

## 'The Big Cough': Tuberculosis, Popular Perceptions and Beliefs in the Eastern Bechuanaland Protectorate, 1932-1964

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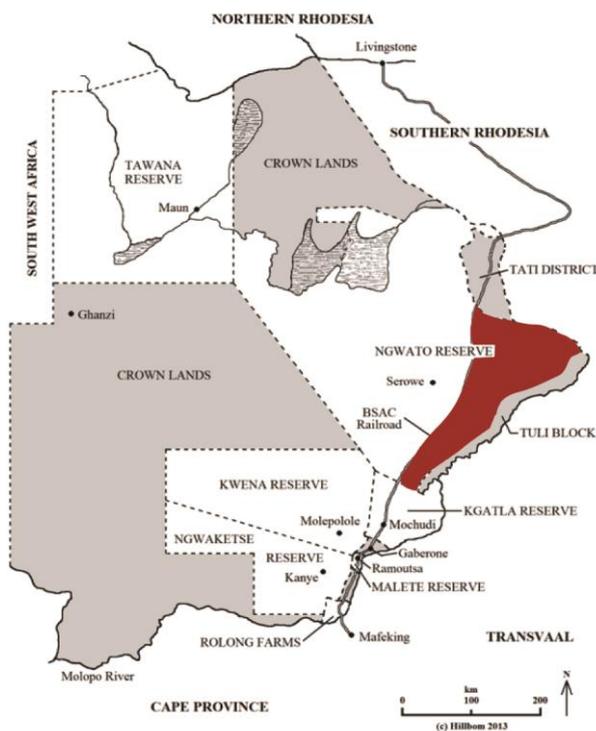
*In the 1930s, migrant labour became the prime determinant of emerging infectious diseases, particularly tuberculosis, in the Bechuanaland Protectorate due to the repatriation of infected workers from neighbouring South African mines. The mining boom had led to an unprecedented increase in migrant labour and this in turn resulted in a high rate of tuberculosis infection and mortality. This article examines local perceptions of tuberculosis in the eastern Bechuanaland Protectorate from 1932 to 1964, when rates of infection and mortality were reduced with the help of medical breakthroughs in antibiotic therapy. While studies of migrant labour in Southern Africa have addressed political, social, and economic aspects of disease, nothing has been written about the multiple ways in which rural communities drew from their cultural repertoire to negotiate this emerging pathology. This article mines the extant medical records housed at the Botswana National Archives and juxtaposes them with oral testimony to examine and illuminate the culturally specific arenas in which the socio-ecological beliefs, values, and meanings of tuberculosis were created and contested among communities of eastern Bechuanaland.*

Between the 1930s and 1960s, the Bechuanaland Protectorate experienced high tuberculosis incidence and related human mortality primarily due to increased repatriations of infected migrants from the mines in South Africa. By the late 1960s, however, the rate of infection had significantly reduced as the World Health Organisation (WHO) embarked on a massive immunization campaign in the country.<sup>1</sup> This article analyses the cultural repertoires rural communities in the eastern Bangwato Reserve, bordering the Transvaal, (see map 1) drew on to negotiate the devastating impact of tuberculosis. These communities, as did other communities in the country, renamed tuberculosis *kgotlholo e tona* (the big cough), thus indigenising its meaning. Profuse coughing accompanied by chest pains was, however, not a new health problem among the Batswana. People had been infected with various types of cough - called *sehuba* (chest disease) - before. But *sehuba* was curable with local remedies and only lasted for a short period, after which the sick person would be restored to good health.<sup>2</sup> Never before had the Batswana experienced so severe a cough

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<sup>1</sup> Tuberculosis and BCG Campaigns, 1952-64, [S. 439/1/1-4] Botswana National Archives (hereafter BNA); Report on BCG Vaccination Programme in Bechuanaland by WHO Regional Office for Africa, November 1962 [S. 438/2/3] BNA.

<sup>2</sup> *Ngaka* (traditional doctor) Sephetso, interviewed by Phuthego Phuthego Molosiwa, 2011, Mokgacha-wadinama Cattle Posts; Thebe Monyepole (former migrant), interviewed by Phuthego Phuthego Molosiwa, 2014, Lesenepole.



Map 1. Bechuanaland Protectorate Native Reserves and Crown Lands showing eastern Bangwato Reserve (in red).<sup>3</sup>

that it led to spitting blood, bodies wasting, and eventual death. The other reason the 'new cough' was conceptualised as 'big' was because its virulence was experienced at a time when environmental shocks and socio-economic processes were impacting the country and the region in quite extraordinary ways.

From 1913 to 1934, a ban on the recruitment of workers from areas north of latitude 22°S due to their high respiratory disease mortality had curtailed the recruitment activities of South African mining companies.<sup>4</sup> In 1932, however, as the mining industry began to recover from the world depression, gold prices rose significantly, fuelling the enormous expansion of demand for labour in the Witwatersrand mines. This period of guaranteed boom saw the South African Chamber of Mines pressurising the Union government to lift the official ban that 'prohibited' formal recruitment of labour from north of 22°S.<sup>5</sup>

As the Witwatersrand Native Labour Association (WNLA) intensified its recruitment drive north of 22°S, the Native Recruiting Corporation (NRC) also increased quotas from pre-existing areas of recruitment south of 22°S, an area in which the Bangwato Reserve was located.<sup>6</sup> The two recruiting competitors (WNLA and NRC) took advantage of a prolonged drought and the outbreak of foot and mouth disease that spanned the entire 1930s, killing large numbers of cattle and forcing many young

<sup>3</sup> Adapted from C. J. Makgala, 'Taxation in the Tribal Areas of the Bechuanaland Protectorate', *Journal of African History*, vol. 45, no. 2, 2004, p. 283.

<sup>4</sup> J. Taylor, 'Mine Labour Recruitment in the Bechuanaland Protectorate', *Botswana Notes and Records*, vol. 10, 1978, p. 101.

<sup>5</sup> J. Taylor, p. 102.

<sup>6</sup> J. Taylor, p. 102.

Bangwato men to abdicate their herding responsibilities in order to seek wage work.<sup>7</sup> The WNLA's recruitment drive was further buoyed by the Resident Commissioner of the Bechuanaland Protectorate, Sir Charles Rey, who upon realizing that tax collection had by 1933 significantly dropped, asked the Chamber of Mines to recruit as many men as possible from the Bangwato Reserve.<sup>8</sup> Between 1934 and the 1960s, the WNLA was recruiting and contracting approximately 4000 labourers per annum from the eastern Bangwato Reserve alone.<sup>9</sup>

Batswana communities from this part of the reserve lived close to the border with the Transvaal, the main destination for migrant labourers. During the period under study, these communities greatly contributed to the rising number of young men migrating to the South African mines, to the elation of colonial authorities. A district commissioner at Serowe, the capital of the Bangwato Reserve, noted in 1936: 'a permanent labour source has now been created in this Reserve whereas about five years ago it was almost impossible to get a native to go to the Gold Mines.'<sup>10</sup> Indeed, as existing scholarship demonstrates, the dramatic increase in wage labour migration had a profound impact on communal agriculture, bringing negative dietary changes.<sup>11</sup> As large numbers of able-bodied young men migrated, leaving behind women to carry the double burden of cultivation and caring for livestock, many households lost their cattle to straying, and the area of cultivated land decreased. During this period of high rainfall variability, drought, and foot and mouth disease, communities' failure to produce enough subsistence led to a short supply of important components of the diet such as milk and dietary fibre. These dietary deficiencies caused malnutrition thus aiding the spread and severity of tuberculosis and sexually transmitted disease.<sup>12</sup>

Returning migrants were largely the vectors as they were re-incorporated into their communities regardless of their health status.<sup>13</sup> Together with infected migrants who had completed their contracts, forced repatriates actively spread the disease. Since the mines never revealed what they were suffering from, these men had no knowledge of the communicability of tuberculosis and therefore did not take precautions to protect their families and seldom sought medical treatment until they were very sick.<sup>14</sup> The same was true for the 1940s when repatriates from the war 'returned without adequate diagnosis' for any disclosure of their condition would make the British liable to compensate them.<sup>15</sup> This argument challenges colonial

<sup>7</sup> D. Wylie, 'The Changing Face of Hunger in Southern African History, 1880-1980', *Past and Present*, vol. 122, 1989, pp. 174-175.

<sup>8</sup> Letter from Resident Commissioner to WNLA, 29 August 1933 [S. 344/3] BNA.

<sup>9</sup> Taylor, 'Mine Labour Recruitment', Fig. 2, p. 105.

<sup>10</sup> G.E. Nettelton, DC (District Commissioner), Serowe, Annual Report for Serowe for 1935, 6 January 1936 [DCS 21/9] BNA.

<sup>11</sup> I. Schapera, *Migrant Labour and Tribal Life: A Study of Conditions in the Bechuanaland Protectorate*, Oxford, Oxford University Press, 1947; W.G. Morapedi, 'Migrant Labour and the Peasantry in the Bechuanaland Protectorate', *Journal of Southern African Studies*, vol. 25, no. 2, 1999, pp. 197-214.

<sup>12</sup> Extract from the Bechuanaland Protectorate Annual Medical and Sanitary Reports, 1935, 12 [S. 438/2/1] BNA.

<sup>13</sup> H.W. Dyke, Principal Medical Officer, Mafikeng, to Medical Officer, Maun, 12 May 1933 [S. 332/5/1] BNA; Acting District Commissioner, Mochudi, to Government Secretary, Mafikeng, 11 March 1938 [S. 332/5/1] BNA.

<sup>14</sup> Extract from Bechuanaland Protectorate Annual Medical and Sanitary Report, 1935, 12 [S. 438/2/1] BNA.

<sup>15</sup> J. Livingston, 'Productive Misunderstandings and the Dynamism of Plural Medicine in Mid-Century Bechuanaland', *Journal of Southern African Studies*, vol. 33, no. 4, 2007, p. 806.

medical officers' claims that the disease spread because the repatriates were 'indifferent' and their relatives 'apathetic.'<sup>16</sup> The speed with which tuberculosis spread transformed the epidemiological landscape of Bechuanaland and profoundly impacted on the public health of rural communities.

The devastating impact of tuberculosis forced these communities to recalibrate their cultural, social, and belief systems to negotiate its effects. Most significantly, they developed contested worldviews about European consumer culture, particularly the overconsumption of sugar and its integration into the everyday diet. As many migrants returned home displaying symptoms of tuberculosis and dental problems, local residents blamed their sickness on the consumption of European foods, particularly sugar.<sup>17</sup> When these 'toothless tubercular migrants' increasingly became vectors and mortality rose to epidemic levels, local communities constructed the 'darkness' worldview of tuberculosis, whereby the *sefifi* (the dark spirit) was believed to be propagating the disease. The perilous movement of the *sefifi* in turn necessitated a profound change in burial systems as communities sought to negotiate the high incidence of the disease. New ideas about tuberculosis, with their impact on cultural funerary practices, reflected a growing sense of spiritual insecurity as death by tuberculosis became a regular feature of public life.<sup>18</sup> The unprecedented mortality rates caused the British colonial government, in collaboration with the World Health Organization (WHO), to embark on a countrywide immunisation campaign, which by 1964 had significantly reduced infection and death rates.<sup>19</sup>

A focus on the cultural politics of tuberculosis stands in sharp contrast to the present state of knowledge. There has been notable interest in the medical history of colonial Southern Africa since Randall Packard established a synergetic relationship between migrant labour and tuberculosis in 1990.<sup>20</sup> This scholarship has put great emphasis on colonial medicine's reconstruction of African bodies into objects of production to be discarded once they deteriorated.<sup>21</sup> Julie Livingston, for instance, chronicles the debilitating effects of mine work on Batswana migrants. Despite acknowledging the presence of infectious disease, Livingston is more interested in colonial medicine's redefinition of able-bodiedness in African society. Her argument that biomedical ideas of physical fitness determined the suitability of African bodies

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<sup>16</sup> Extract from the Bechuanaland Protectorate Annual Medical and Sanitary Reports, 1935, 12 [S. 438/2/1] BNA.

<sup>17</sup> Matubako Maphane (World War II veteran), interviewed by Phuthego Phuthego Molosiwa, 2011, Mogapi; Seepi Gaselarona (village elder), interviewed by Phuthego Phuthego Molosiwa, 2014, Serowe.

<sup>18</sup> Medical Officer of Health to All Tribal Territories, etc, March 3, 1961 [S. 490/1] BNA.

<sup>19</sup> Tuberculosis and BCG Campaigns, 1952-64, [S. 438/2/3] BNA; Report on BCG Vaccination Programme in Bechuanaland by WHO Regional Office for Africa, November 1962 [S. 439/1/1-4] BNA.

<sup>20</sup> R. Packard, *White Plague, Black Labour: Tuberculosis and the Political Economy of Health and Disease in South Africa*, Berkeley and Los Angeles, University of California Press, 1989.

<sup>21</sup> See among others, A. Butchart, 'The Industrial Panopticon: Mining and the Medical Construction of African Labour in South Africa, 1900-1950', *Social Science and Medicine*, vol. 42, no. 2, 1996, pp. 185-197; K. Jochelson, *The Colour of Disease: Syphilis and Racism in South Africa, 1880-1950*, New York, Palgrave and Oxford, 2001; T. M. Mashingaize, 'Power, Disease and Prejudice: A Historical Overview of the Syphilis Contagion in Colonial Sub-Saharan Africa, 1890s-1950s', *Global South: SEPHIS e-magazine*, Special Volume on the history of Medicine in the Context of the Global South, vol. 6, no. 3, July 2010, pp. 1-16; R.K.K. Molefi, *A Medical History of Botswana*, Gaborone, Botswana Society, 1996, pp. 54-67; J. Livingston, *Debility and the Moral Imagination in Botswana*, Bloomington & Indianapolis, Indiana University Press, 2005, pp. 107-41.

for mine work is an important addition to the history of colonial medicine in Southern Africa. At the same time, it constitutes only a small part of the medical history of migrant labour in the region.

Others have studied the social histories of sexually transmitted disease, particularly syphilis, which was one of the major public health problems along with tuberculosis in southern Africa at least until the end of World War II. This body of scholarship focuses its attention on challenging biomedical cultural constructions of Africans as hypersexual and exceptionally syphilitic. It argues that syphilis in Southern Africa existed more in a non-venereal form than it did sexually because Africans lived a benighted life.<sup>22</sup> As with tuberculosis, the historiography on syphilis takes a political economy perspective, attributing communicable disease to large socio-economic transformations of the colonial era. While this line of argument tends to reify theories of colonial modernity wherein Europeans represented Africans as primitive, it succeeds in challenging the colonial essentialism of Africans as inherently diseased.

The objective of this article is not to jettison the grand narrative of the political economy of communicable disease in late colonial Southern Africa. Rather, the article foregrounds this discourse by adding an exploration of the multiple ways in which rural communities in Bechuanaland drew from their cultural repertoire to negotiate the emerging pathology that was tuberculosis. This paper argues that tuberculosis was a disease that engaged beliefs about its causes and consequences that in turn affected local responses. Being a new disease, it led to shifting attitudes and perceptions about infectious disease. As local communities sought to negotiate the impact of tuberculosis, such shifting attitudes and perceptions transformed what was initially a biomedical problem into a social and cultural dilemma. At this particular historical moment of heightened migrant labour, the conceptualization of tuberculosis as a 'white man's disease' and the recalibration of burial systems, for instance, reflected new views of contagious disease. The particular symbols and images which this disease attracted reflected social values. Such symbols and images help us to understand tuberculosis as a complex phenomenon that cannot be explained through a biomedical lens alone.

This article mines the extant medical records housed at the Botswana National Archives (BNA) and juxtaposes them with oral testimony to examine and illuminate the culturally specific arenas in which the socio-ecological beliefs, values, and meanings of tuberculosis were created and contested in the eastern Bangwato Reserve of the Bechuanaland Protectorate. Since interviewing people about traumatic events, such as the death of their loved ones, speaks to ethical issues, informed consent was sought before the interviews could start. In fact all of the informants had no problem with disclosing their identities because they wanted their stories of struggle and creative adaptation to infectious disease told. Most importantly, they wanted to use this study as a platform to reveal the inefficiencies of colonial medicine and the dark side of migrant labour although they acknowledged the positive impact of the remittance economy in their lives.

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<sup>22</sup> K. Jochelson, *The Colour of Disease*; M. Vaughan, *Curing Their Ills: Colonial Power and African Illness*, Cambridge, UK, Polity Press, 1991, pp. 129–54.

### 'Toothless Men': Mine Work, Nutrition, and Popular Perceptions

Mine work was a debilitating occupation. Injuries and disease contracted in the mines produced disability. With the interests of capital given precedence over the social welfare of the workers, rural Southern Africa became a dumping ground for the tuberculosis sick. As Diana Wylie writes of the entire Bangwato Reserve, 'the number of miners being repatriated for [tuberculosis] was rising in the late 1930s.'<sup>23</sup> Randall Packard's influential work also highlights the debilitating effects of tuberculosis in rural South Africa as repatriated migrants propagated the contagion within and without their households. According to Packard, tuberculosis was kept in a latent form for longer periods at the mines because of nutritional diets, but once the migrants were sent back to their communities the disease manifested itself because of poor nutrition.<sup>24</sup> Indeed repatriation subjected the miners to a life of poverty and poor diets as they returned home to a peasant environment where drought and animal diseases had intensified malnutrition.<sup>25</sup>

By the late 1930s, colonial authorities in Bechuanaland were raising red flags about the health risks posed by increasing repatriations.<sup>26</sup> The chiefs also complained about the rising number of young men who returned home only to display 'chest trouble.'<sup>27</sup> Former migrants also reinforce the repatriation perspective, metaphorically revealing that the debilitating effects of mine work led to men with wasted bodies being sent back home.<sup>28</sup> They expressed evocative memories of a place in the Transvaal venerated as 'Western Deep Level *kwanyama ayipheli, kuphele amazinyo endoda*.' The English rendition of this expression is, 'a place where there is so much to feed on that you will run out of teeth before you run out of meat.'<sup>29</sup> Despite seeming to be celebratory, this expression reveals that mine work exploited the bodies of the miners to the point of deterioration. It is a metaphor that expresses the callousness with which mine work brutalized the bodies of the miners. For the Batswana men, teeth were a symbol of masculinity and physical strength because they were used to eat meat. Any

<sup>23</sup> Wylie, 'The Changing Face of Hunger', p. 177.

<sup>24</sup> Packard, *White Plague, Black Labour*, p. 11.

<sup>25</sup> J. Livingston, 'Physical Fitness and Economic Opportunity in the Bechuanaland Protectorate in the 1930s and 1940s', *Journal of Southern African Studies*, vol. 27, no. 4, 2001, p. 804.

<sup>26</sup> Dr. J.G. Burger, Dutch Reformed Mission Hospital to Ag. DC, Mochudi, 27 March 1939; Medical Officer's Report on Sime Modisa's Condition, Lobatsi, 30 December 1940; G.E. Nettelton, Ag. GS (Acting Government Secretary), Mafikeng to Manager of Robinson Deep Ltd., Johannesburg, 11 July 1938 [S. 332/5/1] BNA.

<sup>27</sup> 'Adverse effects of recruiting,' Extract from the Meeting of the Native Advisory Council of 1936 [S. 387/5] BNA.

<sup>28</sup> Bolweleng Sejakgomo (former migrant), interviewed by Phuthego Phuthego Molosiwa, 2014, Maunatla; Molatedi Seree (former migrant), interviewed by Phuthego Phuthego Molosiwa, 2010, Mogapi; Modise Makabe (former migrant), interviewed by Phuthego Phuthego Molosiwa 2015, Bobonong.

<sup>29</sup> Migrant labourers who worked at the South African mines came from many different countries in a region with diverse languages. To be able to communicate, the miners developed a creolized language called *Fanakalo*, which incorporated many Southern African languages including Nguni, Sotho, Tswana, Shangani, and so on. Being a Nguni (specifically Zulu), the phrase, *kwanyama ayipheli, kuphele amazinyo endoda*, was incorporated by the miners into *Fanakalo*. For migrants from the Bechuanaland Protectorate, speaking the *Fanakalo* language was important because it provided testimony that indeed one had worked at the mines, a ritual that, according to Schapera, had replaced the traditional initiation rituals wherein boys graduated into manhood. See I. Schapera, *Migrant Labour*, p. 116.

man who could no longer do physically taxing work was said to have lost his teeth. Migrants whose bodies were weakened by tuberculosis accepted with resignation their forced repatriation following months of physical exertion because they had 'lost the teeth to do hard labour.'<sup>30</sup>

To the mines, the migrants were expendable. Losing their teeth meant that they were no longer able to eat the plentiful meat at the mines and were therefore liable to be returned to their natal homes. Home, however, provided little, if any, reprieve for these unfortunate migrants who were labelled as lesser men within their communities.<sup>31</sup> No longer able to clear and plough the fields, train oxen, and carry out the numerous other heavy tasks expected of the archetypal man, they lost their masculinity, especially since sickness had impoverished them. They became known as the *mashodwe*, or worthless men who could not herd cattle.<sup>32</sup> They were nothing more than vectors, spreading the tuberculosis contagion within and without their already malnourished and vulnerable families. Their role as communicators of disease was confirmed by official impressions at the end of the 1930s:

Disease is ravaging subject groups who have higher numbers of migrants. Many have retreated to the cattle posts hoping to benefit from milk and wild plants and traditional medicine. These do not seek European medicine.<sup>33</sup>

The retreat to the cattle post offered very little reprieve as drought and foot and mouth disease had respectively affected breeding stock, reduced the milk intake, and destroyed many of the veld food plants to which these communities often took recourse during times of distress. These deficiencies contributed to the rise of tuberculosis mortality. Thus, tuberculosis can be placed within the broader context of questions of nutrition. The association of tuberculosis and nutrition saw colonial medical officers redefining cases of tuberculosis infections as symptoms of malnutrition.<sup>34</sup> Although this theory unfairly essentialised the Tswana diet as inherently poor, during this time of disease and drought, the Tswana diet was indeed nutritionally deficient. For this reason, the entanglement of labour migration, agriculture, and nutrition and the intimate connection between tuberculosis and malnutrition are important issues that cannot be dismissed at face value. During a period when drought had made the entire agricultural sector derelict, foot and mouth disease had destroyed breeding cattle, the price of cattle was at its lowest level, the most productive labour was siphoned away, and poverty and malnutrition reigned supreme.<sup>35</sup> As a result, inadequate nutrition increased the severity of tuberculosis.

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<sup>30</sup> M. Seree, interview, 2010; M. Makabe, interview, 2015.

<sup>31</sup> M. Seree, interview, 2010; M. Makabe, interview, 2015.

<sup>32</sup> M. Maphane, interview, 2010; Modisa Mhaladi (former cattle herder), interviewed by Phuthego Phuthego Molosiwa, 2014, Kgagodi; Moreki Montsosi (former migrant), interviewed by Phuthego Phuthego Molosiwa, 2015, Bobonong.

<sup>33</sup> *Bechuanaland Protectorate Annual Medical and Sanitary Report*, 1939.

<sup>34</sup> Extract from Minutes of the 20<sup>th</sup> Session of the Native Advisory Council, 6-10 March 1939 [S. 438/2/1] BNA.

<sup>35</sup> Extract from Minutes of the 20<sup>th</sup> Session of the Native Advisory Council, 6-10 March 1939 [S. 438/2/1] BNA.

The historical process of able-bodied labour extraction, combined with ecological misfortunes that undermined agriculture and cattle production, necessitated reliance on what some local African elites saw as unhealthy European foods. At the 20<sup>th</sup> session of the Native Advisory Council, for example, two African representatives, Messrs S. J. Molema and Lot Moswele, criticised the Principal Medical Officer's argument that there was no tuberculosis, only malnutrition. They argued that tuberculosis existed and that it was a result of European civilisation. Moswele's criticism was particularly damning as he constructed the 'white plague' theory, wherein he conceptualized all things European as vectors of tuberculosis. He explicitly linked tuberculosis to an emerging consumer culture where Batswana communities had become addicted to tea:

Our forefathers did not use sugar because they were not *civilized*. They did not take tea. Tea is the cause of tuberculosis. It is the cause of the various diseases that attack our people. Our native body does not agree with European food.<sup>36</sup>

These sentiments were not peculiar to Batswana men. They resonated across the region as 'many African males, distressed at the erosion of indigenous communities, were equating European culture, urbanization and industrialization with disease.'<sup>37</sup> The Batswana saw a link between sugar and profuse coughing and therefore seldom gave their children tea because *sukiri ya gotlhodisa* (sugar causes a cough).<sup>38</sup> The fact that most of the infected men who were repatriated from the mines displayed symptoms of dental illnesses along with acute coughing convinced local communities that sugar was an agent of tuberculosis. This perception about sugar resonated with the clinical analysis of the impact of sugar on human epidemiology. Sugar, when taken in excessive amounts can cause health problems, including, but by no means limited to, coughs and rotten teeth. It is known to be highly corrosive to teeth.<sup>39</sup>

The metaphor of meat being so plentiful that men lost their teeth, cited above, may also explain the miners' excessive intake of sugar as part of the broader question of nutrition. From the 1930s, tea, taken with sugar, became such a ubiquitous expression of mine culture and society that it was almost impossible to imagine the mining compounds without tea. Nowhere was the sugar consumer culture more discernible than in the mining compounds and the broader urban localities. As Packard argues, African urban diets consisted mainly of starchy foods and sugar.<sup>40</sup> This emerging consumer culture developed as colonial governments actively marketed and sold European consumer wants, such as tea and sugar, in a bid to retract

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<sup>36</sup> Extract from Minutes of the 20<sup>th</sup> Session of the Native Advisory Council, 6-10 March 1939 [S. 438/2/1] BNA.

<sup>37</sup> G. Reynolds, 'From Red Blankets to Civilization': Propaganda and Recruitment Films for South Africa's Gold Mines, 1920-1940', *Journal of Southern African Studies*, vol. 33, no. 1, 2007, p. 150.

<sup>38</sup> M. Maphane, interview, 2010; S. Gaselaron, interview, 2014.

<sup>39</sup> R.A. Austen and W.D. Smith, 'Private Tooth Decay as Public Economic Virtue: The Slave-Triangle, Consumerism, and European Industrialization', *Social Science History*, vol. 14, no. 1, 1990, p. 103; W.D. Smith, 'Complications of the Commonplace: Tea, Sugar, and Imperialism', *The Journal of Interdisciplinary History*, vol. 23, no. 2, 1992, p. 268.

<sup>40</sup> Packard, *White Plague, Black Labour*, p. 147.

some of the money finding its way into the African reserves through migrant remittances.

One of the most obvious places to introduce tea and sugar and perpetuate its consumption was the mining compounds because these foreign tastes gave the miners temporary 'highs' of alertness and energy. Sugar and tea became some of the primary features of an aggressive marketing campaign. Tea and sugar were also marketed alongside soap as contributing to good health.<sup>41</sup> From the 1940s, publicity vans toured rural districts with speakers and films extolling the virtues of tea and sugar and pathologising alcohol.<sup>42</sup> The films projected contrasting images of the tea-drinking, sober, wise African who reaps the health rewards of 'embracing the modernizing project of colonialism' and his foolish, 'corrupted counterpart who imbibed' unhealthy local brews, particularly *skokiaan*.<sup>43</sup> Ironically, *skokiaan*, which in the eastern Bangwato Reserve was known as *sekhokho* (recently as Babirwa Dry Gin), was made of the very sugar praised as healthy by the films.

As with the Industrial Revolution in Britain, where tea was the working class substitute for alcoholic beer, sugared tea in South Africa suited the mine owners as a cheap energy boost for the workers.<sup>44</sup> No wonder the workers developed rotten teeth, as did old people with greater access to tea and sugar back home. Indeed sugar was taken in excessive amounts in a society that came to embrace the new tea drinking culture with alacrity. Fetishised as an elite beverage, tea became a very important component of the diet in the eastern Bangwato Reserve, and perhaps the entire country. The Batswana men who displayed their masculinity by engaging in long hours of physically taxing work, such as ploughing, clearing the fields and herding cattle, believed in filling their tea cups to the brim and drinking tea all day long. They often mocked the white man for his inability to fill up his cup of tea because 'his long nose would swim in the tea before his mouth could reach the cup.'<sup>45</sup> Tea in the eastern Bangwato Reserve formed an integral part of the diet for men and women, particularly during harvesting and thrashing of crops when there was little time to cook.<sup>46</sup> Indeed tea with sugar constituted a temporary energy boost for these hard-working men and women. As a result, it became an indispensable component of their diet. Tea and sugar were thus attractive, yet addictive, parts of a broader imposed colonial capitalist culture, which, as far as rural communities were concerned, was otherwise visible in coughing migrants whose teeth were eroded.

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<sup>41</sup> For a comprehensive social history that demonstrates the interface between colonialism, consumer capitalism and the consciousness of needs and wants in Southern Africa, see T. Burke, *Lifebuoy Men, Lux Women: Commodification, Consumption and Cleanliness in Modern Zimbabwe*, Durham, NC, Duke University Press, 1996.

<sup>42</sup> G. Reynolds, *Colonial Cinema in Africa: Origins, Images, Audiences*, Jefferson, NC, McFarland & Co., Inc., 2015, p. 149.

<sup>43</sup> Reynolds, 'From Red Blankets to Civilization', p. 149.

<sup>44</sup> See for example, R. Moxham, *Tea: Addiction, Exploitation and Empire*, London, Constable & Robinson, Ltd., 2003; M. Berg, *Luxury and Pleasure in Eighteenth-Century Britain*, Oxford, Oxford University Press, 2005.

<sup>45</sup> M. Maphane, interview, 2010.

<sup>46</sup> In colonial East Africa, tea was used primarily as a morning beverage. M. Walsh, 'Fanta, Coca Cola and Tea (Three Sugars) in the Political Economy of Rural Tanzania. Notes from Utengule, Usangu', *Cambridge Anthropology*, vol. 8, no. 3, 1983, p. 73.

The image of sugar as a cough agent was to become a hindrance to the 1950s survey conducted by the British colonial medical department to determine the extent and gravity of tuberculosis, as well as to the immunisation programme of the 1960s (although the two programmes eventually succeeded with the support of the chiefs). With the tuberculosis survey coinciding with high child mortality on account of an epidemic of whooping cough, the popular imagery linking sugar and tuberculosis was used to spread rumours that the survey team administered poisonous substances that intensified the cough and increased the chance of death.<sup>47</sup> Mothers, in particular, impressed on their school-going children that the survey was a biological weapon with the objective to wipe them out.<sup>48</sup> The survey team faced a major challenge as they often found the places they visited deserted with flight becoming a method of resistance. School children would flee on the arrival of the whites-only team. In one school, for example, seventy students fled on the arrival of the survey team in 1952.<sup>49</sup> This observation is not meant to essentialise the eastern Bangwato Reserve as an abode of inherently superstitious people. Such suspicions about biomedical interventions resonated across the Protectorate. For instance, in the Bakgatla Reserve, which bordered the Bangwato Reserve, people were not keen to partake in the survey as Chief Molefi had instructed them to stay away.<sup>50</sup> These African images of European medicine as noxious challenged colonial eco-racial etiologies of tuberculosis.

Although the colonial archive does not provide statistics about the incidence of disease, women were the most at risk because they were the traditional nurses.<sup>51</sup> Repatriates who had been away, abandoning their families for lengthy periods, often came back to be cared for by their wives. These came with only a coat and a small suitcase as their property, and the poor wife, who never received any remittances during her husband's lengthy sojourn at the mines, would customarily be obliged to take care of this *lekgwelwa* (deserter).<sup>52</sup> According to the Batswana traditions of caring for the sick (*go oka*), a woman's domain, isolating sick loved ones was frowned upon because illness was experienced as a collective responsibility. Doing so was tantamount to '*go bihela* (shunning) the loved ones, which was socially reprehensible.'<sup>53</sup> Such visions of social virtue were articulated through keeping close contact with the sick to make them feel comfortable regardless of whether or not the sickness was contagious. Hence tuberculosis spread to uninfected family members and the entire community because of the pre-existing practices, beliefs and feelings of society about being sick and dying.

It is against the background of this social virtue of *go oka* that the tuberculosis sick, who had seen the limits of biomedicine, refused hospitalisation. They preferred 'to go and die at their homes' rather than in isolation and away from the comfort of

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<sup>47</sup> Tuberculosis Survey of BP, Dec. 1948-Feb. 1953 [Med. 8/1/1] BNA.

<sup>48</sup> Tuberculosis Survey of BP, Dec. 1948-Feb. 1953 [Med. 8/1/1] BNA.

<sup>49</sup> Tuberculosis Survey of BP, Dec. 1948-Feb. 1953 [Med. 8/1/1] BNA.

<sup>50</sup> Tuberculosis Survey of BP, Dec. 1948-Feb. 1953 [Med. 8/1/1] BNA.

<sup>51</sup> Medical Officer of Health to All Tribal Territories, etc, 3 March 1961 [S. 490/1] BNA.

<sup>52</sup> B. Sejakgomo, interview, 2014, Mauntlala; Kgolagano Chepete (widow of former migrant), interviewed by Phuthego Phuthego Molosiwa, 2014, Lesenepole; Ketholegile Phuthego (widow of World War II veteran), interviewed by Phuthego Phuthego Molosiwa, 2010, Mogapi.

<sup>53</sup> K. Chepete, interview, 2014.

their families.<sup>54</sup> Indeed the hospital was an isolating institution for the tuberculosis patients who had to endure the trauma of living in solitude, cordoned off in a secluded 'TB Block' or 'Pavilion.'<sup>55</sup> Not used to being quarantined, patients insisted on visiting hospitals from their homes. As noted in the Annual Medical and Sanitary Report of 1935, keeping the tuberculosis sick in isolation at hospitals was a:

well nigh hopeless task.... They desire to return home, the result being that ... the good done in [hospitals] is rapidly undone....When no obvious improvement takes place, the patients insists on returning home.<sup>56</sup>

The chief of the Bangwato, Tshekedi Khama, expressed his people's mistrust of biomedicine in graphic detail as he cautioned:

In a country like ours, still greatly beset with superstitious beliefs in witchcraft, the failure of a scientific doctor to restore his patients to their normal health is watched with an intensely critical eye....<sup>57</sup>

Historian Chiponde Mushingeh also talks of repatriated World War II soldiers deserting hospitals upon realisation that the pulmonary tuberculosis strain that was common among most of them resisted biomedical treatment.<sup>58</sup> The Batswana's loss of confidence in biomedicine buttressed the reification of the racially modulated colonial 'myth of the healthy reserve.'<sup>59</sup> Bechuanaland's medical officers campaigned vigorously for Africans to relocate to the sparsely populated cattle posts so as to reduce the communication of tuberculosis. By the 1940s, official rhetoric about the benefits of 'pastoral, open-air existence' for the African dominated medical officers' reports.<sup>60</sup> Medical officers argued that the Batswana's crowded large villages with their filthy living conditions were facilitating the spread of the disease.<sup>61</sup> While it was true that overcrowding could increase the communicability of disease, such eco-racial disease etiologies failed to take into account prevailing socio-economic factors, particularly the shortage of agricultural labour and the ensuing subsistence crisis, as crop yields were low during much of the 1940s.<sup>62</sup>

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<sup>54</sup> T. Monyepele, interview, 2014.

<sup>55</sup> Extract from the Bechuanaland Protectorate Annual Medical and Sanitary Report, 1935, 12 [S. 438/2/1] BNA.

<sup>56</sup> Extract from the Bechuanaland Protectorate Annual Medical and Sanitary Report, 1935, 12 [S. 438/2/1] BNA.

<sup>57</sup> Tshekedi's Memorandum, 1935 [S. 400/7] BNA.

<sup>58</sup> C. Mushingeh, 'A History of Disease and Medicine in Botswana, 1820-1945', PhD Thesis, University of Cambridge, 1984, pp. 147-58.

<sup>59</sup> Packard, *White Plague, Black Labour*, p. 234.

<sup>60</sup> Extracts from Bechuanaland Protectorate Medical and Sanitary Report, 1933, 1934, 1935, 1936; BNA, S. 438/2/2, R.V. de Villiers, Medical Officer, to District Commissioner, Gaborone, 26 June 1940 [S. 438/2/1] BNA.

<sup>61</sup> Extracts from Bechuanaland Protectorate Medical and Sanitary Report, 1933, 1934, 1935, 1936; BNA, S. 438/2/1, R.V. de Villiers, Medical Officer, to District Commissioner, Gaborone, 26 June 1940 [S. 438/2/2] BNA.

<sup>62</sup> R.V. de Villiers, Medical Officer, to District Commissioner, Gaborone, 26 June 1940 [S. 438/2/2] BNA.

By the mid-1950s, tuberculosis had become endemic in rural areas and could no longer be labelled a European disease. Its spread was exclusively blamed on the migrant labourer. In addition, extra-pulmonary tuberculosis mortality had risen significantly.<sup>63</sup> As a result, it would be reductionist for colonial medical officers to continue with their misguided romanticism of African rural life as the quintessential space of good health. Unfortunately, the endemicity of tuberculosis became conflated with low incidence. For instance a World Health Organization consultancy estimated in 1958 that only one per cent of the total population of Bechuanaland had a highly infectious tuberculosis strain.<sup>64</sup> This estimation, however, did not account for the many cases of infection and casualties that went unreported because sufferers had retreated to the unbounded wilderness where cattle posts, inaccessible to colonial medical officers, were located.<sup>65</sup> In addition, the Batswana's loss of confidence in biomedicine drove many of them to seek recourse to traditional medical help. In a time when wealth had become synonymous with migrant labour and most of the tuberculosis sick were returning migrants, the discourse of the witchcraft of jealousy dominated explanations of the disease. Whenever a returning migrant started showing symptoms of sickness, his relatives would peddle accusatory remarks that so and so had bewitched him because he had money.<sup>66</sup> For this reason, those who believed in this witchcraft discourse seldom sought biomedical help, leading to high infection rates, morbidity and mortality.

Oral sources indicate that tuberculosis continued to ravage rural communities until the late 1960s.<sup>67</sup> The prolonged and insidious drought that destroyed large numbers of cattle and undermined crop production between 1957 and 1965 intensified malnutrition and with it the severity of disease.<sup>68</sup> This combination of tuberculosis and malnutrition proved to be deadly as it produced a new breed of the disabled. In the Tswapong village of Lerala, for instance, local people remembered very skinny men who coughed a lot and could hardly do any work. The expression they used was: '*E ne e le makodopo a a hotholang fhela* (they were just coughing skulls).'<sup>69</sup> The metaphoric reference to people as 'coughing skulls' reflects a pervasive sense of material insecurity as tuberculosis eroded all forms of labour. It also expresses the symbolism of tuberculosis as an impoverishing disease. Infected men could neither work at the mines nor do agricultural work, such as looking after cattle and ploughing the fields. Infected women, who in most cases were the primary producers of subsistence, could no longer tend the crops, scare away the birds, harvest, thrash, and cook for their families. As a result, the disease caused food insecurity.

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<sup>63</sup> A. Mayweather, *Desert Doctor: Medicine and Evangelism in the Kalahari Desert*, London, Lutterworth Press, 1969, p. 50.

<sup>64</sup> Report on a visit to Bechuanaland by World Health Consultant, Antony Geser, 4-7 June 1958 [S. 438/2/3] BNA.

<sup>65</sup> Impressions of Tuberculosis and Venereal Disease in the Bangwato Reserve, 1936 [S. 438/2/1] BNA.

<sup>66</sup> M. Mhaladi interview, 2014; S. Gaselarona interview, 2014.

<sup>67</sup> S. Gaselarona interview, 2014.

<sup>68</sup> 'Report to the Government of the Bechuanaland Protectorate on the Beef, Cattle and Meat Industry, by G. R. Purnell and W.S. Clayton (October 1963); A. Campbell, 'The 1960s Drought in Botswana', *Proceedings of the Symposium on Drought in Botswana*, 5<sup>th</sup>-8<sup>th</sup> June 1978, Gaborone, Botswana Society & Clark University Press, 1979, pp. 98-109.

<sup>69</sup> Keletso Mogami and Goareng Motsamai (former migrants), interviewed by Phuthego Phuthego Molosiwa, 2014, Lerala.

### **‘The Dark Spirit’: Beliefs, Burials, and Spiritual Insecurity**

The redefinition of living people as coughing skulls speaks to the fear of death. Such fear caused spiritual insecurity. To negotiate this spiritual insecurity, people reformulated their cultural beliefs in and about infectious disease. Bereaved persons were mostly in danger of contracting tuberculosis because the lingering specter of *sefifi*, or dark spirit, would contaminate anyone who had had contact with the deceased. The etymology of the word *sefifi* derives from the word *lefifi*, or darkness. This concept assumed a new meaning, albeit temporarily, to refer to the contagion that spread disease. The scientific validity of the Batswana’s notion of the ‘dark spirit’ that propagates disease was echoed in the 1945 Seventh Day Adventist Church (SDA) annual report concerning the repatriation of servicemen from the Second World War in which Dr Paul H. Bringle charged:

The practice of discharging from the Army open, dying cases of far advanced pulmonary and intestinal tuberculosis, whose return to their homes where their wives, mothers, children, sisters, brothers – literally scores of relatives and friends – come into close, daily intimate contact with patients, their clothing and utensils, their excreta etc., is nothing short of deplorable.<sup>70</sup>

In 1961, a medical officer’s commentary about the trajectory of tuberculosis warned that the family had become ‘a source of infection and thus a danger to all people in the village.’<sup>71</sup> In their struggles against tuberculosis, the communities in the eastern Bangwato Reserve used the discourse of darkness as a lens through which to make sense of infectious diseases. The belief in the relationship between disease and darkness helped the Bangwato to face bereavement and the perdition of the souls of their loved ones with hope. They were able to live with a disease that spread from both the living and the dead, particularly the temperature-regulating spirits who wielded so much power over nature that they caused severe cold whenever an infected person died.<sup>72</sup> Such discourses of the association between tubercular mortality and coldness have been studied elsewhere.

Existing historical scholarship has presented synergies of tuberculosis and socio-environmental causes across the world. In their biography of the Emerson brothers who lived during the first half of the seventeenth century, Bosco and Myerson demonstrate that tuberculosis morbidity and mortality increased, both in severity and in noted cases, during the winter season.<sup>73</sup> Recent public health studies have argued that, before the introduction of antibiotic therapy, tuberculosis mortality had a variable seasonal peak, the most predominant being in the winter season when Vitamin D deficiency impaired infected people’s defence and respiratory disease morbidity was

<sup>70</sup> Annual Report of the SDA, 1945 [Med. 1/6] BNA.

<sup>71</sup> Medical Officer of Health to All Tribal Territories, etc, 3 March 1961 [S. 490/1] BNA.

<sup>72</sup> K. Phuthego interview, 2010; B. Sejakgomo interview, 2014.

<sup>73</sup> R.A. Bosco and J. Myerson, *The Emerson Brothers: A Fraternal Biography in Letters*, Oxford & New York, Oxford University Press, 2006, pp. 8-9. See also R. Dubos and J. Dubos, *The White Plague: Tuberculosis, Man and Society*, New Brunswick, Rutgers University Press, 1996 [Original edition, London, Gollancz, 1953].

at its highest.<sup>74</sup> Packard's pioneering work on tuberculosis in colonial Southern Africa also illuminates the association between tubercular infections and illnesses associated with the winter season, such as pneumonia and influenza.<sup>75</sup>

In Bechuanaland, these discourses about the relationship between tuberculosis mortality and the severity of respiratory diseases during winter began to feature prominently in colonial medical reports from as early as 1933.<sup>76</sup> The discourse of the seasonality of tuberculosis mortality resonates with the Batswana's ideas of disease/nature synergy. In the eastern Bangwato Reserve people believed that the spirits of the tuberculosis dead had the ability to manipulate nature such that whenever an infected person died, the temperatures would drop dramatically. As ninety-four year old Ketholegile Phuthego of Mogapi reminisced, 'It would get very cold!'<sup>77</sup> Undeniably, these communities encountered high tuberculosis mortality in winter when the temperatures were low. With Botswana's short winter (May-July) temperatures dropping significantly at night, the tradition of burying the dead under the cover of darkness (in the early hours of the morning or in the middle of the night) also perpetuated such beliefs of spirits manipulating nature.

For these communities (as with many other communities in Africa), death, though a dreaded event, was perceived as the beginning of a person's deeper relationship with all of creation and of communication between the spiritual and the temporal world.<sup>78</sup> The goal of life was to become an ancestor after death. For these reasons, every person who died was given a socially acceptable funeral, supported by a number of religious ceremonies. Flouting the standard funerary rituals would cause the dead person to become a wandering ghost, agitated and unable to sleep properly and therefore a danger to the living. These standard rituals involved nocturnal burials, which were meant to protect children from the wrath of unhappy spirits of the dead or ghosts. Until the late 1970s, death was not disclosed to children and burials were nocturnal rituals in some communities. According to these communities' ideas of the unworldly, children were not supposed to hear about death nor encounter a burial. Whenever somebody died, children were told that the deceased had gone to gather berries, had gotten lost or had been taken by the hyenas.<sup>79</sup> The following testimony confirms the location of death and burials in the space of darkness:

The first time I encountered a burial was in 1969 at the age of fifteen. I still vividly remember that chilly morning of June when my grandfather woke me up to help him re-kraal the goats that had slipped out of the kraal. There were no watches then. But it could have been around three in the morning. As we rounded the goats, which had wandered towards the nearby hill, I saw a group of people sitting

<sup>74</sup> See among others, A. Fares, 'Seasonality of Tuberculosis', *Journal of Global Infectious Diseases*, vol. 3, no. 1, 2011, pp. 46-55; E.N. Naumova, 'Mystery of Seasonality: Getting the Rhythm of Nature', *Journal of Public Health Policy*, vol. 27, no. 1, 2006, pp. 2-12; N. Nagayama and O. Ohmori, 'Seasonality in Various Forms of Tuberculosis', *International Journal of Tuberculosis and Lung Disease*, vol. 10, no. 10, 2006, pp. 1117-11122.

<sup>75</sup> Packard, *White Plague, Black Labour*, p. 232.

<sup>76</sup> H.W. Dyke, PMO, Mafikeng, to MO, Maun, 12 May 1933 [S. 438/2/1] BNA.

<sup>77</sup> K. Phuthego interview, 2010.

<sup>78</sup> J. S. Mbiti, *African Religions and Philosophy*, London, Heinemann, 1969, pp. 4-5.

<sup>79</sup> K. Phuthego interview, 2010; K. Chepete interview, 2014.

quietly at the foot of the hill. When I asked my grandfather what they were doing, he told me that they were killing a hyena that took a man the previous night, before warning me not to ask any more questions lest I get visited by a ghost.<sup>80</sup>

Since the tuberculosis strain that predominated in Bechuanaland was pulmonary, the association of high tuberculosis mortality with the winter season makes perfect sense.<sup>81</sup> As shown above, respiratory diseases, such as bronchitis, pneumonia, and influenza, are most prevalent during cold seasons. The fear of disease and severe cold forced some communities to transgress pre-existing funerary practices. Transgression of traditional funeral practices was a way of negotiating tuberculosis. For instance, in most of the country, men and women were traditionally buried in the cattle byre, behind the house, or under the thrashing floor. By the beginning of the Second World War, however, burial sites were moved to the outskirts of the villages and, in an attempt to banish the disease, every deceased person was buried there regardless of gender and/or social status.<sup>82</sup>

Still, people who were known to have died of tuberculosis were not buried in these designated sites. Bodies of people who died of tuberculosis were buried further away in isolated places, and many of the burial sites cannot be located today.<sup>83</sup> In the Tswapong area, the tuberculosis dead were mutilated by dislocating their legs and the corpses buried in a sitting position. As oral sources indicate, 'it was a way to stop the spread of the disease.'<sup>84</sup> The isolation of the tuberculosis dead in untraceable burial sites and with their legs dislocated was a way of completely banishing their spirits from the realm of the living and throwing such diseased spirits into eternal oblivion. Oblivion in this case constituted, as Augé tells us, a 'non-place' where memory could not reach.<sup>85</sup> This abstract, timeless space, which was bereft of geographical location, was dreaded because it symbolised darkness.

Forgetting and remembering are socially mediated processes. They speak to the construction of collective memory, as well as that of time and space. According to the local communities, everyone whose relative died of tuberculosis had a social responsibility to forget about the deceased because the dead get reborn when the living continue to think about them.<sup>86</sup> Augé describes this obligation to forget in these terms: for the victims of past misfortunes and traumas, 'to live again and not just survive, [they] must be able to do their share of forgetting, become mindless, in order to find faith in the everyday again and mastery over their time.'<sup>87</sup> The symbolism of the new

<sup>80</sup> Supang Makabe (former migrant), interviewed by Phuthego Phuthego Molosiwa, 2015, Bobonong.

<sup>81</sup> Tuberculosis in the BP (Bechuanaland Protectorate), 1933-1967 [S. 438/2/1-5] BNA; Tuberculosis Survey of the BP, Dec 1948-Feb 1953 [Med. 8/1/1] BNA; Phthisis: Miners' Compensation for BP Native Mine Workers, 1933-1965 [S. 332/5/1-4] BNA.

<sup>82</sup> Mmirwa Malema, interviewed by Phuthego Phuthego Molosiwa, 2011, Bobonong; Sedieng Kgamane, interviewed by Phuthego Phuthego Molosiwa, 2011, Serowe.

<sup>83</sup> Moloko Makgoba, interviewed by Phuthego Phuthego Molosiwa, 2010, Sefophe; K. Chepete, interview, 2014.

<sup>84</sup> Ngaka Sephetso, interviewed by Phuthego Phuthego Molosiwa, 2011, Tsetsebjwe.

<sup>85</sup> M. Augé, *Non-places: Introduction to an Anthropology of Supermodernity*, London, Verso, 1995.

<sup>86</sup> Sekonopo, interview, 2011; Potlako Bakane, interviewed by Phuthego Phuthego Molosiwa, 2014, Serowe.

<sup>87</sup> M. Augé, *Oblivion*, trans. Marjolin de Jager, Minneapolis, University of Minnesota Press, 2004, p. 88.

burial practices interfaced with the politics of memory. Individual and collective responsibility to forget a traumatic past helped to banish a previously unknown contagion and ensured it got lost in the wilderness. The wilderness represented a boundless, unmediated space of evil and darkness beyond the boundaries of human settlements.

In line with the idea of oblivion, other communities developed a custom of removing the dead from a mud hut, not via the door but through a hole in the wall, and feet first, symbolically pointing away from the former place of residence. Immediately after removing the corpse, the hole would be closed. A winding path would be taken to an isolated burial site in the wilderness. The reason for this was to make it difficult (or even impossible) for the dead person's spirit to remember the way back to the living.<sup>88</sup> When asked why it was necessary to prescribe isolated and untraceable burial sites for the tuberculosis dead, a sixty-five year old *ngaka*, a traditional medical practitioner-cum-diviner, explained:

The new disease was untreatable with our traditional remedies. Even the white man's medicine failed to treat it. So there was need to throw away those who died of it. We had to make sure that their spirits would not return to the village. If they ever came back, we would all catch disease. We would all die.<sup>89</sup>

Popular beliefs that tuberculosis infected the spirit as much as it did the body were compounded by fears that because the spirits of the dead had influence on the realm of the living, they could also have a negative impact on public health as the spirits of the tuberculosis dead might walk right back into the village and spread the disease. The burying of people in a sitting position was a re-appropriation of an ancient practice conforming to the 'hereafter' belief, whereby the dead were expected to rise again.<sup>90</sup> Tswapong communities believed that if their tuberculosis dead were buried lying down, death could easily assume the shape of the body and spread. The reconfiguration of this ancient ritual was therefore a creative strategy to try and localise death and prevent it from spreading.

This spiritual insecurity reshaped the Batswana's ideas of colonial medicine. While some of them used mutilation of the dead as a strategy to stop disease, the Batswana were completely against postmortem examination, which entailed the dissection of the body, and where necessary, the removal of body parts for examination. According to the Babirwa and Batswapong's ideas of burial, or *go boloka* (safe-keeping), removal of body parts from a corpse was a religious aberration.<sup>91</sup> The

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<sup>88</sup> T. Monyapele interview, 2014; Moagi Makepe, Ookeditse Osentse, and Bonang Manowe, interviewed by Phuthego Phuthego Molosiwa, 2013, Tsetsebjwe.

<sup>89</sup> Sekonopo interview, 2011.

<sup>90</sup> S. M. Mothulatshipi, 'The recent archaeological research of the Shashe-Limpopo confluence zone: a perspective from eastern Botswana', Paper presented at the *Biennial conference of the Society for Africanist Archaeologists SAfA 2006*, Calgary, Canada, 2006, <http://cohesion.rice.edu/CentersAndInst/SAFA/emplibary/Dingalo,SM.SAfA2006.pdf>, (accessed 1 June 2012).

<sup>91</sup> K. Phuthego interview, 2010; B. Sejakgomo interview, 2014.

<sup>91</sup> S. Makabe, interview, 2015.

concept of *go boloka*, often used concurrently with the mainstream Tswana word *phitlho*, a derivative of the verb *hitlha* (hide), connoted the burial of the body with all its parts. This wholesale burial was necessary to avoid the risk of body parts falling into the hands of witches who society feared could use them to harm other people.<sup>92</sup> As a result, the mutilation of the tuberculosis dead was done such that no body parts were removed from the corpse. Whoever extracted body parts from a corpse was believed to be a witch because witchcraft mutilation was part of the local communities' beliefs. This embeddedness of witchcraft in local belief systems may have shaped colonial images of the 'superstitious native' who lacks 'experience of hospitals' and is suspicious of biomedicine.<sup>93</sup> The Bangwato believed that witches often connived with some evil *dingaka* (singular *ngaka*) to harm innocent people.<sup>94</sup> Generally, the *dingaka* who combined herbalism and ritual practice were believed to possess the power to produce both healing and noxious medicines.

The word, *ngaka* was re-appropriated and applied to missionary doctors during the first half of the nineteenth century, and it has continued to refer to both traditional and biomedical doctors into the present. Medical missionaries, who were widely known as the *dingaka* among the southern Tswana, 'were often asked by the local rulers to make rain, one of the major tasks of ... ritual practitioners.'<sup>95</sup> Chief Sekgoma, who encountered a medical missionary for the first time in 1842 when David Livingstone visited the Bangwato, was convinced he had met a *ngaka* because of Livingstone's 'apparent interest in rain-making' and his medical work.<sup>96</sup> Writing about a conversation he had with the troubled Bangwato chief, Livingstone spoke of Sekgoma beseeching him to give him medicine to transform his 'proud heart':

I wish you would change my heart. Give me medicine to change it.... I wish to have it changed by medicine, to drink it and have it changed at once, for it is always very proud and very uneasy, and continually angry with someone.<sup>97</sup>

Sekgoma's request reflects the wider Tswana society's projection of the image of a medical missionary as a *ngaka* who could harness supernatural and profane powers to cure spiritual and physical conditions respectively.

Postmortems were interpreted in the eastern Bangwato Reserve according to local ideas of ritual. They brought a sense of spiritual insecurity because people feared that the biomedical *dingaka* were capable of performing witchcraft rituals, such as removing body parts from the bodies of their deceased loved ones. As the Government Secretary, G.E. Nettelton, observed in 1947, 'the relations of the deceased labourers,

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<sup>92</sup> K. Phuthego interview, 2010; K. Chepete interview, 2014.

<sup>93</sup> S. Makabe interview, 2015.

<sup>94</sup> Nettelton, Resident Magistrate, Serowe, to PMO, Mafikeng, 26 November 1934 [S. 413/9] BNA.

<sup>95</sup> Sekonopo interview, 2011; Sephetso interview, 2011.

<sup>96</sup> J.L. Comaroff and J. Comaroff, *Of Revelation and Revolution, Volume 2: The Dialectics of Modernity on South African Frontier*, Chicago, University of Chicago Press, 1997, p. 345.

<sup>97</sup> B.S. Bennett, 'Suppose a Black Man Tells a Story: The Dialogues of John Mackenzie the Missionary and Sekgoma Kgari the King and Rainmaker', *Pula: Journal of African Studies*, vol. 11, no. 1, 1997, p. 46.

<sup>98</sup> I. Schapera (ed.), *Livingstone's Missionary Correspondence, 1841-1856*, London, Chatto & Windus, 1961, p. 20.

understandably enough, do not wish to have a postmortem examination held on one for whom they have a natural affection.’<sup>98</sup>

Because of their beliefs about the potential of the *dingaka* to mutilate dead bodies for ritual purposes, the Batswana imagined biomedical doctors as witches. Posthumous compensation for former migrant workers who died before it was ascertained that they were infected with tuberculosis was only awarded to dependents following a postmortem. This in effect denied most beneficiaries of the deceased’s terminal benefits.<sup>99</sup> Indeed, compensation produced a heated debate between the British colonial administration and the South African Chamber of Mines that lasted until the 1960s as the mines refused to compensate many of their former workers who had completed their contracts, were repatriated and/or fell sick while at home.<sup>100</sup> The compensation debate is, however, beyond the scope of this paper, though it is worthy of historical inquiry for another research project.

## Conclusion

There exists a corpus of literature on the medical history of industrialization, with special reference to migrancy, health, and disease in colonial Southern Africa. This literature, however, puts great emphasis on the political economy of health and disease. Various works have documented the paradoxes and contradictions of colonial medicine wherein industrializing South Africa used it both as an instrument of acquiring a healthy workforce and a political tool to consolidate hegemonic discourses of racism. The narrative of biomedicine’s reconstruction of African bodies into objects of capitalist production alone, however, constitutes only a minute aspect of the medical history of migrancy.

This paper tells the medical history of migrancy from the vantage point of the local African communities. It argues that tuberculosis produced new contested meanings of certain cultural constructs, ideas, and virtues about disease, being sick, and health. As communities were weakened physically, materially, and spiritually, they recalibrated their traditional ideas and beliefs of disease and medicine and therefore reimagined biomedicine as noxious. Overall, communities in the eastern Bangwato Reserve of the Bechuanaland Protectorate reformulated their cultural and spiritual epistemologies and practices to negotiate the emerging pathology that was tuberculosis.

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<sup>98</sup> G.E. Nettelton, GS (Government Secretary), Mafikeng, to High Commissioner, Cape Town, 13 February 1947 [S. 332/5/3] BNA.

<sup>99</sup> DC, Serowe, to GS, Mafikeng, 7 November 1946 [S. 332/5/1] BNA.

<sup>100</sup> Phthisis: Miners’ Compensation for BP Native Mine Workers, 1938-1955 [S. 332/5/1-4] BNA.