fitkin Memorial Hospital

According to Hynd, following the official opening of the RFM Hospital, an increasing number of women came especially to deliver their babies[47] and these women faced challenges due to limited space. Although Hynd observed an increase, we should note that deliveries at RFM remained very small compared to the numbers for prenatal

43. SNA, RCS 36/34: Annual Report of work done at the Bremersdorp Hospital for the year ended in December, 1933. Hynd was succinctly expressing this crisis in a letter to the British Resident Commissioner. The contents of the letter are cited in footnote 21.
44. Jennings, 'A Matter of Vital Importance', 232.
45. See J.H. Hammond, 'Evangelization, Injections, and the Baganda: Mengo Hospital and Biomedicine in Uganda' (B.A. Honours paper, University of Michigan, 2012); and Van Heyningen, 'Agents of Empire', 450.
46. Amponsah, 'Colonizing the Womb', 219.
47. SNA, RCS 63/28: Medical Report of RFM Hospital, Bremersdorp, for the period from January to December, 1927.

examinations. The increase in maternity cases referred to here must have been more glaring from the 1930s onwards due to increasing rates of maternal and infant mortality in the country. The increased mortality caused distress for Dr Hynd who in his 1932 report wrote:

> … Maternity and child welfare mortality is one of the chief concerns of medical work in Swaziland. During the first few years, I have had cases of maternal deaths in the kraals and hospital. Also, whilst taking histories of maternity cases, I found a very high foetal death rate, and still births due to the high incidence of syphilis. …, the infant death is enormous.[48]

The British Red Cross Society commissioned Ruby Sipple, a midwife, to the RFM Hospital in 1933 not only to address Hynd's distress but also to implement some of the recommendations of Alan Pim's survey by instituting MCW services.[49] The report recommended that MCW services be introduced in clinics in rural Swaziland where maternal and infant mortality were quite high. Upon arrival, she assumed responsibility for MCW and played a crucial role in enhancing the nurse training programme by developing a course on midwifery and the well-being of new-born infants: 'she gave classroom lectures in midwifery and taught the midwives in the ward, and delivery room.'[50] Furthermore, Sipple conducted home visits during pregnancy to provide education and guidance on various aspects of maternal and child health such as nutrition, sanitation, and caring for babies. She was in charge of teaching Swazi nurses district maternity work.[51] To promote maternal and child care, Hynd built a small room with a veranda for Sipple to use as a MCW clinic until 1936.[52]

Worth noting too is the fact that the 1932 medical report by Hynd does not provide the specific numbers of maternal deaths, but only mentions that the numbers were 'concerning'. It does not reflect the number of women who came for maternity services. The concealment of maternal mortality rates was a common practice in Britain and in British colonial Africa. However, the concealment of maternal mortality was not always deliberate. It was usually due to reasons beyond control such as lack of registration of maternal deaths, which came to an end in the late 1920s in Britain when the Registration of Maternal Mortality Act was promulgated.[53] Similarly, in the

48. SNA, RCS 39/32: Annual Report of work at RFM Hospital, Bremersdorp, Swaziland, from January to December, 1931.
49. SNA, RCS 461/34: Grants towards Medical and Nursing Training of Natives in High Commission Territories, 1934.
50. Davis, *Nursing in Swaziland*, 20.
51. SNA, RCS 461/34: Grants towards Medical and Nursing Training of Natives in High Commission Territories, 1934.
52. SNA, RCS 608/37: Discussions between Dr Hynd and the high commissioner (Sir W. Clark) aimed at regulating certain medical matters at Bremersdorp, July 1937.
53. G. Chamberlain, 'British Maternal Mortality in the 19th and early 20th Century', *Journal of the Royal Society of Medicine*, 99, 11 (2006), 559.

British Empire, this concealment should not be understood to be deliberate. In most cases, it was impossible to reveal the number of maternal mortality because there were no laws and policies enforcing the counting of maternal mortality cases. It was only after the promulgation of the Maternal Mortality Act in Britain that British colonies from the 1930s onwards began promulgating similar legislations. In Swaziland, as this article will demonstrate, the concealment of maternal mortality statistics was promoted by the fact that most Swazi women did not visit health centres for birthing services. They delivered their babies at home with the assistance of indigenous birth attendants.

Mary Blacklock, a member of the Colonial Medical Advisory Committee for Africa, criticised the practice of concealing maternal mortality during the Imperial Social Hygiene Congress of July 1931 in London when saying:

> It has often surprised me to find how easy it is to raise interest in the welfare of children while comparatively little interest is taken in the welfare of women. Yet, women's welfare should surely arouse equal interest, ... because her welfare is so closely interwoven with that of the child. One can obtain figures for the infant mortality rate for most of our colonies but rarely for maternal mortality and when the latter rate is given, it is often appallingly high.[54]

The sustainability of the MCW services was made possible by the connections Dr Hynd had with colonial officials and King Sobhuza II.[55] Ainsworth Dickson, the resident commissioner from 1928 to 1935 was a key supporter of Hynd's social services. Additionally, King Sobhuza II played a significant role in the establishment of the MCW Department and had close relations with Hynd. On Hynd's arrival in 1925, Sobhuza II made him his personal physician and the only medical practitioner responsible for rendering medical services to members of his royal household.[56] Having received reports, from Hynd, about the increasing numbers of women utilising maternal care, and the ever-increasing numbers of maternal mortality which convinced him that the Swazi nation was at risk of experiencing a serious population decline, a common occurrence in countries such as Uganda, King Sobhuza II became interested in building a maternity and child welfare block to accommodate the growing number of women seeking maternal care. The block would have wards for expectant mothers and separate rooms for the Kings' wives.[57] The King was happy

54. Mrs Blacklock is quoted in Amponsah, 'Colonizing the Womb', 20.
55. In British colonial Africa, indigenous African monarchs, previously known as Kings became known as paramount chiefs presumably to preserve the title for the king in imperial Britain.
56. Interview conducted by the author with Dr Samuel Hynd, Manzini, 25July, 2012. Dr Samuel Hynd was Dr David Hynd's son.
57. SNA, RCS 608/37: Interview between Dr Hynd and Sir W. Clark (the high commissioner) to discuss the regulation of certain medical matters at Bremersdorp, July 1937.

that 'his people were beginning to realize the value of this department and was willing to contribute something towards the erection of this block.'[58] According to Dr Anderson Nxumalo, a member of the CON, King Sobhuza II donated 16 herd of cattle to kick-start the project.[59]

In 1933, the King advised the resident commissioner to constitute a committee of chiefs to work with the missionary doctor in a fund-raising campaign.[60] This committee recommended to the King that each Swazi man had to contribute one beast. The King approved the suggestion and specified that the region where contributions would be collected would be the same one serviced by RFM Hospital. He delimited this area as the region between the Komati and Usuthu rivers including the Siteki District.[61] Contributions were made through local chiefs charged with supervising their collection. The chiefs' committee often met with Dr Hynd to discuss details of building the MCW block. The funds raised by the King and the chiefs' committee commenced construction of the MCW block at the the RFM Hospital in 1934 and it was completed using top-up contributions from the United States of America (USA).[62]

Justifying the need for a whole building designated to MCW, Hynd had this to say in his 1934 report: ' … the work done at the MCW Department was impressive. There had been 2,666 attendances, 653 ante-natal examinations, 116 deliveries, and 117 baby show entrants.'[63] The PMO, Dr R. Jamison, added that there had been a significant increase in the number of women seeking MCW services at RFM Hospital. He expressed satisfaction in seeing more Swazi women accessing these services across the territory.[64] According to Hynd, in 1934, there was a 100 percent increase in women coming for delivery at RFM.[65] Hynd observed that this increased uptake of the services was more notable among those who had syphilis because Swazi women were aware of the devastating effects of the disease to their children. Hence, they 'often bring their infants a few weeks after birth to find out whether any stigmata of the disease are present.'[66] Their coming was cause for great gratification to colonial officials who valued reproduction of healthy children in order to promote the production of a healthy labour force and reduce medical expenditure.

58. SNA, RCS 608/37: Discussions between Hynd and Clark at Bremersdorp, July 1937.
59. Interview conducted by the author with Dr Anderson Nxumalo, Manzini, 5 May 2013. Nxumalo was a member of the CON and was based in Manzini in 2013.
60. Interview by the author with Dr Anderson Nxumalo, Manzini, 5 May 2013.
61. SNA, RCS 608/37: Discussions between Hynd and Clark to regulate certain medical matters at Bremersdorp, July 1937.
62. Extract from a personal letter from Dr Hynd to Mrs Fitkin concerning the Raleigh Fitkin Memorial Hospital.
63. SNA, RCS 31/34: Medical and Sanitary Report for the year 1934.
64. SNA, RCS 31/34: Medical and Sanitary Report for the year 1934.
65. SNA, RCS 608/37: Interview with the high commissioner (Sir William Clark) at Bremersdorp regarding medical matters in July, 1937. This was divulged in a letter Dr Hynd wrote to the assistant commissioner on 23 February 1935.
66. SNA, RCS 31/34: Medical and Sanitary Report for the year 1934.

The block was completed in 1936 and was called Sobhuza II Maternity and Child Welfare Block, commemorative of the interest and material support given by Sobhuza II. Its completion was a significant achievement for both the nation and the medical officers concerned with promoting the health of mothers and children. The RFM Hospital was the only one in the territory to offer these services until the early 1940s. The Mbabane and Hlatikhulu government hospitals could not offer these services because they lacked proper obstetric facilities. The two government hospitals: Hlatikulu and Mbabane were established in 1930 and 1931 respectively. They were situated in areas with high population density of British officials and their establishment was induced by the need to offer medical services to the colonial officers. For a long time, these two health facilities were not concerned with providing MCW services because of the desire of all colonial medical departments in Africa to minimise the costs of their own services by relying on mission-owned hospitals where possible.

The RFM Hospital played a crucial role in sustaining the Swazi nation by providing essential services such as the MCW especially in the era of destructive diseases such as syphilis. Affirming this, Dr Lindokuhle Dlamini, a general medical officer at Nhlangano Health Centre, revealed that women's regular examinations and screening for STIs such as syphilis helped to prevent still-births, congenital deformities and blindness of the babies born. Screening and prenatal immunisation of pregnant women also prevented pregnancy-related diseases such as gestational diabetes and pre-eclampsia-Eclampsia.[67] Prenatal and child welfare services ensured that children's growth progressed well and their health was constantly monitored until birth. Post-natal services such as immunisation ensured children's protection from contracting deadly yet preventable diseases such as pertussis, diphtheria and tetanus.[68] During the post-natal clinic visitations, mothers were instructed on proper nutrition for themselves and their babies during lactation.[69] In view of this, it becomes obvious that although the CON instituted MCW services to facilitate conversion to Christianity, these services contributed to the protection and sustenance of the lives of mothers and their children through preventing and further reducing their morbidity and mortality.[70] A healthy population reduced the government's expenditure on health and guaranteed a reliable source of labour.

67. Interview conducted by the author with Dr Lindokuhle Dlamini, Ngwane Park, 28 August 2023.
68. Interview with Lindokuhle Dlamini, Ngwane Park, 28 August 2023.
69. Interview conducted by the author with Matron Amy-Joyce Manthatha, Piggs Peak, 28 January 2014.
70. SNA, RCS 36/35: Annual Report of the work done at Bremersdorp Hospital from January to December 1934.

Swazi women's response and the colonial and missionary officers' compromise

The benefits of the MCW services extended beyond just the Swazi women and their children to the nursing training programmes, notably the midwifery course. The MCW Department provided this programme with clinical material for the training of midwives. Additionally, regular antenatal and child welfare clinical check-ups were done at the hospital and maternity work was expanded to surrounding areas as Swazi nurses were trained and assigned to neighbouring CON clinics.[71] By the 1930s, the RFM Hospital was fully preoccupied with the training of Swazi nurses who knew the siSwati language and were used by the CON medical missionaries to encourage Swazi women to come to the hospital for MCW services.[72] This is how the need for change in MCW practices was communicated by the CON medical missionaries to the Swazi women and their communities at large. Midwifery students were responsible for teaching women about personal hygiene, vaccinations, reproductive health, nutrition, and overall hygiene during and after pregnancy.

Upon Ruby Sipple's arrival, the RFM Hospital started offering a three-month training course on midwifery to student nurses. Her arrival enabled midwifery students to take theoretical lessons and have practical experience assisting 20 women to deliver their babies.[73] Acquiring 20 pregnant women who were prepared to undergo delivery procedures would not have been possible if all Swazi women's response to the institutionalisation of birthing was homogenous. The fact that the midwifery programme went on without interruption and the women made themselves available, demonstrates that although some Swazi women were opposed to the institutionalisation of birthing, others were more amenable to change. A few Swazi women, especially those who had converted to Christianity, went to the RFM Hospital and to the few CON clinics for this purpose[74] because they had begun to appreciate the value of biomedicines.[75] This is apparent from the evidence of Ellinah Simelane who went to the Mliba Clinic of the CON in the early 1940s to deliver her firstborn son.[76]

Furthermore, the CON had a great deal to gain from training midwives. In the agreement between the CON and the state, 'doing missionary work to (sic) the Swazis'[77] was one of the things the two parties agreed the CON would do and Swazi

71. SNA, RCS 38/33: Annual Report of the work done at RFM Hospital in Bremersdorp, 1933.
72. For more information, see Dlamini, 'Medical Missions and Proselytisation', 20-42.
73. SNA, RCS 461/34: Grants towards Medical and Nursing Training of Natives in High Commission Territories, 1934.
74. Dlamini, 'Medical Missions and Proselytisation', 36.
75. D. Hynd, 'Raleigh Fitkin Memorial Hospital at Work in Africa', *The Other Sheep,* 1928, 5.
76. Interview conducted by the author with Emmah Simelane, Mliba, 14 September 2013.
77. Wits Historical Papers, File, A1441/D: Church of the Nazarene World Missions Work and Missionaries' Information.

nurses and midwives played a significant role in spreading biomedicine and reducing reliance on indigenous medicine which European missionaries condemned as the 'locus of paganism.'[78] Lukhele recalled:

> We had been advised by the tutor and our maternity and child welfare sister to accommodate newly delivered babies for ten days in the clinics before discharging them. This was done to allow the navel to heal completely because if we discharged the mother before it had healed, the Swazis applied indigenous medicine to help it heal.[79]

From this advice we learn of the fear by CON missionaries that the success of MCW work in Swaziland would be hampered by the local people's adherence to indigenous medicine.[80] Lukhele's words also reveal that the CON medical missionaries were aware that Swazis were so entrenched in indigenous healing that those using biomedicine were inclined to integrate it with indigenous medicine.[81] By keeping women who had delivered for ten days in clinics, they were attempting to wean them from the use of indigenous medicine while simultaneously exposing them to relentless proselytisation in sermons given by the 'nurse-evangelists.'[82]

Although there was an increase in the number of women attending antenatal clinical check-ups at RFM Hospital and in other CON clinics, only a few of these women were interested in delivering their babies in the hospital in the 1930s and early 1940s. Of the 1 982 women attending the antenatal clinic at RFM Hospital in 1934, only 268 delivered their babies in the hospital.[83] An interview with Murrel Shabangu, a teacher at Sydney Williams Primary, revealed why some expectant women did not choose to go to RFM hospital for delivery.

> We gladly utilised the prenatal services provided by RFM Hospital and were happy to be immunized because these were helpful in determining our health and the health of our babies during pregnancy. We appreciated the lessons we received on how to keep healthy. But we did not go to RFM Hospital for childbirth because young Swazi girls were responsible for the birthing process. We did not trust these young girls and felt they were too young to be solely responsible for

78. Dlamini, 'Medical Missions and Proselytisation', 28.
79. Interview with Eva Lukhele, Croydon, 14 September 2013. Lukhele was one of the first-generation nurses trained at ADNT School. She worked in various CON clinics in the country.
80. Dlamini, 'Medical Missions and Proselytisation', 9.
81. For more information on the integration of Western medicine with indigenous medicine see K. Flint, 'Competition, Race and Professionalization: African Healers and White Medical Practitioners in Natal, South Africa in the Early Twentieth Century', *Social History of Medicine*, 14, 2 (2001), 199-221.
82. Dlamini, 'Medical Missions and Proselytisation', 9.
83. SNA, RCS 36/35: Annual Report of the work done at Bremersdorp Hospital from January to December 1934. The source does not stipulate the number of still-births recorded.

> such a task. We also felt embarrassed to be told by these young girls what to do during the birthing process because some of them were our own children's age-mates. We preferred delivering at home with the assistance of indigenous birth attendants who were old and experienced enough to command our trust.[84]

Mrs Shabangu, a member of the female educated Swazi elite, lived only 2.7km from the RFM Hospital. However, she would go home to Ngculwini, located 17km from the hospital, for her confinement and childbirth. Despite the distance, she chose to give birth at home. This underlines the evidence provided by Mrs Manthatha, a nurse who worked at the RFM Hospital and subsequently became matron from 1968 to 1992. She confirmed that midwives and the midwifery students were responsible for conducting deliveries in the labour ward. They instructed mothers in personal hygiene, the importance of vaccinations, nutrition, and general hygiene and sanitation after delivering their infants.[85] Experiences narrated by Shabangu and her colleagues at Sydney Williams Primary School, who were members of the female educated elite in Swaziland, suggest that not all educated and urbanite women participated in institutional birthing.

Although the utilisation of prenatal services was increasing, most Swazi women were unhappy about some of the changes introduced in their maternal lives and the birthing process. According to Thulinah Nxumalo, a teacher at Nkambeni Primary School, they resented and contested the idea that they were to blame for the death of their children which was implied by linking infant mortality to bacteriology and unhygienic practices related to feeding infants.[86] Contestation was shown by 'refusing to follow instructions and advice intended to persuade them to come for confinement and delivery, refusing to bathe their children every evening, and continuing to feed thin porridge, *inembe,* to newborn babies.'[87] Despite receiving instructions on hygiene from midwives, many Swazi women were unable to boil drinking water and their children were not bathed daily due to scarcity of biomass fuels and lack of water, soap and energy because the mothers also engaged in physically demanding work in the fields.

Julia Sihlongonyane is one of the indigenous birth attendants I interviewed to gain insight into Swazi women's response to maternal health services.[88] She revealed that she was responsible for most of her grandchildren being born at home instead of the RFM Hospital. She pointed out that while the hospital was excellent in ensuring the safety of the child and the mother during pregnancy, she felt that it could not be trusted fully in matters of childbirth because if anything went wrong, a Caesarean

84. Interview by the author with Murrel Shabangu, Ngculwini, 7 March 2019. Shabangu was speaking on behalf of most of her female colleagues at Sydney Williams, hence the use of the first person plural.
85. Interview by the author with Amy-Joyce Manthatha, Piggs Peak, 28 January, 2014.
86. Interview by the author with Thulinah Nxumalo, Nkambeni, 10 December 2019.
87. Interview by the author with Julia Sihlongonyane, Ndzevane, 30 June 2019.
88. Interview by the author with Julia Sihlongonyane, Ndzevane, 30 June 2019.

section was always the first option, yet the indigenous birthing methods allowed a number of other options such as the midwife inserting a hand to deal with a number of maternity-related problems. She explained:

> I have 49 grandchildren and only three of them were delivered at [the] RFM Hospital. All my 46 grandchildren were delivered here at home and I was the chief birth attendant responsible for instructing my daughters on what to do during the birthing process to ensure a safe delivery. I have six daughters and only one utilised [the] RFM Hospital for birthing purposes. All my other five daughters never went to hospital to deliver their babies. They delivered live babies here at home and none of them lost a child at birth or underwent the trauma of Caesarean birth. They usually went back to [the] RFM Hospital two weeks after birth to start immunizing their children.[89]

Although Sihlongonyane did not reveal this, other reliable sources revealed that rampant ill-treatment of women by midwives in hospitals was a common problem in colonial and post-colonial Africa,[90] and could have been another reason why some Swazi women preferred giving birth at home under the tutelage of *babelekisi* (indigenous birth attendants). Table 1 below demonstrates the comparatively low number of women who delivered at the RFM Hospital.

Table 1: Maternal and Child Welfare Attendance at the RFM Hospital

Year	Antenatal examinations	Deliveries	Child welfare attendance
1936	1044	112	2396
1937	1258	180	2212
1938	1754	203	2682
1939	1445	201	2308
1940	1982	268	2457
1941	1982	260	2378
1942	4818	566	3696
1944	4869	1063	2921

Source: Swaziland National Archives (SNA), R.C.S.31/36, R.C.S. 31/37, R.C.S.31/38, R.C.S.31/39, Annual Medical and Sanitary Report, 1940, 1941, 1942, and 1944.[91]

89. Interview by the author with Julia Sihlongonyane, Ndzevane, 30 June 2019.
90. This phenomenon has been studied in many African countries. For more information, see D.R. Allen, *Managing Motherhood, Managing Risk: Fertility and Danger in West Central Tanzania* (Michigan: University of Michigan Press, 2002); N.R. Hunt, 'An Acoustic: Register and Repetition in Congo', in *Imperial Debris: On Ruins and Ruinatio*n, ed. A.L. Stoler (Durham: Duke University Press, 2013), 39-66. P.A. Afulani, B. Phillips, R.A. Aborigo, C.A. Moye, 'Person-centred Maternity Care in Low-income and Middle-income Countries: Analysis of Data from Kenya, Ghana, and India', *Lancet Global Health*, 7 (2019), 96–109.
91. The 1935, 1943 and 1945 reports indicate that Dr Hynd, the medical superintendent of the Bremersdorp Medical mission was too busy and therefore unable to submit yearly

Sihlongonyane's words and the statistics above suggest that most Swazi women objected to the CON and colonial government's efforts to institutionalise birthing. However, after the birth of their children, even those who had not attended antenatal clinical check-ups presented their newborn babies for child welfare services, as is reflected in the numbers of antenatal examinations compared to child welfare attendance in the years 1936 to 1941. Even as deliveries increased, antenatal examinations and numbers of children attending welfare services remained significantly higher than deliveries.

The medicalisation and institutionalisation of childbirth threatened the role of indigenous birth attendants, who were highly regarded for their expertise in resolving birthing complications. These attendants were at risk of losing their social roles. Instead of presenting themselves for confinements, mothers brought newly born babies to the RFM Hospital for examination during their early months of life. This 'was appreciated and welcomed by government medical officers as an indication of the appreciation of Western medical methods by Swazis.'[92] However, this also reveals the extent to which European doctors were prepared to bend in negotiating the uptake of these services by Swazi women. Furthermore, it indicates that the success or failure of maternity and child care in Swaziland was highly dependent on Swazi women's personal choices regarding beneficial biomedical practices. Prenatal services were preferred because pregnant women believed these measures improved their health and the health of their babies during pregnancy. Child immunisation was valued because it was seen as a way to protect infants from preventable diseases such as diphtheria, tetanus and others.

Another way in which Swazi women resisted the transition of birthing from the private to the public domain was by choosing to stay at home and request midwives from RFM Hospital or nearby CON clinics to come and assist with their delivery. Despite the existence of a nearby RFM Hospital, women living in areas such as Matsapha, Gundvwini, Nhlambeni, Maliyaduma, Ngculwini often preferred to have midwives attend to them in their homes rather than going to the hospital. In 1943, the PMO observed that there was a steady increase in the number of expectant mothers '... calling upon the nurses at outposts to attend them in their homes.'[93] This practice was called 'district nursing' and is still a very common practice in Britain.

According to Joyce Manthatha, in Swaziland in the 1930s and early 1940s there was no policy facilitating the practice of district nursing but it was sometimes enforced by circumstances, and nurses employed by CON did indeed practise district

reports on work done at RFM Hospital. Hence the gaps in the information provided in Table 1.

92. SNA, Annual Medical and Sanitary Report for the year ended 31 December, 1943, 6.
93. SNA, Annual Medical and Sanitary Report for the year ended 31 December, 1943, 7.

nursing[94] although this was contrary to the CON plan of confining pregnant women in hospitals. This was an exception and arose because of the shortage of physical structures to accommodate expectant mothers. Confirming this, Dr Samuel Hynd explains that due to lack of funds, in the first few years of their existence, some CON clinics were obliged to operate under the shade of trees in rural areas and the nurses had to store the necessary medicinal drugs in their houses. The CON nursing staff carried out 'consultations with their patients, took vital signs and further gave medication under [the shade of] a tree. They [also] gave injections in the privacy provided by the screen.'[95] Such anomalies bolstered Swazi women's resistance to institutionalised birthing.

Although missionaries and colonial officers encouraged expectant women to call on midwives to come and help them deliver in the comfort of their homes, the persistence of this practice indicates that the imposition of institutionalised birthing among the Swazis was not widely accepted, leading to the women's resistance and compromise by missionaries. By calling midwives to their homes, some Swazi women appeared to appreciate the nurses but had problems with institutionalised birthing. They wanted to maintain some aspects of their own birthing practices which involved a familiar environment and the use of indigenous medicine for both mother and infant.

In precolonial times pregnant Swazi women had used *timbita* to quicken the advancement of labour. The women's use of *timbita* was an indigenous historical practice which continued in colonial times to accelerate the progression of labour in order to 'shorten the period of languishing in labour pains.'[96] The women's choice to continue using *timbita*, despite discouragement by colonial biomedical officials, was a form of resistance against colonial control. The few women who went for confinement at the RFM Hospital and other CON clinics carried *timbita*[97] with them and to date, herbal medicine use during pregnancy is widespread in Africa.[98] Further, after birth, women would take their children to indigenous medical practitioners for protection and strengthening, in addition to taking them to the hospital and clinics for immunisation.[99] This indicates that local women used both Western and indigenous medical treatments despite the CON missionaries' efforts at promoting Western medicine and discouraging indigenous medicine. Western medicines were only 'an addition to, not a substitute for, the indigenous' medication.[100]

94. Interview by the author with Matron Amy-Joyce Manthatha, Piggs Peak, 28 January, 2014.
95. Interview by the author with Dr Samuel Hynd, Manzini, 25 July, 2012.
96. Interview by the author with Julia Sihlongonyane, Ndzevane, 30 June 2019.
97. Interview with Eva Lukhele, Croydon, 14 September 2013.
98. D. Makombe, E. Thombozi, W. Chilemba, A. Mboma, K.J. Bamda, and E. Mwakilama. 'Herbal Medicine use during Pregnancy and Childbirth: Perceptions of Women living in Lilongwe Rural Malawi – A Qualitative Study', *BMC Women's Health*, 23, 228 (2023), 1-12.
99. Interview by the author with Thulinah Nxumalo, Nkambeni 10 December, 2019.
100. H. Kuper, *The Swazi: A South African Kingdom* (London: Holt, Rinehart & Winston,

In view of all these strategies, it can be concluded that the introduction of MCW services in Swaziland only served to provide a wider range of options for expectant Swazi women. They could utilise Western birthing centres, or call upon midwives to help them deliver at home. While the aspects of Western medicine that reduced morbidity were welcomed, confinement and the attendant proselytisation were the most loathed elements of the CON. Most women would rather avert confinement and enjoy the Western birthing services in the comfort of their homes. The midwives' home-birthing service was established through consensus and negotiations between missionaries, colonial officers and the Swazi women themselves. These practices and their combination continued even after 1945 with colonial and missionary medical officers encouraging pregnant women to at least come for check-ups and advising that they should then call upon midwives for assistance during labour at home.[101] Appreciating this practice, in 1945 the PMO wrote that a 'very satisfactory response is being received in this direction.'[102]

Conclusion

Using archival, oral and secondary sources, this article contributes to the historiography on the African response to the introduction of biomedicine by presenting the case of the Swazi women's contestation and rejection of some Western maternal health practices, an act of agency which forced the CON medical missionaries to negotiate the use of these services by Swazi women. The article discusses the introduction of MCW services in Swaziland focusing on the significant role of the Bremersdorp medical mission of the CON in its commencement. It highlights how the CON medical mission was instrumental in the territory in providing MCW services in the period under study. The CON medical mission not only initiated MCW service provision in Swaziland but it remained the sole provider of this essential service until the early 1940s.

The article also demonstrates that while the main goal of the staff at the RFM Hospital was to convert Swazis to Christianity, this conversion was hampered by local women's resistance to confinement. The practice of confining expectant mothers before and after giving birth in CON facilities was intended to expose them to relentless evangelisation. But this practice had a limited impact because Swazi women resisted confinement into so-called Westernised hospitals. This indicates that the success of maternity services in Swaziland and in Africa as a whole, did not depend on the planning or influence of medical missionaries or colonial officers. Instead it was greatly influenced by the choices made by African women to incorporate certain aspects of European healthcare into their indigenous beliefs and practices.

1963), 83.

101. SNA, Annual Medical and Sanitary Report for the year ended 31 December, 1945, 3.
102. SNA, Annual Medical and Sanitary Report for the year ended 31 December, 1945, 3.

Many Swazi women engaged in MCW services, to some extent, on their own terms. They re-shaped the CON and colonial government's maternal and child care agenda to meet and indeed complement their own. This article demonstrates that even though Swazi women utilised MCW services, this was not with ease and inevitability. Neither was it without reaction and resistance. Instead, Swazi women's resistance to the institutionalisation of birthing was a critical factor forcing the colonial government and the CON to compromise and negotiate with local women regarding confinement. Although the CON valued confinement, the stiff resistance to it by Swazi women forced medical missionaries to comply with the women's preferences and begin to encourage them to stay at home and send messengers to call midwives to attend to them during childbirth.

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