Smallpox and Epidemic Threat in Nineteenth-Century Xhosaland

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The most significant advance to date in the historiography of the Xhosa Cattle-Killing connects the slaughter of cattle with lungsickness. In *The Dead Will Arise*, Jeff Peires (1989) established the link between epidemic and adherence to prophecy. Other factors certainly contributed to the movement. Subjects obeyed their chiefs’ orders to kill cattle and not cultivate the fields. Drought in the 1850s diminished harvests. War rumours led to non-cultivation and eventually famine. Colonial incursion into Xhosa lands over the preceding decades had its effects, as did the mixing of Xhosa and Christian cosmologies. Numerous historians have debated these alternative interpretations, seeking to amend (or upend) Peires’s analysis. For all the acerbic debate, little remains settled, and it is becoming clear that Xhosaland of the 1850s provides more than enough territory to accommodate multiple, overlapping – even conflicting – interpretations. To kill cattle may have signified concurrent peasant revolt, adherence to Xhosa hierarchies, belief in the prophecy, and preparation for inevitable war. Yet the correlation between lungsickness and the movement remains strong and sets it well within a millenarian framework.

Another epidemic influenced events during the Cattle-Killing and nineteenth-century Xhosaland more broadly: smallpox. Its lingering presence in the Eastern Cape receives scant attention from historians, and yet archival evidence reveals how the disease and its threat affected Xhosa political structures and epistemologies, consistent with other medical frontiers. From its deadlier outbreaks in the Cape Colony in the eighteenth century to the mineral revolution, smallpox established itself as an unpredictably violent and terrorising malady, for coloniser and colonised alike. The disease constituted but one of many persistent threats to Xhosa autonomy, akin to imperial politicians, foreign epizootics, natural disasters, proselytising missionaries, and colonising doctors. It affected Xhosa cultural practices and led some to claims that the British wielded it as a biological weapon. A brief, broad survey of its presence in Xhosaland, followed by a closer examination of the disease and two efforts to vaccinate during the 1850s, exposes this serious threat to the Xhosa. Smallpox heightened tensions along the frontier during the time of Nongqawuse and contributed to the cataclysmic environment necessary for the Cattle-Killing. The extent to which it caused the killing of cattle is
impossible to assess, but an understanding of the movement remains incomplete without accounting for the disease.

Mention smallpox to most historians of South Africa, and ‘Khoi’, ‘decimation’, and ‘1713’ typically follow. Some will speak of the infamous ‘smallpox war’ in Kimberley during the mineral revolution (Viljoen 2003). But few histories allude to the prevalence and continued influence of the disease beyond the eighteenth century in Xhosaland, where archives give voice to doctors, the dead, and the frightened that remained in the wake of recurring epidemics. These documents testify that smallpox appeared in the Cape Colony, the Eastern Cape, and the broader region in the late eighteenth and early nineteenth centuries (Alberti 1810:42–43; Lichtenstein 1812:286–287, 296, 444–445). Crampton (2006), drawing upon Theal, suggests that the Grosvenor shipwreck in 1782 introduced a deadly epidemic that ‘almost exterminated’ the Thembu (quoted in Crampton 2006:122). The epidemic surfaced again in Grahamstown several times between 1837 and 1862 (Hunt 1963:202), in Cape Town in 1839 and 1840, near Salem in 1841, in King William’s Town in 1855 (Mullins 1998:240, 241), in Cape Town and its vicinity in 1858–1860 (Malherbe and Malherbe 1999:73–90), in Grahamstown, Colesberg, Smithfield, and King William’s Town in 1859–1861 (Grahamstown Journal 23 February 1861), at Mgwali and throughout Xhosaland and the Colony in 1862 (Soga 1983:25, 27, 154) and again twenty years later (Grahamstown Journal 15 July 1882; Gibbens 1982:208). This broad – and incomplete – survey emphasises persistency rather than body count; there can be little comparing the thousand deaths in Cape Town in 1858 (King William’s Town Gazette 20 November 1858) with the single victim in Salem, or with the epidemic in Colesberg of 1860, when ‘one-fourth of the coloured population fell victim to the disease . . . During the height of the disease, many Kafirs inoculated themselves; and, of those who did so, about one-half perished.’ The fear of impending outbreaks weighed on minds and was often more pernicious than the mortality rates of sporadic flare-ups. The threat of epidemic on the frontier shaped events in ways unconsidered to date.

Consistent with its recurrence in southern Africa, smallpox thrived in many parts of the world decades after the propagation of Edward Jenner’s vaccine. The vaccine originates from cowpox; those exposed to this milder bovine disease remained resistant to its deadlier human counterpart. Transportation of the vaccine lymph, though, made the task of treating distant geographical areas nearly impossible. Cape Town’s vaccine stock from London often failed due to heat exposure on the voyage by sea, a common problem worldwide, despite inventive efforts in other regions to cool specimens by packing them in watermelons (Hartwig 1981:20). Shipping the lymph beyond the boundaries of the Cape Colony compounded the problem exponentially. Vaccines regularly failed, and when they did, missionaries – often called upon to distribute vaccines – relied on ‘arm-to-arm’ transmission of the weakened disease as early as 1840 (Laidler and Gelfand 1971:300). To have a supply ready for continual use, medical professionals...
required patients to return after eight days as a check-up to see if the treatment worked, and to provide lymph for future recipients. But patients rarely returned.  

Another persistent danger to the Cape Colony and Eastern Cape frontier came daily: ships and their cargo carried the threat of new epidemics to Table Bay, Port Alfred, East London, Port Elizabeth, Delagoa Bay, and elsewhere. Ships entered quarantine for up to forty days on a regular basis. And when an actual outbreak did not prompt quarantine, fear alone nearly sufficed. In 1856, the Cape Colony struggled against the imminent threat of smallpox arriving on ships from Mauritius, where the epidemic raged. The Colony’s dependence on the island left Cape ports vulnerable. For much of the 1850s, only England sent more ships to South African ports than did Mauritius. And critically for Xhosaland, the docks at Port Elizabeth came under greater use between 1850 and 1859; the number of importing ships arriving there grew by eighty-two per cent while ships docking in Table Bay increased by only fourteen per cent. Considering the continual arrival of ships, in May 1856 the Cape Town municipality appealed to the Colonial Medical Committee and suggested radical measures: that all vessels from the island be placed under quarantine, with or without a smallpox break-out on board. Finally, the Cape Colony passed Act Number 1 (1856), which gave resident magistrates the ‘stringent and immediate’ ability to enforce vaccination for smallpox should an epidemic break out (quoted in Hunt 1963:257). The Quarantine and Port Regulations Act (1857) soon followed to manage the threat of smallpox, measles, and cholera arriving at South African ports. Smallpox and other diseases continually endangered both the health and the economy of the expanding Colony.

The invisible threat of epidemic loomed large over the frontier, as did the rumour of epidemic and, consequentially, panic. The lead article in the King William’s Town Gazette of 2 October 1858 warned, ‘The small-pox appears to be spreading in the Western Province . . . As yet, however, we regret to state that no steps have been taken by the Kaffrarian Government to soften the effects of the disease, should it ever travel thus far . . . The disease has spread through some of the most sparsely populated districts of the West, and is fast nearing the boundary line of the East . . .’ And later in the same issue: ‘intelligence has been received of small-pox having broken out at Port Elizabeth’. Articles sometimes sparked action by government authorities, as this case eventually did, but they also instilled fear and fanned the flames of rumour. On 12 October, the Gazette reprinted a report contradicting rumours that smallpox had appeared on a coloured man: ‘The District Surgeon, Dr Maasdorp, visited the supposed patient . . . but discovered not the least sign of small-pox or anything else upon him, beyond the odour of brandy . . .’ And eleven days later: ‘As some alarm has been lately caused in King Wms. Town by the reported existence of small-pox, we think it but right the public should be informed that the rumour is not correct.’

Nonetheless, rumours and official notices precipitated action. The Gazette reported that doctors vaccinated three hundred people at the Pensioners’ Village
on Monday, three hundred and ten at Fort Murray on Tuesday, and, ‘[f]rom 9 o’clock in the morning till late in the day, crowds of natives were to be seen coming from all directions to undergo the mysterious operation ... The Kafir mind at the present moment is under great apprehension and the natives come long distances’ (30 October 1858). By the end of 1858, more than a thousand people had died in Cape Town, and significantly less in the vicinity of King William’s Town thanks, in part, to the frontier’s rumour mill.

**Xhosa responses to smallpox**

Although deaths from epidemics in the nineteenth century rarely amounted to more than a few hundred, the accumulated effect of the disease – and its visual stigma – left deep collective scars on Xhosa society. Henry Lichtenstein, a German doctor who travelled beyond the Cape Colony in 1803, provided a glimpse of early reactions to the disease. In hearing of smallpox in their path ahead, Lichtenstein portrayed his African guides and companions so terrified that ‘they must renounce serving us any longer ... [T]his new danger threw them into such dreadful apprehensions, that they no longer saw any thing but inevitable death in the prosecution of our plans’ (Lichtenstein 1812:286–287). Thenceforward, whenever Lichtenstein’s travelling party stayed at missionary stations, ‘[n]one of our African companions would venture to go near the missionaries for fear of taking the infection from them; nay, their apprehensions were carried so far, that they kept always to windward of the missionary camp’ (Lichtenstein 1812:296).

This fear testifies to the severity of past epidemics, and the Xhosa, like other populations around the world, adapted their beliefs and practices to accommodate smallpox and other life-threatening diseases. Elsewhere in Africa, for example, Ugandan Bantu ‘worshipped a smallpox spirit, Ndua’ (Hopkins 1983:183); the Yoruba cosmology allowed for the earth god, Shapona, to punish men with smallpox (Hopkins 1983:200); and the WaBungu of southwest Tanzania personified the disease as *Ndui* (Singleton 1976:172–178). The disease uniquely affected the Xhosa as well. Burial rituals and traditional medicine practised by Xhosa doctors (*amagqirha*) changed under the imprint of epidemics, which Peires attributes to an epidemic in Xhosaland about 1770 (Peires 1989:31). Moodie noted in 1835 that the Xhosa ‘had formerly always buried their dead; but that several years ago an infectious disease, or plague, had broken out among them and carried off great numbers, and since that time they had been afraid to touch a dead body’ (Moodie 1835:271). Cross-referencing this with three other sources confirms the aforementioned disease to be smallpox.\(^{11}\)

Beyond changing Xhosa behaviour, smallpox influenced notions of sickness. Healers added it to their practice, identifying it when either sucking or pulling diseases from patients. In August 1862, Tiyo Soga witnessed the death of Namba, son of Maqoma, at Thomas River. Two *amagqirha* offered conflicting reasons for Namba’s impending death; the second saw ‘small-pox and bewitching wood
coming from two persons who are intent on destroying Maqoma’s home/family … that small-pox was smeared on him as a disease to kill him’, but that the doctor ‘took them out … the Puludyax [smallpox] seemed to look like ant-eater’s excreta’ (Soga 1983:154). By the 1860s, smallpox had left a sizeable imprint on Xhosaland. Its intermittent presence over a broad geographical territory equipped the Xhosa with a number of strategies to minimise the risk of epidemic. By the time an epidemic hit in 1841, ‘many native villages, and kraals, [were] deserted and the inhabitants … fled to the mountains. Sandille in consequence directed all intercourse with the respective divisions of his country where the disease was most active should cease, and also, to prevent wagons crossing the boundary.’12 These spatial restrictions – and Lichtenstein’s companions staying to the windward side of mission stations – show an awareness of the principles of contagion in the first half of the nineteenth century. Whether the Xhosa practised arm-to-arm inoculation before 1860, as other southern African societies did (Herbert 1975), is unclear; but their coastal geography and interaction with settlers and Khoi would make inoculation plausible. Culturally, then, smallpox affected burial traditions and the healing practices of the amagqirha. It also continually spread panic among settler communities in King William’s Town and farther a field. These effects were intensified by environmental and political developments of the preceding decade.

Other historians have noted the significance of environmental disasters to the climate of impending doom during the 1850s: plagues of locusts, droughts, torrential rains, earthquakes, and maize grubs (Peires 1989; Bradford 2008, 2000). These exacerbated the effects of recent land loss and the War of Mlanjeni, and they extended from a longer historical trajectory of millenarian movements and upheaval (Bradford 2006). Most notably, according to Peires, lungsickness and its cultural interpretation signified a dirty, defiled, dying community, and the epizootic likely contributed to the rise of Nongqawuse and adherence to her prophecy. ‘Truly’, notes Peires, ‘it seemed as if nature herself was in league with the enemies of the Xhosa’ (Peires 1989:71). Yet visual cues imparted by the environment also foretold of salvation. During the Cattle-Killing, Mhlakaza drew strength from the lunar cycle, promising great events after the ‘moon of wonders and dangers’, and Xhosa faith in the prophecy renewed with a full lunar eclipse on 13 October 1856. Writing five years later, a young Xhosa pupil at St Matthew’s Mission School in Keiskammahoek remembered, ‘the moon was all dark, that thing I saw in (the time) of Nongqawuse; people said something is coming to pass, they said so from not knowing that it was the earth [causing the eclipse]’ (J.Z. 1861:11).13 At the risk of stating the obvious, the environment and the landscape had been central to Xhosa culture for centuries, but the tumultuous era during the nineteenth century – intensified in the 1850s – maximised pressure on Xhosa society to an unprecedented degree. Lungsickness led the epistemic attack with a series of other environmental maladies behind it, among them smallpox. The threat of this epidemic would flare yet again in 1856.
In the midst of this tumultuous era worked John Patrick FitzGerald (Figure 1), an Irish doctor trained at Glasgow and a specialist in ophthalmology. Before arriving in South Africa, FitzGerald practised as a ship’s surgeon aboard a vessel headed to New Zealand in 1840, where he would subsequently serve as Assistant Colonial Surgeon, Coroner and Health Officer for Port Nicholson, and finally Superintendent of Wellington Hospital. There he practised under the watchful eye of Sir George Grey, then Governor of New Zealand (1845–1853). FitzGerald’s industriousness and ambition impressed Grey, and the doctor was generally supportive of his governor’s expansionist policies. Their camaraderie, which would strengthen further in South Africa in 1856, was built upon their shared experience in New Zealand with the Maori. After taking his post in Wellington, FitzGerald became known as ‘a champion of the Maori’ (Dow 1999:35). He studied their language (Donaldson 1988a:636) and practised a care-for-all philosophy. FitzGerald considered his own medicine superior to that of the tohunga.
Maori doctors) whom he ‘tried to discredit [as] medical frauds, but he was only partially successful in his campaign against them’ (Donaldson 1988a:637). Because of FitzGerald’s steadfast loyalty to Grey, and perhaps out of jealousy at his success in attending to the Maori, two other colonial medics charged FitzGerald of ‘quackery’ and of running a ‘propaganda institution’ where ‘patients could either be killed or converted to Catholicism’ (quoted in Donaldson 1988a:637). He was never convicted of either charge, but FitzGerald became embroiled in a politicised climate – not to mention his exhaustion from being overworked, underpaid, and grief-stricken by his wife’s death in 1852, leaving him four children to raise alone. Two years later, when the Wellington Provincial Council denied his request for leave, he abandoned his post and returned to England. FitzGerald rested for a year and then petitioned Queen Victoria, ‘beg[ging] to place himself at the disposal of your Majesty’s Government, to return to New Zealand after his health is re-established . . . and if that should be impossible or impracticable, he is willing to proceed to the Cape of Good Hope, to aid Sir George Grey’ (FitzGerald 1855). Although he was not invited to fill a new position in the Cape Colony before setting sail (Donaldson 1988b:144), FitzGerald had faith that Grey would use his services. He would not be disappointed.

FitzGerald landed in the Cape Colony in January 1856, finally arriving on the Eastern Cape frontier in March, just before Nongqawuse began to prophesy. His appointment as Superintendent of Native Hospitals introduced a new medical frontier into Xhosaland. This alternative system of medical care, the constant threat of smallpox, and FitzGerald’s vaccination programme became enmeshed in a series of environmental disasters and intensified the strain on Xhosa social and political structures. New medical epistemologies and the threat posed by lethal foreign diseases intensified the strain on Xhosa social structures. While it would never directly cause indigenous social collapse, colonial medicine contributed to the highly combustible atmosphere on the frontier, its tinder set alight with a young girl’s prophecy that April.

FitzGerald set lofty goals for himself and his institution:

> before ten years pass over, many a savage heart will be won to the British Government . . . [T]he medical institutions in British Kaffraria will be received by both races not only as blessings in the country but as lasting monuments of that benevolence which planned that wisdom, which approved the founding of institutions within which both races[,] it will be seen[,] may be lying side by side with the same attention and relief administered to both alike.

The doctor’s faith in the supremacy of his remedies allowed him to see beyond the contradictions of his statements. He vowed that the ‘poor man’s medicine should be as carefully prepared as the rich man’s and the black man’s as the white man’s’, and yet he served as an active proponent of George Grey’s political machine. While he subscribed to an egalitarian philosophy and strived to care for black and white, rich and poor alike, he simultaneously sought to
undermine the influence of the *amagqirha*. He saw himself in battle against Xhosa healing systems so that ‘the chiefs could no longer use this power and influence for political ends if once the mass of the people were convinced that disease did not depend on witchcraft, which in time they would, by our treatment of disease’.

FitzGerald’s earnest and zealous desire to effect change – for the better, he assumed – came not only from his past experience in New Zealand, but from his geopolitical position as a doctor on the Eastern Cape frontier of the 1850s.

FitzGerald relished his post in King William’s Town. With full backing from Sir George Grey, the doctor had the unique opportunity to attend to Xhosa patients without many of the challenges that once confronted him in Wellington. He was assured of funding and political backing, and he worked beyond the direct oversight (but not beyond reach) of the Colonial Medical Committee in Cape Town. This ensured him of autonomy and minimised the risk of political turf-battling that had in part led to his previous resignation. FitzGerald could craft his institution from the ground-up. Until he began practising, the only doctors between the Keiskamma and Kei rivers were military surgeons, and sources of medical remedies – particularly east of the Kei – were to be found at missionary stations (Van Heyningen 2004:176). These would become important outposts for FitzGerald’s growing practice. He would occasionally ride on horseback to attend to ailing Xhosa or Mfengu who could not otherwise make the journey into King William’s Town, and the missions served as critical points of distribution for his fledgling vaccination initiative in 1856.

**Epidemic threats: smallpox, lungsickness and war, 1856–1857**

By the time of FitzGerald’s arrival, the Colonel Office recognised the imminent threat of smallpox and had issued a circular to emphasise that ‘[v]accination should be kept up throughout the Colony as extensively as possible ... ’

FitzGerald, too sought to confront any threat to his practice and to establish the sovereignty of his institution. To ensure central authority in caring for the Xhosa, the doctor insisted three things in early April 1856: that ‘immediate steps should be taken to promote vaccination both amongst the natives and Europeans of British Kaffraria’, that ‘supply of vaccine matter ... be forwarded ... without delay’, and that ‘no communication be made relative to [his] department without [his] consent’. In case the government would not oblige with his immediate call for vaccines, FitzGerald warned John Maclean and George Grey a month later of the imminent threat of smallpox. The unknown danger posed by the epidemic in Mauritius worried FitzGerald, and he reminded Maclean of ‘the danger which may occur to the native population should the troops which are expected from Mauritius be permitted to land without undergoing some quarantine’. 

...
With FitzGerald’s three-part request that April, he aimed to centralise care for all residents within his reach. Imagine his surprise, then, when he received a package of notices for circulation – written in isiXhosa and dated 17 March – about smallpox and the need for vaccination. The problem lay not in the notice itself, but that it had already been in circulation for some time, or so FitzGerald thought, and he was neither prepared for his vaccination programme, nor did he have the necessary lymph. Grey had not yet sent any, despite the doctor’s previous request. In this discrepancy, FitzGerald saw motive.

He scribbled an uncharacteristically stern letter to the governor’s interpreter: ‘You have taken upon yourself without ever consulting me to circulate papers on medical subjects, calculated to alarm the native mind, and to cause them to seek a remedy, where no remedy is to be found. Any one conversant with natives must be aware of the effect these circulars will produce amongst them ...’ FitzGerald had arrived in South Africa only five weeks earlier, and already he found himself challenging the decisions of his benefactor, the governor. FitzGerald saw this circular as ‘nothing but obstruction in the faithful and zealous discharge of [his] duties’. What if the Xhosa came to the hospital for vaccinations and there were no matter? The doctor demanded the governor to ‘stop the circulation of these papers and to have them all sent to [him] until [he] receive a supply of vaccine matters’.

Vaccine material did not arrive until 25 April, almost a month after FitzGerald’s initial request, at which point the doctor bypassed approval from the governor’s office, distributed vaccines directly to missionary stations, and issued his own notice on smallpox. Four days later, FitzGerald realised the vaccine lymph sent from Cape Town had failed. In addition to requesting new vaccines from the governor’s office once again, FitzGerald appealed to the Lieutenant Governor in Grahamstown, later known as the Colony’s ‘lymph emporium’ (Grahamstown Journal 15 July 1882).

The demarcation and active enforcement of FitzGerald’s responsibilities reveals a doctor who saw himself as one of a breed of ‘faithful, zealous, and long tried public servants’ seeking to improve the lives of those around him. The initial months showed promising signs for his practice; the doctor’s office was typically ‘thronged with [Xhosa and Mfengu patients] pressing on his door to obtain an early admission’. With the threat of smallpox from Mauritius and beyond – exemplified by the arrival of troops from the island in May – FitzGerald threw heart and soul into keeping the disease from Xhosaland and building the reputation of his hospital, especially among the Xhosa. His frustration with Grey and Ayliff stemmed from his need for total control of all things medical between the Keiskamma and Kei rivers. Receiving the circulars without forewarning infuriated the doctor, coming as they did two weeks after his request for centralised control and open communication. With notices written in isiXhosa, Governor Grey (and the Colonial Medical Committee) could have pre-empted the doctor’s introduction to his future patients and promised ‘a remedy, where no remedy is to be found’.
In an era of shifting and competing geopolitical and cosmological boundaries, it was critical that FitzGerald himself earn the trust of his patients. Xhosa faith in this new doctor would be damaged forever, he feared, should his arrival coincide with an outbreak of smallpox, and FitzGerald proudly claimed that the epidemic never broke out among the Maori during his residence in Wellington (Donaldson 1988a:636). Intent to repeat this success, FitzGerald was dedicated to vaccinate for and wide. Early frustrations with obtaining the vaccine and with his political superiors only strengthened his resolve.

Once he secured doses of the vaccine, FitzGerald sent a note, written in isi Xhosa, to the ‘chiefs and native inhabitants of British Kaffraria’. He sought to explain the gravity of the disease in order to ‘excite in you a solicitude for your safety and welfare’. FitzGerald warned:

You can have no stronger proof of [the Governor’s] Kindness than the steps he wishes to be taken in order to prevent your dying like the Cattle by a frightful disease called the Small Pox which has recently appeared at Cape Town and which if it should extend here will most likely be as fatal to you as the Lung Sickness was and is to the cattle.29

As Peires has shown, lungsickness contributed to the Cattle-Killing and was devastating Xhosa herds after 1855, killing between a half and two-thirds of all cattle. They ‘began to believe that their cattle were rotten and impure’, and in some locations up to ninety-six per cent were killed by the disease (Peires 1989:312).30 To liken lungsickness to smallpox sent a singular, powerful message throughout Xhosaland.

FitzGerald’s motivations for sending such a note to his patients were numerous and not altogether altruistic. While he may have wished genuinely to protect the Xhosa from uncontrolled epidemics, he also aimed to promote western medicine over what he considered, on the whole, to be primitive, ineffective practices. More immediately, he wanted to safeguard his own position and reputation, which he would acknowledge to Maclean two years later: ‘I fear should Small Pox break out in any part of British Kaffraria where vaccination is not being properly carried out some blame may attach to me’.31 With his lungsickness/smallpox note, then, the doctor turned a blind eye to his previous denunciation of the governor’s circular which intended, he suspected, to ‘alarm the native mind’. FitzGerald’s distressing note almost certainly startled the Xhosa. It was an approach he had employed with the Maori of New Zealand eight years earlier. The island experienced smallpox scares in 1845, 1848, and 1851, during which time FitzGerald distributed a pamphlet – written in Maori – containing medical advice and stressing the importance of vaccination (Dow 1999:51). After a polite introduction, he identified Maori clothing, diet, and housing as the reasons ‘why so much sickness prevails amongst you’, and continued, ‘unless you lay the axe to the root and try to remove these causes your race will soon become extinct and a prey to the worst forms of disease’ (quoted in Donaldson 1988b:73). A contemporary of FitzGerald’s
described the pamphlet as an ‘indiscreetly alarming account’ to promote vaccination (quoted in Dow 1999:51). It sparked panic and ‘resulted in Maori self-vaccination, imperfectly administered’ (Dow 1999:51). In the case of the Xhosa, the notice comparing smallpox to lungsickness likely intensified fears of the doctor and his hospital more than it helped prevent the spread of disease. His notice came at the worst possible moment, as Mhlakaza and Nongqawuse attracted believers to their prophecy, an inherently inward-looking movement that apparently diminished FitzGerald’s influence.

The doctor’s warning to the Xhosa spread via missionary stations throughout Xhosaland, and it was received in a climate of mounting pressures. War cries permeated every corner of the region. As reports of ‘the suspicious restlessness’ of the Xhosa reached officials, ‘regiment after regiment is dispatched ... until at length there is collected such an army on this frontier as has not been equaled ... by any force stationed in peaceful times in Africa since its conquest by the British’ (King William’s Town Gazette 16 October 1856). Helen Bradford explores this prevalent militancy on the frontier in an unpublished article, which claims that the Cattle-Killing ‘emerged, above all, from the cauldron of war’ (Bradford 2000:3). Bradford convincingly argues that Grey used his Moshoeshoe-Sarhili war-plan theory as a premise for ‘rushing redcoats to the frontier’ and heightening tensions (Bradford 2000:14). The British and Xhosa became engaged in a cold war of threats: the amassing of troops provoked the cessation of cultivation and the killing of cattle, which in turn justified adding more troops on the frontier. This did not escape the attention of one reader who commented ‘from beyond the Kei’ in 1856:

You are perhaps still full of war alarms at King William’s Town. The Galekas certainly manifest a restless spirit, proceeding not from a desire to go to war, but from the force of circumstances ... That they may be compelled to go to war is not impossible, but there is no immediate danger to be apprehended. (King William’s Town Gazette 11 November 1856)

Within this environment of threatening one-upmanship, FitzGerald began his practice and attempted to institute his vaccine programme with a startling notice to the Xhosa. The Xhosa had to face the possibility of recurring smallpox in addition to epidemic – that is, widespread – threats of war and subjugation. Some Xhosa therefore began to think of FitzGerald less as ‘the good doctor’ and more as a government agent, Grey’s policies cloaked as benevolent medical care.

FitzGerald’s claims amounted to a paradox: to treat all bodies equally and to simultaneously advance the colonial agenda lock-in-step with Colonel Maclean’s views, that Xhosa ‘political and religious governments ... are so intimately connected that the one cannot be overturned without the other; – they must stand or fall together’ (Maclean 1855:110). FitzGerald and Maclean knew that one could
not isolate the Colony from colonial medicine. Xhosa fears circulated about the new white doctor in 1856. FitzGerald wrote,

It was said that one man was turned into a woman for disbelieving the Kaffir Doctors, and coming to me. That once a person came to me they could never again go to a Kaffir Doctor. That they would get Small Pox to drink in the medicine and that our medicine was made of the excrement of white people.

There was a visible fear, and reluctance on the part of some of the chiefs to come to me.

At one time it was said I was a missionary, now I believe some think I am a political agent of the government, and that the Governor is using this department for drawing power and influence to himself.32

These comments are remarkable for their representation of converging influences around FitzGerald’s practice and Xhosa-Colony interactions. Race, medicine, religion, and politics mixed in a kind of primordial soup conducive to conflict on the frontier. Smallpox and its vaccine had become politicised, yet another example in South African history when disease and medicine were conflated with race and power.

This was nothing new. In 1841, when several people died of smallpox near the Buffalo River, the Xhosa suspected ‘that the Government was secretly destroying them’.33 They often referred to British soldiers as amarwexu, literally ‘a person who still has the mark of small-pox’ (Kropf 1899:357) which others have translated as ‘small-pox Satans’ (Peires 1986:458; James 1997:255). Given that the Xhosa were locked in perpetual struggle against encroaching colonial forces, sporadic smallpox outbursts, and threats from Grey and even nature herself, at the apex of these threats the Xhosa sought an answer outside their traditional epistemologies. Nongqawuse’s prophecy, akin to other millenarian movements, sought to address a litany of national threats that fused together in the mid-1850s. Writing on the effects of eighteenth-century smallpox epidemics and nineteenth-century lungsickness, Terence Ranger suggests that ‘neither smallpox, nor drought, nor cattle disease were being kept at bay, and taken together were creating a general ecological crisis’ (Ranger 1992:249). Smallpox and its threat, furthermore, continued throughout the nineteenth century, which only compounded the effects and the disastrous outcome of a ‘coincidence of plagues of both beasts and men’ (Ranger 1992:268). FitzGerald, it would appear, could not avoid his politicisation, neither from his reliance on Grey for the creation of the hospital nor from the opinions of the Xhosa, who increasingly avoided his care in late 1856. Many Xhosa characterised him as a ‘political agent of the government’.34

For this reason, FitzGerald actively fought against such perceptions and tried to defend the boundaries of his medical practice as vigorously as he had established them. In an effort to avoid criticism that befell him in New Zealand, the doctor attempted to keep his practice free from religious and political influences. In early December 1856, as tensions rose between believers and
disbelievers of the Cattle-Killing prophecy, FitzGerald sent a circular to officers, interpreters, and servants in his care, stipulating that nobody ‘should ever argue or discuss the subject of religion or politics with any of the patients . . . under pain of suspension from office’. As apolitical as FitzGerald intended to be, in less than two weeks after distributing this circular, he would need to intervene politically to protect his own assistants from retribution by Cattle-Killing believers. FitzGerald wrote to the Chief Commissioner and explained that Ned and Kona Maqoma – sons of Chief Maqoma, an active believer – were ‘marked men and they are talked about all over Kaffir land and blamed for attaching themselves to Government’. FitzGerald asked that the government ‘afford [them] protection’. Kona especially faced a significant threat, as he cultivated his fields against orders in his father’s land. He eventually landed safe near Fort Murray, although FitzGerald was ‘told that he did not understand politics and should mind his own business’ (Peires 1989:162). Nevertheless, the vicissitudes of frontier life in 1856–1857 led the doctor to break his own rules. Separating medical treatment from religious and political influences proved impossible, not least because the missionary stations doubled (and would continue to do so) as outposts of a network for medical treatment, and because FitzGerald, ‘the most politically active of colonial physicians’ (Salesa 2001:24), relied heavily on Grey’s support for his practice. Many Xhosa had reason, indeed, to see the hospital as a thinly-veiled extension of the government, and FitzGerald as a threatening force.

Writing to Maclean on 6 December 1856, FitzGerald noted ‘a powerful opposition’, lamenting,

> When I first commenced practice in this place the Kaffirs were flocking from all directions of the country to me . . . But a short time elapsed after I commenced when ‘Umhlakaza’ the political agent arose beyond the ‘Kei’ and almost suddenly the Kaffirs ceased coming in numbers their place however was instantaneously filled up by Fingos, and Hottentots.

Statistics of dispensary cases at the Pensioners’ Village (what would later become Grey Hospital) confirm FitzGerald’s statements. As Gordon has pointed out, ‘The number of people who visited the dispensary more than halved as the prophecies of Nongqawuse spread’ (Gordon 2001:175). Between May and November 1856, Xhosa patients to the dispensary fell by nearly two-thirds, from six visits per thousand in May to just above two visits per thousand in November (Figure 2). By February 1857, with the Great Disappointment of the Cattle-Killing, FitzGerald was both despondent and overwhelmed by his work at the hospital. His influence among the Xhosa dissipated; the success of his medical establishment wavered in the millenarian winds stirred across the Kei. For FitzGerald, the prospects of success were bleak. Only nine months previously he looked to King William’s Town in part to re-establish his reputation as the kind-hearted doctor sympathetic to native health, not the proselytising quack his political enemies in Wellington had painted him to be. He spent considerable time courting amagqirha and
sharing the secrets of his miracles (he performed twenty-six successful eye operations within his first ten months of service).\(^40\) Phato’s son, Smith, reportedly rebuked his father’s belief in the prophecy, ‘You look the wrong way, father. The real Umhlakaza is in King William’s Town. Had you seen a blind man’s eyes opened you would stop listening to Kafir talk’ (quoted in Rutherford 1961:323).\(^41\) Despite these achievements, many Xhosa lumped FitzGerald and his institution together with colonial powers. The millenarian movement underway at the same time as FitzGerald’s fledgling practice overpowered the doctor’s best intentions. Two weeks before the Great Disappointment, the doctor rightly feared a famine would result from Mhlakaza and Nongqawuse’s prophecies. However convinced he was that his services would be in demand with the Xhosa, he requested time off to recover strength. Furthermore, the shortage of Xhosa patients and the difficulty of procuring lymph led FitzGerald to abandon his vaccination programme. On 4 February 1857, he wrote, ‘I have worked without ceasing for the last nine months ... I assure you I am nearly worn out, tired, and discouraged ... ’ \(^42\) Indeed, it would appear that he had underestimated the strength of Xhosa healing systems and his own weak position as a political agent of the governor. FitzGerald had lost ground to his Xhosa counterparts, his ‘Professional Brethren in their uncivilized state’. \(^43\)

If some Xhosa in fact boycotted the hospital as an external factor to the Cattle-Killing movement, Xhosa visits to the dispensary should rise after the strongest believers finally abandoned hope for the prophecies. FitzGerald’s logbooks

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**Figure 2.** Dispensary cases per thousand, May through November 1856
confirm this hypothesis. Xhosa visits rose back to the level of six visits per thousand between September and December 1857 (Figure 3). 44 With the failure of the prophecies in February, increasing visits of emaciated Xhosa to the hospital in the winter, rising visits on par with initial interest in FitzGerald’s work, and the acquisition of Dr Egan and Dr Peters in December, the closing of 1857 marked the end of the first phase of Grey’s great experiment … (T)he hospital was well launched on its career and had already made a deep impression on the Xhosa (Rutherford 1961:324). Rutherford identified the end of 1857 as a shift to the next phase of the hospital’s administration. However significant FitzGerald’s and the hospital’s roles, they contributed to the millenarian environment which heightened tensions in the region and facilitated the Cattle-Killing. FitzGerald’s inability to distribute smallpox vaccines far and wide throughout 1856 shows that his and the hospital’s role with the Xhosa was also a reactionary one, dependent upon their perceptions of this latest extension of the government’s power and influence.

Immediately after the Cattle-Killing and through 1858, the number of patients at the hospital declined. Gordon has interpreted this as proof that the ‘Cattle-Killing episode damaged Xhosa faith in colonial medicine’ (Gordon 2001:177). But Gordon does not account for population loss as a result of the Cattle-Killing. Over a period of two and a half years, between May 1856 and December 1858, British Kaffraria lost about seventy-five per cent of its population (Peires 1989:319). So while the actual number of dispensary patients declined, the proportion of visitors in fact rose dramatically, immediately after the movement

![Figure 3. Dispensary cases per thousand, September through December 1857](image-url)
(Figure 4). Thus, it was not an outcome of the Cattle-Killing that lessened any ‘Xhosa faith’ in colonial medicine. If anything, the end of the Cattle-Killing marked a new phase in FitzGerald’s practice, when Xhosa resistance to the ‘political agent of the government’ imploded along with the inherently anti-colonial movement.

**Vaccination and the rise of Grey Hospital, 1857–1859**

In stark contrast to FitzGerald’s first and failed attempt at widespread smallpox vaccination, his second effort starting in mid-1857 had significantly more success. Accurate vaccination figures and population totals are difficult to assess for the 1850s, but even the most conservative of estimates shows the smallpox vaccinations to be common in Xhosaland by 1859. Patchy archival evidence places the vaccination count above 10,500 given to ‘natives’ in Xhosaland. (FitzGerald alone vaccinated 1,207 people at the hospital; 4,308 were performed between 1 July 1858 and 30 June 1859. On FitzGerald’s ride through the region, of the numbers he gave, 3,460 were mentioned. And a total of 1,709 were administered by Drs Hazard, Wilmans, Peters, and Egan between October 1857 and April 1858.) These totals are only suggestive, yet they do demonstrate that FitzGerald’s vaccination programme was widespread and substantial. The population of British Kaffraria, according to totals provided by Maclean, was 37,500 in January 1858, and 25,916 in January 1859. Using an average of the population totals (31,700), a conservative estimate suggests that at least a third of non-European inhabitants of British Kaffraria received the vaccination. And it is

![Figure 4. ‘Natives’ per thousand treated at the Native Hospital, May 1856 through December 1858](image-url)
entirely possible that the percentage was much higher. For example, when smallpox broke out in Tyumie in July 1859, the Superintendent of the Crown Reserve appeared disappointed that less than two-thirds of residents had been vaccinated. It was perhaps the most extensive vaccination campaign in Xhosaland to date, facilitated by a lack of any significant resistance prevalent just two years earlier. By 1859, the Colony had considered legally enforcing smallpox vaccines, but the bill would not pass until 1883.

These estimates present a fair, if vague, approximation, but narrative can supply another glimpse into the region where numbers fail. When FitzGerald received word that two cases of smallpox broke out on board a ship in East London in November 1858, he went to various stations to survey the completeness of vaccination. He and his interpreter left King William’s Town on horseback, where ‘nearly ... all the Natives’ had been vaccinated. FitzGerald’s letter describes the level of vaccination in several locations they visited:

<table>
<thead>
<tr>
<th>Location</th>
<th>Level of Vaccination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pirie</td>
<td>‘Mr Ross ... had vaccinated almost all the natives’</td>
</tr>
<tr>
<td>Keiskammahoek</td>
<td>‘60 had been done’</td>
</tr>
<tr>
<td>Burnshill</td>
<td>‘about 400 more’</td>
</tr>
<tr>
<td>Middledrift</td>
<td>‘unable to ascertain how many ... but I believe a good many’</td>
</tr>
<tr>
<td>Lovedale</td>
<td>‘between three and four thousand ... on the Colonial side and the Missionaries ... were still engaged in the work’</td>
</tr>
<tr>
<td>Tyumie, Elands Post, and</td>
<td>‘Mr Keyser promised to commence vaccinating’</td>
</tr>
<tr>
<td>Windvogelberg</td>
<td>‘many had been done’</td>
</tr>
<tr>
<td>‘Gaika Commissioners Station’</td>
<td>‘a great number had been vaccinated’</td>
</tr>
<tr>
<td>‘Rev Tiyo Soga’</td>
<td>‘vaccination was being carried on’</td>
</tr>
<tr>
<td>‘Rev Mr Ryans Station beyond</td>
<td></td>
</tr>
<tr>
<td>the Dohne and the Rev Mr Crofts Station at the Dohne</td>
<td></td>
</tr>
</tbody>
</table>

Overall, FitzGerald found that ‘every effort to have been made by the different missionaries to spread the benefits of vaccination.’

The doctor’s survey underscores the unfinished and contested nature of vaccine coverage in the late 1850s. Responses to it were equally mixed. Many inhabitants in King William’s Town exhibited ‘considerable prejudice’ against receiving vaccine material ‘transferred from native pustules’ (King William’s Town Gazette 2 November 1858). To combat these fears, both FitzGerald and Dr Peters ‘vaccinated themselves from Kaffir children’ (King William’s Town Gazette 23 October 1858). The body and the syringe constituted another site of resistance.
With the Xhosa, although Dr Egan ‘found the Natives well disposed’ towards him, and that they ‘seem perfectly to understand the nature of [vaccination] and are very anxious to have it carried into effect’, response to FitzGerald’s programme was not always as enthusiastic. Upon the instruction of FitzGerald, Dr Peters left King William’s Town in April 1859 to inquire about reports that smallpox had broken out in the region. At a village outside of Windvogelberg, of nineteen total inhabitants, four patients had died of smallpox and another eight were infected, and ‘[a]ll the people in this village refused to be vaccinated when requested by Mr Keyser’. By August, twenty-one people in the region would die.

Why would segments of the population, such as this entire village, refuse to receive the smallpox vaccine? Is this resistance explainable by highlighting the epistemological differences between Xhosa notions of healing and the principle of vaccination? Or was it something inherent in the vaccine? For certain, smallpox inoculation and vaccination has been controversial in other societies the world round, let alone on a politicised frontier of vastly different medical systems. In eighteenth-century America, for example, ‘the questions about the efficacy of [vaccination] were often secondary to doubts about the morality of using it to intercede against an illness . . . To sicken oneself as a way of preventing God from sickening you – that was a terrifying spiritual risk’ (Allen 2007:27). Furthermore, there ‘was no way to test the efficacy of a vaccine except to expose a group of vaccinated people to smallpox’ (Allen 2007:53). But the Xhosa had been vaccinating themselves at missionary stations for years before the introduction of FitzGerald and Grey’s medical establishment. Exposing a body to the weakened form of the disease did not, by then, conflict entirely with epistemic or spiritual beliefs. The resistance likely stemmed from a particular, local rejection of an imported and foreign vaccine, a response more common to the Cattle-Killing movement of two years previous.

While reasons for rejection can be only suggested, this example illustrates that by 1859 the number of Xhosa refusing the vaccine diminished: if not from the collapse of much of independent Xhosa society two years earlier, then from fear of a new smallpox epidemic sweeping the countryside. By the end of the decade, construction of a permanent hospital had been completed, later christened ‘Grey Hospital’ (Figure 5), and FitzGerald had created a temporary ‘smallpox hospital’ outside and employed a Xhosa attendant to care for the patients. FitzGerald’s second attempt at a vaccination programme succeeded as much as his earlier effort had failed, and the primary cause of this was beyond his control, beyond the Kei. Despite his best intentions, but due to his own ambitions, FitzGerald’s practice became highly politicised from his arrival to the Great Disappointment in February 1857. His notices written in Maori and isiXhosa – threatening extinction to the former and equating smallpox and lungsickness to the latter – worked as a scare tactic to ensure the success of his institution. Unlike the case in New Zealand, however, these notices were distributed at the same time that a millenarian movement took hold throughout Xhosaland.
Many Xhosa saw the doctor as the governor’s political agent. He constituted the latest attempt of the government, in the view of some, to undermine their autonomy, using smallpox as a biological weapon.

The continual threat of one epidemic (smallpox), the prevalence of another (lungsickness), and the rumours of impending war all contributed to the mounting pressures on Xhosa society in 1855 and 1856. While lungsickness prompted the killing of cattle, disease colluded with other social and environmental factors to make the broader movement possible. Using smallpox as a case study reveals a number of ways that diseases and European treatments left their mark on the Xhosa. The epidemic continually appeared throughout Xhosaland. It changed Xhosa burial practices. The disease fused itself into amagqirha healing practices. Its continual threat, partly thanks to FitzGerald’s notice and his new practice concurrent with Nongqawuse’s prophecy, may have fed into the millenarian movement. The Cattle-Killing, wrote Ranger, was ‘the most totalist of responses to the collapse of a public orthodoxy of health which had been precipitated by one epidemic [smallpox] and rendered intolerable by another [lungsickness]’ (Ranger 1992:256). The movement had left FitzGerald’s dispensary without its previously abundant Xhosa visitors, and the vaccination programme he initiated upon his arrival had to be abandoned until the Cattle-Killing failed in 1857. Thereafter, vaccinations and visits to the hospital rose, as Xhosa resistance to colonial power crumbled for the next twenty years.

Acknowledgement

Yale University’s Fox International Fellowship generously supported this research.
Notes

1. Laing to Colonial Secretary, 18 September 1855, CA MC29; Fairbairn to Bell, 31 July 1840, CA MC23.
2. W Matthews to M West, 7 January 1841, Cory Library (hereafter CL), Rhodes University, MS 16582.
3. See also Abercrombie to Rawson, 10 September 1858, CA CO4100; Inhabitants of D’Urban and Tygerberg to George Grey, 19 October 1858, CA CO4101; C Garisch to Rawson, 13 November 1858, CA CO4102; J Tancred to George Grey, 2 October 1858, CA CO4106; W Crow to Rawson, 6 September 1859, CA CO4107.
4. ‘Appendum to “Extracts from Reports of Civil Commissioners”’, Cape of Good Hope Blue Book 1860, JJ40. See also Houghton and Dagut 1972:33. My thanks to Helen Bradford for calling my attention to this source.
5. Lichtenstein noted that ‘cow pox was brought, in November 1803, to the Cape Town by a Portuguese slave-ship from Mozambique, after the English Government had in vain attempted to introduce it from England’ (Lichtenstein 1812:445).
6. CMC to Colonial Secretary, 18 February 1856, CA MC29; Report of the Select Committee Appointed to Consider and Report upon the Vaccination Bill (Cape Town: Saul Solomon and Co., June 1859).
7. Between 1856 and 1858, for example, records identify the troop ship Eveline with nineteen cases of smallpox on board, the steamer Baltic with yellow fever, and several other ships in Table Bay continually bringing both of these and measles to the Cape Colony. See for example Colonial Medical Committee (CMC) to Colonial Secretary, 18 September 1856, 11 May 1857, 1 March 1858, and 8 March 1858, CA MC29.
8. These figures were compiled from the Cape of Good Hope Blue Book from 1850 to 1859. Ships importing goods and those in ballast were counted together, as the cargo did not matter so much as the crew for the transmission of disease. When ships arriving from Mauritius did not come in second to England, they were a close third behind England and Madras/Calcutta.
9. CMC to Colonial Secretary, 9 May 1856, CA MC29. The CMC rejected the Cape Town Municipality’s proposal, suggesting the presence of smallpox in Mauritius did not justify such drastic measures.
11. Kay’s observations reinforce Moodie’s: ‘It is said that they buried their dead in former times; but this must have been many generations back’ (Kay 1833:193); as does Alberti’s account: ‘Some years ago small-pox which is otherwise rare among these Kaffirs was spread amongst them, probably by the crew of a stranded vessel and according to their accounts, many people perished at the time. One still sees some Kaffirs who show the marks of this disease’ (Alberti 1810:42–43); as well as Maclean’s: ‘Though the Kafirs have a great repugnance to touch a dead body, particularly when disease has been the cause of death, those who touch or bury the body are not considered unclean, and undergo no purification’ (Maclean 1855:124).
12. Stretch to Hudson, 7 September 1841, CA LG400.
13. The pupil first describes an eclipse on 1 August 1860, and then refers to the previous eclipse in the time of Nongqawuse. Comparing this with data on lunar eclipses confirms the first observation and suggests the second occurred on 13 October 1856.
14. FitzGerald to Secretary to His Excellency the High Commissioner, 13 April 1856, CA BK100.
15. Ibid.
16. FitzGerald to Maclean, 6 December 1856, CA BK100.
18. FitzGerald to Ayliff, 1 April 1856, CA BK100; FitzGerald to Ayliff, 3 April 1856, CA BK100.
19. FitzGerald to Maclean, 2 May 1856, CA BK100. The government heeded this warning; see Robinson to Maclean, 15 May 1856, CA BK1.
20. FitzGerald to Ayliff, 1 April 1856, CA BK100; FitzGerald to Ayliff, 3 April 1856, CA BK100.
21. Ayliff later reported to Grey that, after receiving FitzGerald’s rebuke for distributing the circular, that ‘owing to a delay in the transmission of a mail, the notices were still in King William’s Town, [and] I withdrew them and retain them for His Excellency’s farther instructions’. Grey replied, ‘The vaccine matter has already been sent . . . When Dr. Fitzgerald is prepared, the notices can be issued.’ Ayliff to His Excellency the High Commissioner, Schedule of Documents, 17 April 1856, CA GH8/28. They were distributed later, along with an accompanying note from the doctor.
22. FitzGerald to Interpreter to His Excellency the High Commissioner, 14 April 1856, CA BK100.
23. FitzGerald to Ayliff, 27 April 1856, FitzGerald letterbook, Amathole Museum, King William’s Town.
24. FitzGerald to Interpreter to His Excellency the High Commissioner, 14 April 1856, CA BK100.
25. John FitzGerald to John Ayliff, 27 April 1856, CA BK100.
26. Ayliff to Grey, 30 May 1856, NLSA MSB 223 1(5).
27. FitzGerald to Interpreter to His Excellency the High Commissioner, 14 April 1856, CA BK100.
28. FitzGerald to Secretary of His Excellency the High Commissioner, 7 May 1856, CA BK100.
29. FitzGerald to the Chief Commissioner, 18 November 1858, FitzGerald notebook typescript, CL PR3624.
30. Andreas (2005) has revised Peires’s figures.
31. Stretch to Hudson, 7 September 1841, CA LG400.
32. FitzGerald to Maclean, 6 December 1856, CA BK100.
33. ‘Circular to officers, interpreters and servants attached to the medical department of British Kaffraria’, FitzGerald to Maclean, 3 December 1856, CA BK100.
34. FitzGerald to Maclean, 16 December 1856, CA BK100.
35. It is probably not coincidental that the death of Namba Maqoma in 1862, mentioned earlier in this article, would be attributed to two persons using ‘small-pox and bewitching wood’, aiming to destroy his family.
36. FitzGerald to Maclean, 6 December 1856, CA BK100.
37. Hospital Dispensary Logbook, CA HGK6/1. Totals for December 1856 through October 1857 are not available. FitzGerald categorised each visitor as ‘Kaffir’ (Xhosa), ‘Fingo’ (Mfengu), or ‘Hottentot’ (Khoi). These categories are of course subjective, exemplified by an occasional patient scratched out as one race and identified as another, but the general pattern is reliable for comparative purposes.
38. FitzGerald to Maclean, 11 December 1856, CA BK100.
39. FitzGerald to Chief Commissioner, 11 December 1856, FitzGerald notebook typescript, CL PR3624.
40. Campbell to Maclean, 29 July 1859, FitzGerald notebook typescript, CL PR3624.
41. Campbell to Maclean, 29 July 1859, FitzGerald notebook typescript, CL PR3624.
48. FitzGerald to the Chief Commissioner, 8 December 1858, FitzGerald notebook typescript, CL PR3624.
49. This was by no means unique to South Africa. In England, ‘[w]orking people were anguished at the thought of mingling the blood of their children with that of common paupers’ (Allen 2007:65).
50. Egan to FitzGerald, 1 May 1858, FitzGerald notebook typescript, CL PR3624. Dr Peters also remarked that he ‘found the natives anxious for advice . . . and in their desire to procure the benefit of vaccination for themselves and children’, Peters to FitzGerald, 4 May 1858, FitzGerald notebook typescript, CL PR3624.
51. James Peters to the Chief Commissioner, 20 April 1859, FitzGerald notebook typescript, CL PR3624.
52. Kayser to Maclean, 16 August 1859, CA BK85.
53. FitzGerald to Maclean, 30 December 1859, FitzGerald notebook typescript, CL PR3624.

References


