

**Divided Facilities: Early Cottage Hospitals and the Provision of  
Health Care Services in Natal, 1880-1910**

**BY**

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**COLLEGE OF HUMANITIES**  
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## **ABSTRACT**

### **Divided Facilities: Early Cottage Hospitals and the Provision of Health Care Services in Natal, 1880-1910**

This dissertation investigates the history of the introductory of the cottage hospital system in the colony of Natal. This thesis examines the history of three cottage hospitals that were erected in Natal from the late 1880s to 1910, namely; Umsinga (1889), Newcastle (1901) and Dundee (1903). This thesis examines the reasons behind the formation of these public health care facilities and how they worked. Furthermore, this study considers the contributions made by these cottage hospitals in the magisterial districts where they were erected. Initially, these cottage hospitals were located in small villages that were fully funded by the colonial government, but in later years were also built in more urbanised areas. Similar to other institutions, these cottage hospitals were not immune from inequalities that were associated with race. This research also considers whether or not these cottage hospitals were used as tools or instruments of empire by the British. Finally, this study also investigates the decline of the cottage hospital system in Natal in 1910, including the effect the formation of the Union of South Africa had on these health care institutions.

## **DEDICATION**

This Master's thesis is dedicated to my grandmother, Mrs. G. M. Ngubane (Maxasibe), who took up the role of being a mother to me after the passing of my mother when I was only 5 years old. Her love, prayers, support and motivation have kept me inspired, even in difficult moments. All credit for my achievements should go to you. *Ngiyabonga!* Further, I humbly dedicate this thesis to my children, Aphile and Esihle Ngubane. Your presence in my life has kept me inspired. I love you.

## **ACKNOWLEDGEMENTS**

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## **ACRONYMS AND ABBREVIATIONS**

AGO	Attorney General's Office
CH	Cottage Hospital
CNC	Chief Native Commissioner
CSO	Colonial Secretary Office
DPH	Department of Public Health
II	Indian Immigration
MJPW	Minister of Justice and Public Works
MO	Medical Officer
NT	National Treasury
PWD	Public Works Department
SGO	Survey Generals' Office
SNA	Secretary of Native Affairs
TP	Town Clerk Pietermaritzburg

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## CHAPTER ONE

### Introduction

This thesis will investigate the development, operation and impact of three cottage hospitals in the colony of Natal between the 1880s and 1910. It will also examine the role played by these cottage hospitals as instruments facilitating British colonisation. Numerous scholars have examined how the British colonised many regions around the world between the 1600s and 1800s.<sup>1</sup> While the British certainly took with them their cultural ideas, particularly their beliefs about British cultural superiority, they also took with them technologies and practices that greatly influenced the populations they colonised.

The British first arrived in what is today the region of KwaZulu-Natal in 1824, a couple of decades after its occupation and formal colonisation of the Cape.<sup>2</sup> An important reason for the eventual British colonisation of this region was the arrival of the Voortrekkers in Natal in 1837.<sup>3</sup> The Voortrekkers were descendants of the Dutch, who had established an imperial presence in the Cape since the mid-1600s. After the British defeated the Dutch and formally colonised the Cape in the early 1800s, Voortrekkers, hoping to escape British rule, began leaving the Cape. When they arrived in Natal in the late 1830s, went to war with the Zulu kingdom in 1838 and starting creating an independent Republic of Natalia, the British called for the colonisation of this region too. They had come to see Natal as a place with commercial possibilities, because of its harbour, and its strategic location on route to India.<sup>4</sup> In May 1838, the Governor of the Cape Colony, Sir George Napier, called for the military

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<sup>1</sup> See for example, C.A. Bayly. *Indian Society and the Making of the British Empire*. (New York: Cambridge University Press, 1987) 130-156; David Armitage. *The Ideological Origins of the British Empire*. (New York: Cambridge University Press, 2000) 116-138 and Kenneth Morgan. *Slavery and the British Empire: From Africa to America*. (New York: Cambridge University Press, 2007) 50-88.

<sup>2</sup> David Welsh. *The Roots of Segregation: Native Policy in Colonial Natal 1845-1910*. (Cape Town, and New York: Oxford University Press, 1971) 15-32 and Edgar H. Brookes. *The History of Native Policy in South Africa from 1830 to the Present Day*. (Pretoria: J.L. van Schaik, 1927).

<sup>3</sup> Welsh, *The Roots of Segregation*, 6.

<sup>4</sup> Charles Ballard. "Traders, Trekkers and Colonists". *Natal and Zululand from Earliest Times to 1910: A New History*. Andrew Duminy and Bill Guest eds. (Pietermaritzburg: University of Natal Press, 1989) 121-126.



occupation of Port Natal.<sup>5</sup> In June 1840, Lord John Russell, the Colonial Secretary authorised Napier to formally colonise Port Natal, which led to several battles in Natal between the British and the Boers and took a few years to finalise. When British forces were able to outnumber and defeat the Boers, the British were eventually able to formally annex Natal on 31 May 1844.<sup>6</sup>

During this early stage of colonisation, Africans living in Natal depended on traditional methods of healing for their health care needs. These were provided by the services of *Izangoma* (diviners) and *izinyanga* (herbalists) who used various plant and animal body parts to make medicines to help those who were sick. When European doctors started arriving in the region, they viewed these methods of healing as inferior due to their lack of scientific basis and concerns that these experimentally untested methods of treatment would poison or overdose those that they tried to treat. In later years when the services of biomedical European healers spread across Natal, African healers were also viewed as a threat because most Africans in Natal continued using so-called “traditional” methods as their primary source of healing and those who did consult a European doctor usually did so only as a last resort.<sup>7</sup>

In their quest to build their colony and spread their civilization in Natal the British introduced several institutions. An important set of institutions, which I will focus on in this thesis, was the cottage hospital system. In the late 1880s these small government funded facilities came to operate alongside a few mission dispensaries or clinics which were funded

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<sup>5</sup> Welsh, *The Roots of Segregation*, 7.

<sup>6</sup> Welsh, *The Roots of Segregation*, 8-10 and E.H. Brookes and C.de B. Webb. *A History of Natal*. (Pietermaritzburg: University of Natal Press, 1965) 52.

<sup>7</sup> Anne Digby. *Diversity and Division in Medicine: Health Care in South Africa from the 1800s*. (Oxford and Berne: Peter Lang, 2006) 279-283.

by various church bodies and aimed at spreading Christianity and winning the souls and minds of Africans.<sup>8</sup>

The idea of cottage hospitals was first developed and used in Britain before it expanded to other parts of the world. In 1858, Dr Albert Napier built the first cottage hospital in Cranleigh, England.<sup>9</sup> Cranleigh was a rural village in the county of Surrey, southeast of London. According to Spencer Thomson in his book, *Nurses and Cottage Hospitals for the Sick Poor*, a cottage hospital was a small building or house that was used as a hospital without major alterations having been made to it.<sup>10</sup> Indeed, it was usually a detached house, with two or three separate rooms and just a few beds, which were used for the care of the sick.<sup>11</sup> The main aim of the cottage hospital, such as Cranleigh, was to serve patients in this rural area, particularly poorer patients, who found it difficult to pay for transport to hospitals in larger towns. Many cottage hospitals were built in the UK, particularly in rural communities, during the late nineteenth century. Steven Cherry has argued that there were approximately 148 cottage hospitals in operation in Britain by 1875.<sup>12</sup>

Typically, during this period, medical men living in small rural villages founded cottage hospitals. Usually, a doctor or small group of doctors worked with a team of other people, such as a treasurer, and secretary, constituted a committee. This committee took measures to secure a suitable property for a cottage hospital and was responsible for drawing up the rules of operation and collection of fees.<sup>13</sup> The doctor appointed in charge of the day-

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<sup>8</sup> See for example, David Hardiman. "The Mission Hospital, 1880-1960" and Helen Sweet, "Expectations, Encounters and Ecclesiastics: Mission Medicine in Zululand, South Africa" both in *From Western Medicine to Global Medicine: The Hospital beyond the West*. Mark Harrison, Margaret Jones and Helen Sweet eds. (New Delhi: Orient Blackswan, 2009), 198-220, 330-359.

<sup>9</sup> Steven Cherry. "Change and Continuity in Cottage Hospitals c.1859-1948". *Medical History*. (1992, 36) 271-272.

<sup>10</sup> Spencer Thomson. *Nurses and Cottage Hospitals for the Sick Poor*. (Grangewood Lodge: Burton-on-Trent, 1854) 1019.

<sup>11</sup> Thomson, *Nurses and Cottage Hospitals for the Sick Poor*, 1019-1021.

<sup>12</sup> Cherry, "Change and Continuity in Cottage Hospitals", 273.

<sup>13</sup> Horace Swete. *Handy Book of Cottage Hospitals*. (London: Hamilton, Adams and Co., 1878) 68.

to-day running of the hospital was called the medical director or the manager.<sup>14</sup> During the 1800s, the cottage hospital system allowed general practitioners within an area to practice privately (e.g. to do house calls), but also to attend to patients that they admitted to the cottage hospital for more serious conditions. Moreover, working at the hospital helped local GPs to earn extra fees when they assisted with casualties affecting patients unknown to them who were brought into these institutions because of accidents, for example.<sup>15</sup>

Generally, a medical director, part time general practitioners (GPs), and a nurse or two staffed each cottage hospital.<sup>16</sup> The director/manager, in consultation with the patient's GP, usually approved the admission of a patient into this facility. This enabled patients to receive institutional care from their own doctors.<sup>17</sup> Furthermore, this system was advantageous as it enabled patients to get assistance in times of emergency, when their own doctors might not have been available to assist them.<sup>18</sup>

Services were not usually free. Although fees were kept low because of donations provided by wealthy philanthropists, patients were still expected to pay for the services provided, but according to their means. Another way in which cottage hospitals were funded were through payments made by wealthy landlords and other employers of labourers who paid for the services rendered to their poverty-stricken tenants or workers who either lived on their land, or worked for them.<sup>19</sup>

Because of Britain's empire-building activities overseas, by the late nineteenth century, it spread its cottage hospital model to many of its colonies. From the 1880s, this included its Natal colony. Several decades after colonising Natal, the British colonial

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<sup>14</sup> Swete, *Handy Book of Cottage Hospitals for the Sick Poor*, 68.

<sup>15</sup> Cherry, "Change and Continuity in Cottage Hospitals", 271.

<sup>16</sup> Swete, *Handy Book of Cottage Hospitals*, 69-70.

<sup>17</sup> Swete, *Handy Book of Cottage Hospitals*, 71.

<sup>18</sup> Cherry, "Change and Continuity in Cottage Hospitals", 273-274 and Swete, *Handy Book of Cottage Hospitals*, 69.

<sup>19</sup> Cherry, "Change and Continuity in Cottage Hospitals", 275-276 and Swete, *Handy Book of Cottage Hospitals*, 66.

government opened several cottage hospitals in a number of its Natal magisterial districts, to provide biomedical services in little serviced areas.<sup>20</sup> Unlike in Britain, these Natal cottage hospitals developed as government funded institutions. A Medical Officer, who often acted as a District Surgeon of a particular magisterial district too, as well as a nurse and a couple of non-medical staff, responsible for cleaning or domestic duties, staffed these cottage hospitals. In the colonial context, these cottage hospitals were created on a racially segregated basis. Several cottage hospitals were built in Natal by the colonial government between the mid-1880s and 1910.<sup>21</sup>

### **Aims and Objectives of this Thesis**

This thesis will investigate the establishment, operation and impact of three cottage hospitals in the colony of Natal between the 1880s and 1910: Umsinga (1889), Newcastle (1901), and Dundee (1903). I chose these cottage hospitals because I wanted to investigate cottage hospital services that were provided – if not throughout their histories, then at least initially – for black patients in Natal. Initially, these three cottage hospitals were established for black patients, particularly Africans and people of Indian descent, and were thus created on a racially segregated basis, separate from white health care services in these areas.

Umsinga served African patients, while Newcastle and Dundee served both African and Indian patients. These hospitals were also chosen as they were created to serve populations living in rural communities (e.g. Umsinga) and more urbanised populations (e.g. Newcastle and Dundee) to try to bring in a comparative element. This thesis will stop in the Union

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<sup>20</sup> Pietermaritzburg Archives Repository (hereafter PAR), Colonial Secretary Office (hereafter CSO) Vol 1735 Ref 1903/6274 Minute Paper from the Colonial Secretary to Dr. Ernest Hill (Health Officer for the Colony of Natal), re “Request for Report from the Health Officer for the Colony to determine whether Cottage Hospitals should be Established in Certain Villages”, 2 May 1903.

<sup>21</sup> PAR Secretary of Native Affairs (hereafter SNA) Vol 1/1/184/ Ref 1310/1894 Minute Paper from Henry F. Fynn (Resident Magistrate of Umsinga) to Mr. C. John Bird (Principal Under-secretary), re “The Establishment of a ‘Native’ Cottage Hospital as the Seat of each Magistrate”, 2 May 1894.

period (1910) as it brought significant changes to the new country of South Africa's public health care system and resulted in the collapse of the British funded cottage hospital system.

The following are key questions that will frame this thesis:

1. What was a cottage hospital in the context of the colony of Natal?
2. Why and by whom were cottage hospitals erected in Natal in the late nineteenth and early twentieth centuries?
3. How did they differ to other health care services available at the time in the colony?
4. What role did "race" play in the provision of cottage hospital services?
5. What impact did cottage hospitals have on the provision of health care services in colonial Natal?

Although there has been much research done on Christian missionary provisions of early health care services for blacks<sup>22</sup> particularly in rural areas in South Africa, there has been less focus on early government service provisions. Indeed, some historians have made the case that the colonial and early segregationist governments provided inadequate public health care services, particularly for black communities living in rural areas, which were, for many decades, essentially left in the hands of Christian missionary doctors and nurses.<sup>23</sup> I would like to investigate whether this was the case and whether a study of the colonial government's cottage hospital system can change or at least qualify this perspective.

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<sup>22</sup> The use of racial classifications has been contested in South Africa because of this country's history of racial discrimination against people who were not classified as white. These racial classifications have also changed over time. Although terms such as 'non-European' or 'non-white' were in common use during the colonial period to refer to persons who were not white, I will use the more socially acceptable term today, which is 'black', to refer to such persons. Furthermore, in the past, terms such as 'Natives' and 'Asians' were commonly used to refer to groups of people who are today referred to in common usage as 'Africans' and 'Indians'. The terms African and Indian will be used to discuss these groups of people, unless quoting from original documents produced in the colonial era.

<sup>23</sup> See for example, Michael Gelfand. *Christian Doctor and Nurse: The History of Medical Missions in South Africa from 1799-1976*. (Sandton, RSA: Aitken Family and Friends, 1984) and Digby, *Diversity and Division in Medicine*, chapters 2 and 3.

This thesis also aims to explore whether the cottage hospital system served as a tool of empire in Britain's Natal colony. Historically, the British used different techniques or approaches in order to establish its imperial presence or to build a more formal system of colonial rule overseas.<sup>24</sup> The use of biomedicine was one such tool. This is because on some occasions, biomedical health care providers were able to provide effective treatments, such as treatment for malaria that allowed colonizing agents to enter a disease-ridden area or to treat disease outbreaks that could have hindered colony-building activities. This thesis will examine whether such a perspective can be promoted for the colonial Natal or whether the cottage hospital system had little impact, and thus did not play a significant role in Britain's imperial project in Natal.

Another major issue to be analysed is the role that "race" played in provision of health care services in colonial Natal. Did the issue of racial inequality play a significant role in ensuring divided facilities within the public health care sector? Related to this issue I would like to explore whether these colonial era race policies affecting public health care services provided a blueprint moving forward into the Union of South Africa period.

### **Limitations of this Study**

This thesis only investigates three cottage hospitals, even though within the colony of Natal, there were fifteen cottage hospitals that were erected by the colonial government. I have done this due to the larger number of sources available on these three cottage hospitals in the Pietermaritzburg provincial archives, which allowed me to conduct an in-depth, qualitative study. Another limitation of this study is that it focuses on cottage hospitals that treated black (i.e. Africans and Indians) patients. I did this deliberately as I wanted to explore whether racial segregation negatively affected the quality of health care services provided for

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<sup>24</sup> Daniel R. Headrick. *The Tools of Empire: Technology and European Imperialism in the Nineteenth Century*. (New York: Oxford University Press, 1981). 116-179.

black patients in the colony of Natal. A few months after its creation, Dundee cottage hospital was converted into a whites-only hospital in 1904, so some comparative aspects of the services provided for black and white patients in cottage hospitals will be analysed when considering this cottage hospital example. Finally, because of reliance on colonial government archival sources this thesis is skewed towards analysis of government officials' (e.g. Resident Magistrates) and hospital employees' (particularly the Medical Officer-in-charge) perspectives on the establishment and operational aspects of these hospitals. Due to the period of this study, I was not able to investigate other voices, such as those of patients or other lower level hospital employees because of lack of oral sources.

## Literature Review

Several scholars have done research on the cottage hospital system in a broader international context. Scholars such as Henry C. Burdett, Spencer Thomson, Steven Cherry and Horace Swete have studied the origins, structure, funding and the management of cottage hospitals in England in the nineteenth century. The work produced by Henry Burdett is a general study that provides analysis of cottage hospitals that were established in different parts of England, namely: Cranleigh (1859), Wrington (1864) and King's Sutton (1866).<sup>25</sup> This book is important as it provides a historical analysis of the cottage hospital system in its country of origin, and provides insights into how these cottage hospitals operated as institutions in the communities they served. Burdett highlights how these hospitals offered general and emergency health care services to patients.<sup>26</sup>

Horace Swete's book, *Handy Book of Cottage Hospitals*, was published in the 1870s. Written as an instructional type of manual, it gave people advice about the founding, management, staffing and equipping of cottage hospitals. Swete argued that in England,

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<sup>25</sup> Henry C. Burdett. *Cottage Hospitals, General, Fever, and Convalescent*. (London: The Scientific Press, 1896) 6-13.

<sup>26</sup> Burdett, *Cottage Hospitals*, 120.

cottage hospitals were non-governmental institutions that did not have stable funds.

Reviewing the situation of cottage hospitals already established in England at the time, he noted that these hospitals did not have adequate facilities or staff and that the staff was under paid. This was because patients paid according to their means, which meant no fixed hospital fee that those running these hospitals could depend upon. Swete also showed how regardless of the difficulties, these hospitals continued to have a large number of patients.<sup>27</sup>

Steven Cherry also investigates the establishment of early cottage hospitals in different regions of England in the 1850s. In his article “Change and Continuity in Cottage Hospitals”, Cherry looked at the changing nature of cottage hospitals from those that were established in the mid-nineteenth century to those established in the early twentieth century. In his book, he examined changes related to their funding, management and the types of health care services offered to their patients.<sup>28</sup>

Other scholars, such as Bryan Gondevia, Mark Harrison, Anna Greenwood and Henry Burdett also discuss how the cottage hospital system spread to various parts of the world, including Ireland, North America, Australia, India and Africa as a result of British imperialism. Cottage hospitals were introduced to the indigenous populations of these various colonies as a part of Britain’s “civilization” drive and to spread western biomedicine through provision of public health care services. These cottage hospitals developed differently from those in Britain. This was because, in many of these regions, they were used by British colonisers as instruments to help spread western forms of biomedicine, and were state owned and funded institutions.<sup>29</sup>

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<sup>27</sup> Swete, *Handy Book of Cottage Hospitals*, 66-82 and Burdett, *Cottage Hospitals*, 20-25.

<sup>28</sup> Cherry, “Change and Continuity in Cottage Hospitals”, 272-276.

<sup>29</sup> Bryan Gondevia. “The Pattern of Australian Medical History”. *Journal of the Royal Society of Medicine*. (1957, 50:8) 591-597; Mark Harrison. *Public Health and Medicine in British India: Anglo-India Preventative Medicine in 1859-1914*. (New York: Cambridge University Press, 1994) 151-160; and Anna Greenwood. *Beyond the State: The Colonial Medical Services in British Africa*. (Manchester: Manchester University Press, 2016) 39-50.



When reviewing literature on the region of South Africa, one finds that scholars have done much research on a variety of medical history subjects. This is particularly the case for the twentieth century. For example, one finds much written on subjects such as Christian medical missionaries;<sup>30</sup> medical institutions such as hospitals, clinics and schools;<sup>31</sup> histories of different health care providers, such as of the training and work difficulties of nurses,<sup>32</sup> doctors,<sup>33</sup> and other types of health care workers;<sup>34</sup> the development of experimental public health care services;<sup>35</sup> histories of particular diseases and their impacts;<sup>36</sup> and surveys of healthcare services provide in particular cities.<sup>37</sup>

Closer to my subject matter, it is also important to note that other scholars have done research on medical history subjects that focus on the nineteenth century period. Here we find works, such as those on general early histories of the establishment of biomedical

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<sup>30</sup> Other than Gelfand, *Christian Doctor and Nurse* and Digby, "Missionary Medicine" in *Diversity and Division in Medicine*, see for example, Sweet, "Expectations, Encounters and Ecclesiastics: Mission Medicine in Zululand: South Africa" in *From Western Medicine to Global Medicine*, 330-359 and John L. and Jean Comaroff. "The Medicine of God's Word". *Of Revelation and Revolution: The Dialectics of Modernity on a South African Frontier*. Volume 2. (Chicago and London: University of Chicago Press, 1997) 323-364.

<sup>31</sup> Anne Digby and Howard Phillips. *At the Heart of Healing: Groote Schuur Hospital, 1938-2008*. (Auckland Park, RSA: Jacana, 2008) 169-180; Vanessa Noble. *A School of Struggle: Durban's Medical School and the Education of Black Doctors in South Africa*. (Pietermaritzburg: University of KwaZulu-Natal Press, 2013) 25-26 and Simonne Horwitz. *Baragwanath Hospital, Soweto*. (Johannesburg: Wits University Press, 2013) 3.

<sup>32</sup> Shula Marks. *Divided Sisterhood. Race, Class and Gender in the South African Nursing Profession*. (Johannesburg: University of Witwatersrand Press, 1994) 204; T.G. Mashaba, *Rising to the Challenge of Change: A History of Black Nursing in South Africa*. (Cape Town: Juta, 1995); and Anne Digby and Helen Sweet. "Nurses as Culture Brokers in Twentieth-Century South Africa". *Plural Medicine, Tradition and Modernity, 1800-2000*. W. Ernst ed. (London: Routledge, 2000) 113-29.

<sup>33</sup> Anne Digby. "Early Black Doctors in South Africa". *Journal of African History*. (2005, 46:3) 427-54; Noble, *A School Struggle*; and Karen Flint. *Healing Traditions: African Medicine, Cultural Exchange and Competition in South Africa*. (Athens, OH: Ohio University Press and Pietermaritzburg: University of Natal Press, 2008).

<sup>34</sup> Karin A. Shapiro. "Doctors or Medical Aids: The Debate over the Training of Black Medical Personnel for the Rural Black Population in South Africa in the 1920s and 1930s". *Journal of Southern Africa Studies*. (1987, 13:2) 234.

<sup>35</sup> Shula Marks. "South Africa's Early Experiment in Social Medicine: Its Pioneers and Politics". *American Journal of Public Health*. (1997, 3) 452-457.

<sup>36</sup> John Iliffe. *The African AIDS Epidemic: A History*. (Athens: Ohio University Press, 2006); Howard Phillips. *Plague, Pox and Pandemics*. (Auckland Park, RSA: Jacana, 2012) and Randall M. Packard. *White Plague, Black Labour: Tuberculosis and the Political Economy of Health and Diseases in South Africa*. (Berkeley: University of California Press, 1989).

<sup>37</sup> Julie Dyer. *Health in Pietermaritzburg (1838-2008): A History of Urbanisation and Disease in an African City*. (Pietermaritzburg: Natal Society Foundation, 2012).

institutions and practitioners in the region that would become South Africa;<sup>38</sup> early public health care initiatives, particularly linked to the spread of infectious diseases;<sup>39</sup> the early establishment of Christian missionary clinics and hospitals;<sup>40</sup> the establishment of psychiatric hospital services in South Africa;<sup>41</sup> problems such as racial and gender divisions that plagued the setup and running of early health care services;<sup>42</sup> histories of indigenous healing,<sup>43</sup> and histories of cultural borrowings that have taken place between different healers and their patients/clients.<sup>44</sup> However, despite reading a number of books and articles on the nineteenth century period for the region of South Africa, I have not found much written on the cottage hospital system. Indeed, when something is mentioned about these hospitals, it is usually done in passing or only briefly.

One such book is that written by Edmund Burrows. In his significant early publication on medical historical developments in the pre-Union South Africa region titled, *A History of Medicine in South Africa up to the End of Nineteenth Century*, Burrows provides a history of early public health care developments in Natal. In a brief section of his book, Burrows tells his reader that cottage hospitals were established in a few rural villages or small towns, such as Newcastle, Umsinga (Pomeroy) and Stanger between the 1880s and early 1900s.<sup>45</sup> For example, he discusses how Stanger's cottage hospital was built exclusively for Indians to reduce the high mortality and morbidity rates, especially among indentured workers, and was

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<sup>38</sup> See for example, Edmund H. Burrows. *A History of Medicine in South Africa up to the End of the Nineteenth Century*. (Cape Town and Amsterdam: A.A. Balkema, 1958) and Percy W. Laidler and Michael Gelfand. *South Africa: Its Medical History, 1652-1898*. (Cape Town: Struik, 1971).

<sup>39</sup> See for example, Marcia Wright. "Public Health among the Lineaments of Colonial Natal, 1901-1910". *Journal of Natal and Zulu History*. (2006-2007, 24:25) 138-150; and Maynard Swanson. "The Sanitation Syndrome. Bubonic Plague and Urban Native Policy in the Cape Colony 1900-1909". *Journal of African History*. (1977, 18:3), 387-410.

<sup>40</sup> See again the book by Gelfand, *Christian Doctor and Nurse*.

<sup>41</sup> Julie Parle. *States of Mind: Searching for Mental Health in Natal and Zululand, 1868-1918*. (Pietermaritzburg: University of KwaZulu-Natal Press, 2006) 39-41.

<sup>42</sup> Digby, *Diversity and Division in Medicine*, 279-283.

<sup>43</sup> Harriet Ngubane. *Body and Mind in Zulu Medicine: An Ethnography of Health and Diseases in Nyuswa-Zulu Thoughts and Practice*. (London: Academic Press, 1977) 23-33.

<sup>44</sup> Flint, *Healing Traditions*, 40-100 and Karen Flint. "Indian-African Encounters: Polyculturalism and African Therapeutics in Natal, South Africa, 1886-1950s". *Journal of Southern African Studies*. (2006, 32:2) 367-385.

<sup>45</sup> Burrows, *A History of Medicine in South Africa*, 222-223.

controlled by the Indian Immigration Trust Board. In addition, he briefly discusses how the cottage hospital established for Africans at Umsinga aimed to substitute a western type of healing for indigenous healing approaches, or what European colonisers called “witchcraft”.<sup>46</sup>

Similar points were made in brief by Percy W. Laidler and Michael Gelfand in their book *South Africa: Its Medical History 1652-1898*. This book outlines how cottage hospitals were created as “agents of civilisation”, particularly to combat the influence of “witchcraft”.<sup>47</sup> In addition, Burrows considers the role played by missionaries in the field of medical institutional care, especially the contributions made by American Board missionaries.<sup>48</sup> He highlighted the role played by the first biomedically-trained African, Dr Nembula, who was appointed as District Surgeon of the cottage hospital in Umsinga in 1889 (which I will speak more about in a later chapter).<sup>49</sup> This book also contributed to my project because it provided a helpful outline of the development of health services in Natal in the nineteenth century.

Michael Gelfand’s book *Christian Doctor and Nurse* examines the part played by mission hospitals in providing early biomedical care in Natal. It also discusses the role of the mission cottage hospital that was established by American Board Mission doctor, James B. McCord. Gelfand argues that after Dr Burt Bridgeman resigned as a doctor at Adams Mission Station (south of Durban) due to his wife’s ill health, Dr McCord was appointed by the American Board Mission in 1899 to replace him.<sup>50</sup> However, due to limited transport and difficulties experienced by patients in terms of accessing this rural south coast based Adams Mission Station, McCord decided to move his practice to the larger town of Durban in 1904. There McCord rented an old building for \$40 a month and created a small cottage hospital where he admitted maternity and serious cases requiring surgery or extended care.<sup>51</sup> This

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<sup>46</sup> Burrows, *A History of Medicine in South Africa*, 222.

<sup>47</sup> Laidler and Gelfand, *South Africa: Its Medical History*, 295-296.

<sup>48</sup> Burrows, *A History of Medicine in South Africa*, 223.

<sup>49</sup> Burrows, *A History of Medicine in South Africa*, 224-225.

<sup>50</sup> Gelfand, *Christian Doctor and Nurse*, 104-105.

<sup>51</sup> Gelfand, *Christian Doctor and Nurse*, 106-108.

cottage hospital was 24 feet square in size and it could hold up to 12 patients.<sup>52</sup> It was staffed by McCord who was assisted by his wife Margaret, who helped as his nurse and operating assistant, as well as male and female assistants, such as Katie Makanya, who became an important interpreter and nurse aide.<sup>53</sup>

According to Gelfand, the McCord's cottage hospital was understaffed and due to this, it allowed relatives and friends to prepare and bring food for their patients.<sup>54</sup> At this institution, Dr McCord's assistant, Umqibelo, was given the duty to preach every morning, and he also quoted verses from the Bible. The aim was to try to win the souls of new patients by gaining more converts.<sup>55</sup> Gelfand also discussed the pressures on this small cottage hospital caused over time by the increased number of patients. This eventually forced McCord to search for an alternative location to build a bigger hospital. This was achieved when a piece of land, high on the Berea (then on the outskirts of the town of Durban) was bought for this purpose. In 1909, a Mission Nursing Home was opened and all patients at his little cottage hospital were transferred to this newly erected, larger, hospital, which could no longer be classified, because of its size, as a cottage hospital.<sup>56</sup> This example highlights how cottage hospitals were not exclusively state funded or operated institutions in colonial Natal.

Marcia Wright's article, "Public Health among the Lineaments of the Colonial State in Natal, 1901-1910", seeks to outline the medical care services that were established for indentured Indians in the colony of Natal. The Indian Immigration Trust Board was established in 1874 because of the high number of Indian immigrants to the colony. Although more will be discussed on this issue in the next chapter, Wright argues that after the Wragg Commission of 1875, the Natal colonial government erected several cottage hospitals in

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<sup>52</sup> Gelfand, *Christian Doctor and Nurse*, 108.

<sup>53</sup> James B. McCord and John Scott Douglas. *My Patients were Zulus*. (London: Frederick Muller, 1946) 112-115. For more on the life story of Katie Makanya, see Margaret McCord. *The Calling of Katie Makanya*. (Cape Town and Johannesburg: David Philip, 1995).

<sup>54</sup> Gelfand, *Christian Doctor and Nurse*, 108.

<sup>55</sup> Gelfand, *Christian Doctor and Nurse*, 107-108.

<sup>56</sup> Gelfand, *Christian Doctor and Nurse*, 110.

different districts where large concentrations of Indians lived and worked. Furthermore, the Indian Protector and the Indian Immigration Trust Board oversaw the operation of these particular facilities.<sup>57</sup> Wright highlights how Indian Medical Officers were employed to head several of these cottage hospitals and they provided public health care services to Indians who worked as indentured labourers in the colony. The employers of the indentured Indians were responsible for the health of their workers, and thus paid for the costs of their workers if they were sick or injured.<sup>58</sup>

In this thesis, I will explore the little analysed contributions made by three cottage hospitals that were established in the colony of Natal during the period of the 1880s and 1910. There has not been much written on the work and contributions of these small cottage hospitals in colonial Natal, and my research will aim to contribute to better understanding of this early cottage hospital public health care service.

## **Theoretical Framework**

This thesis has been influenced by three theoretical approaches. Firstly, Critical Race Theory (CRT) has influenced it. CRT emerged in the mid-1970s.<sup>59</sup> Derrick Bell was the founder of the CRT movement, who was a professor of Law at New York University.<sup>60</sup> CRT emerged as a movement amongst activists and scholars in the USA, but also in regions such as Asia where activists and scholars aimed to transform the relationship amongst race, racism, and power.<sup>61</sup>

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<sup>57</sup> Wright, “Public Health among the Lineaments of the Colonial State in Natal”, 146.

<sup>58</sup> Wright, “Public Health among the Lineaments of the Colonial State in Natal”, 147.

<sup>59</sup> Richard Delgado and Jean Stefancic. *Critical Race Theory: An Introduction*. Second Edition. (London: New York University Press, 2012) 3.

<sup>60</sup> Delgado and Stefancic, *Critical Race Theory*, 5.

<sup>61</sup> Delgado and Stefancic, *Critical Race Theory*, 2.

Critical race theorists have argued that terms, such as “race” and “racism” are products of social thought and relations.<sup>62</sup> These theorists hold that “race” and “racism” are “not objective, inherent or fixed, they correspond to no genetic reality; rather races are categories that society invents, manipulates, or retires when convenient”.<sup>63</sup> Instead, these theorists argue that such concepts are socially constructed entities, and thus, products of societies. For example, critical race theorists have examined the emergence of Europe’s “Age of Reason” in the seventeenth and eighteenth centuries as important for development of ideas about “race” and “racism”. Scientific advances, overseas exploration, colonization, and slavery influenced this Enlightenment period. This led to greater experimentation, but also categorization of people, especially those who were not European, as different and inferior, based on certain physical and mental characteristics.<sup>64</sup>

Influenced by these Enlightenment ideas, Critical Race Theorists have asserted that European colonisers worked together with various institutions to shape ideas about racism, and these ideas helped the British to colonise other regions because they believed that their race and culture was superior to those of others.<sup>65</sup> Over time, racist thoughts or mentalities produced inequalities and experiences of discrimination for different people.<sup>66</sup> CRT approaches are useful as they helped me explore some of the driving ideas behind British

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<sup>62</sup> Howard Winant. “Race and Race Theory”. *Annual Review of Sociology*. (2000:26) 175.

<sup>63</sup> Delgado and Stefancic, *Critical Race Theory*, 7.

<sup>64</sup> Gay Peter. *The Enlightenment: An Interpretation and Double Consciousness*. (New York: Norton, 1969) 126-127 and Philip Curtin. *The Image of Africa: British Ideas and Action, 1780-1850*. (Madison: University of Wisconsin, 1964) 3-57.

<sup>65</sup> Delgado and Stefancic, *Critical Race Theory*, 323; Gloria Ladson-Billings. “Just What is Critical Race Theory and What’s it Doing in a Nice Field like Education”. *International Journal of Qualitative Studies in Education*. (1998, 11: 1) 8-22; William F. Tate IV. “Critical Race Theory and Education: History, Theory, and Implications”. *Review of Research in Education*. (1997: 22), 195-247; Les Back and John Solomos. *Theories of Race and Racism: The Reader*. (London and New York: Routledge, 2000); and Frantz Fanon. “The Fact of the Blackness”. *Theories of Race and Racism: A Reader*. Les Back, John Solomos eds. Translated by Charles Markmann. (London: Routledge, 2000) 324-338.

<sup>66</sup> Delgado and Stefancic, *Critical Race Theory*, 4-6 and Winant, “Race and Race Theory”, 175. Also see the important works of Michael Banton. *Racial Theories*. (Cambridge: Cambridge University Press, 1987) 169-200; Nancy Stepan. *The Idea of Race in Science: Great Britain 1800-1960*. (London: MacMillan Press, 1982) 105-125 and Stephen Jay Gould. “The Geometer of Race”. *The Concept of “Race” in Natural and Social Science: Essays on the Social Construction and Reproduction of “Race”*. E. Nathaniel Gates ed. (New York: Garland Publishing, 1997) 1-5.

colonialism, and helped me to consider the impact of racism in the colony of Natal's public health care system.

In addition, this thesis is influenced theoretically by the work of Michel Foucault. In his book, *The Birth of the Clinic*, Foucault explored the development and expansion of the medical profession in France in the eighteenth century.<sup>67</sup> In his analysis, Foucault coined the term "clinical gaze" which was used on patients by doctors when they entered clinical spaces. When patients entered a clinic or hospital, the doctor had the power to diagnose problems, design treatments and speak as an expert on health matters, and nobody could challenge the doctor's experience.<sup>68</sup> Foucault argued that patients were thus rendered powerless in such clinical spaces, while doctors were rendered powerful and all knowing, and as individuals who could intervene in their patients' lives.

Although Foucault explores the development of the medical profession in eighteenth century France, his theories are relevant to my research as he examines the role played by doctors employed in state clinical institutions.<sup>69</sup> He outlines how doctors played a key part in identifying and labelling "normality" and "abnormality" within population groups, as well as how they had the power to act on patients' bodies. He speaks of "disciplinary institutions" such as hospitals and clinics, which became places where doctors gained more power over the lives of their patients.<sup>70</sup> Foucault's work links well with my topic as cottage hospitals were places where patients were admitted and treated by doctors and nurses who worked for the colonial government. I would like to explore whether these institutions developed as "disciplinary institutions" in the colonial Natal context.

Finally, I have drawn on the works of scholars who have considered various "tools" that enabled the expansion of European empires in Africa, Asia and the Americas. Here the

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<sup>67</sup> Michel Foucault. *The Birth of the Clinic: An Archaeology of Medical Perception*. Translated from French by A.M Sheridan Smith. (London: Routledge, 2012) 30-32.

<sup>68</sup> Foucault, *The Birth of the Clinic*, 8, 31-50, 54-55, 89-91, 107-110.

<sup>69</sup> Foucault, *The Birth of the Clinic*, 64-107.

<sup>70</sup> Michel Foucault. *Discipline and Punish: The Birth of Prison*. (New York: Vintage books, 1994) 190-194.

works of people such as Daniel R. Headricks, Maryinez Lyons and Maynard Swanson are important. Daniel Headricks coined the phrase “Tool of Empire” with the aim of investigating methods and techniques used by Britain to enable their colonisation of Africa.<sup>71</sup> Headrick analyses how British advances in areas such as medicine and in steam transportation in the 1800s and early 1900s, for example, made the penetration of Africa by Europeans possible. He asserts that it would have been impossible for the British to take control of many regions of Africa if they had to go on foot, while without medications, such as quinine against malaria, European soldiers, missionaries, explorers and settlers would not have survived their stay on this continent.<sup>72</sup> Thus, advances made in drug technologies and transportation served as vital instruments or tools that enabled the British to build their empire overseas.<sup>73</sup> The work of Amna Khalid and Ryan Johnson “Public Health in the British Empire”, *Intermediaries, Subordinates, and the Practice of Public Health, 1850-1960* uses Headricks concept of “tool of empire” in order to explain how biomedicine and transportation helped Britain to have a greater degree of power over its colonies.<sup>74</sup>

Maynard Swanson has also investigated whether biomedicine was used as an instrument of imperial authorities in the latter 1800s in the Cape Colony when authorities faced an outbreak of bubonic plague.<sup>75</sup> In addition, Swanson considers the role played by public health care authorities, which advocated for segregationist policies as a solution to the spread of this contagious disease.<sup>76</sup> Africans were viewed by colonial authorities, doctors and Europeans as a threat because they were regarded as unhygienic, and thus carriers of diseases.<sup>77</sup> Swanson discusses how doctors encouraged the state to build racially segregated

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<sup>71</sup> Headrick, *The Tools of Empire*, 116-179.

<sup>72</sup> Headricks, *The Tools of Empire*, 75.

<sup>73</sup> Headricks, *The Tools of Empire*, 63-66, 73-74.

<sup>74</sup> Amna Khalid and Ryan Johnson. “Public Health in the British Empire”. *Intermediaries, Subordinates, and the Practice of Public Health, 1850-1960*. Amna Khalid and Ryan Johnson Eds. (New York: Routledge, 2012) 6.

<sup>75</sup> Swanson, “The Sanitation Syndrome”, 389.

<sup>76</sup> Swanson, “The Sanitation Syndrome”, 387.

<sup>77</sup> Swanson, “The Sanitation Syndrome”, 390-393.



African locations to keep Africans away from the colony's white population.<sup>78</sup> Thus, public health care policies became a tool of empire that assisted the British to segregate and control African population groups in the Cape Colony.

Other scholars have problematised biomedicine's impact. For example, Maryinez Lyons has analysed whether the rollout of particular public health policies, such as quarantine to halt the spread of sleeping sickness in the Belgian Congo and Uganda, was a tool that assisted or hindered British imperial ambitions in these colonies.<sup>79</sup> Lyons examines the spread of sleeping sickness amongst people living along the rivers of the Belgian Congo, and the measures taken by the Belgian authorities to prevent and treat the sickness. During the sleeping sickness campaign, the African population was introduced to the idea that European doctors and their medications were the solution to problems of ill health. In their quest to provide solutions, the government established camps for the isolation of the sick where they were injected with atoxyl.<sup>80</sup> Within these camps, sick individuals suffered many difficulties, namely; abusive treatment, poor living conditions, lack of food, and permanent separation from their families. Moreover, these camps were unpopular because the sick were treated like prisoners and guarded by soldiers to ensure that they did not escape.<sup>81</sup> The colonial government imposed a *cordon sanitaire*, which aimed to protect those living in non-infected regions. All travellers were screened when travelling between different regions and those already infected were not allowed to travel further.<sup>82</sup> This example also highlights the coercive nature of some governments' public health care approaches in their colonies.

David Arnold investigates the medical services that were provided by the British to the indigenous population of India and resistance by Indians towards the use of Western

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<sup>78</sup> Swanson, "The Sanitation Syndrome", 388.

<sup>79</sup> Maryinez Lyons. "Sleeping Sickness Epidemics and Public Health in the Belgian Congo". *Imperial Medicine and Indigenous Societies*. David Arnold ed. (Manchester and New York: Manchester University Press, 1988) 105-24.

<sup>80</sup> Lyons, "Sleeping Sickness and Public Health in the Belgian Congo", 105-108.

<sup>81</sup> Lyons, "Sleeping Sickness and Public Health in the Belgian Congo", 111-113.

<sup>82</sup> Lyons, "Sleeping Sickness and Public Health in the Belgian Congo", 106-108, 116.

biomedicine. This book highlights how institutions such as the army and jails were places where western biomedicine was introduced to colonial subjects. For example, when Indians joined the British army or imprisoned, when sick, they were treated with western medicines. He also examines three epidemics that occurred in India in the nineteenth century, namely smallpox, cholera and plague. Similar to Lyons, Arnold shows how fear of the spread of infectious diseases led to draconian public health care measures, including segregation between Europeans and Indians, to try to stop the spread of these diseases. Arnold argues that the nineteenth century saw the development of colonial medicine, which the British used, as a tool of empire in expanding its colonies.<sup>83</sup>

The works of Daniel R. Headrick, Maryinez Lyons and Maynard Swanson all stress that Europeans used a number of “tools” in gaining control over the African continent. Western biomedicine (e.g. quinine), religion (e.g. Christianity) and transport (e.g. steamboats and railways) made empire-building activities in European colonies possible. Of concern to these scholars is whether biomedicine enabled empire-building activities to take place successfully in different colonies or whether its influence was insignificant for a variety of reasons. This will be particularly important when considering the role that cottage hospitals played in the British imperial project in Natal.

## **Research Methods and Methodology**

This thesis has used a qualitative research design to analyse the history of three cottage hospitals. A qualitative research method involves the process of collecting, analysing and interpreting written or oral data, looking for in-depth meanings and understandings around particular issues.<sup>84</sup> It also allows the use of pre-existing data, gathered not by the

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<sup>83</sup> David Arnold. *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth Century India*. (Berkeley: University of California Press, 1993) 242-345.

<sup>84</sup> S. Taylor and Robert Bodgan. *An Introduction to Qualitative Research Methods* (New York: Willey Publishers, 1998) 183-192.

researcher only, but also by, for example, government agencies housed in archives which I will rely upon for my primary sources.

My primary sources come from the Pietermaritzburg Archive Repository, a publicly funded provincial archive that specialises in providing government and other official documentation from colonial era Natal and early twentieth century Natal. Most of my archival materials are from the Secretary of Native Affairs documents, the Chief Native Commissioner, the Attorney General's Office, the Department of Public Health, the Public Works Department, the National Treasury, the Survey General's Office, the Indian Immigration Department and Minister of Justice and Public Works documents.

Because of the large number of files on different cottage hospitals and the need to choose a smaller number of case studies to create a more focused topic, I have used the purposive sampling method for this thesis. This entailed selecting the material considered important in answering the key research questions.<sup>85</sup> I chose the three cottage hospitals, Umsinga, Dundee, and Newcastle because of the greater amount of archival material available in the archival collection on these particular cottage hospitals compared to some of the other cottage hospitals opened in the colony of Natal between the 1880s and 1910. As mentioned earlier, these cottage hospitals were also chosen because of their establishment – at least initially anyway – to serve black patients.

Scholars such as Anna Laura Stoler and Antoinette Burton have examined and provided in-depth studies of the establishment and operations of archives.<sup>86</sup> Antoinette Burton argues that there are public and private archives.<sup>87</sup> Archives are a significant source of

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<sup>85</sup> Bruce L. Berg. *Qualitative Research Methods for Social Sciences*. (Boston: Allyn & Bacon, 2009) 5-15.

<sup>86</sup> Ann Laura Stoler. "Colonial Archive and the Art of Governance: On the Content in the Form". *Refiguring the Archive*. Carolyn Hamilton, Verne Harris, Jane Taylor, Michele Pickover, Graeme Reid and Razia Saleh eds. (Cape Town: David Philip, 2002) 85 and Antoinette Burton. *Archive Stories: Facts, Fiction and the Writing of History*. (London: Duke University Press, 2005) 1-22.

<sup>87</sup> Burton, *Archive Stories*, 1-6; Carolyn Hamilton. "Living by Fluidity, Oral Histories, Material Custodies and the Politics of Archiving". *Refiguring the Archive*. Carolyn Hamilton et al eds. (Cape Town: David Philip, 2002) 209-228.

primary material for historians in pursuing their research. However, there is a need to use archival sources critically because of biases.<sup>88</sup> Although biases cannot be avoided, I will draw on post-structuralist analyses of archives to help me interrogate my sources.

In recent decades, scholars have increasingly shifted away from understanding archives as places where historians find “objective facts” or “the truth” about the past, to understanding archives as constructed entities themselves that were created by particular people, at particular moments, with particular agendas.<sup>89</sup> Historically, most archives have tended to collect and provide narratives of powerful individuals, not ordinary people. Scholars such as Achille Mbembe and Michel-Rolph have argued that archival sources, depending on their methods of collection and cataloguing often provide a limited range of perspectives on issues, and often, certainly in state archives, primarily provide the perspectives of elites e.g. government officials or those in power.<sup>90</sup> The side of non-elites often remains silenced, which can skew the focus of historical analyses.<sup>91</sup> Moreover, Foucault’s argument about power being diffuse, or “capillary-like”, or as a web influencing people’s lives at different levels links up with Trouillot’s arguments about the various levels of silencing in the production of historical narratives.<sup>92</sup> Trouillot recognises the importance of distinguishing between “what happened” and “what is said to have happened” (the “two-sides of historicity”) when doing historical research, but also the various levels of silencing that occur within documents and archives to understand that the sources historians use never come to us unfiltered in terms of biases or agendas.<sup>93</sup>

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<sup>88</sup> Achille Mbembe. “The Power of the Archive and its Limits”. *Refiguring the Archive*. Carolyn Hamilton et al eds. (Cape Town: David Philip, 2002), 19-23.

<sup>89</sup> Kevin Passmore. “Poststructuralism and History”. *Writing History Theory and Practice*. Stefan Berger and Heiko Feldner eds. (London: Arnold, 2003) 118-119.

<sup>90</sup> Mbembe, “The Power of the Archive and its Limits”, 19-23 and Michel-Rolph Trouillot. *Silencing the Past: Power and the Production of History*. (Boston: Beacon Press, 1995) 8-44.

<sup>91</sup> Passmore, “Poststructuralism and History”, 118-119 and Trouillot, *Silencing the Past*, 26.

<sup>92</sup> Trouillot, *Silencing the Past*, 26-27.

<sup>93</sup> Trouillot, *Silencing the Past*, 49.

Poststructuralists view archives as texts that need to be deconstructed and critically analysed for how and why and by whom they were made.<sup>94</sup> These scholars' critiques of archives and their sources are important for my thesis as they helped me to remain critically aware of when, why and by whom primary sources were created.<sup>95</sup> They also helped me to remain mindful of the fact that the Pietermaritzburg Archival Repository sources I have used to write this thesis were generated primarily by the colonial state, and thus present issues from a biased coloniser perspective. Attempts will also be made to fill in gaps in state archival records by using other sources, such as early newspaper sources and secondary sources.

### **Structure of this Dissertation**

This research is made up of six chapters. The present chapter – Chapter One – has provided the reader with an introduction, considered the aims and objectives of this study, considered the important literature on and around my topic, as well as provided an overview of the theoretical framework and research methodology.

Chapter Two starts by looking at the pre-cottage hospital era in the Natal colony. It analyses what health care services were available for people living in the colony from the early to mid-1800s. In addition, it considers a number of factors that led the British colonial government to establish cottage hospitals in its Natal colony from the 1880s.

Chapter Three examines the colonial government's establishment of three cottage hospitals, namely Umsinga, Newcastle and Dundee. It also analyses how racial concerns influenced the establishment of these cottage hospitals. Umsinga was opened in 1889 for African patients, followed by Newcastle in 1901 and Dundee in 1903, both of which were initially created to serve black (i.e. African and Indian) patients, though Dundee had by 1904

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<sup>94</sup> Passmore, "Poststructuralism and History," 118-119.

<sup>95</sup> Trouillot, *Silencing the Past*, 52.

switched to providing health care services for white patients only. Umsinga was created to serve a rural population, while Newcastle and Dundee were opened to serve people living in and around towns. These cottage hospitals were established in different magisterial districts in the colony of Natal.

Chapter Four investigates the operation of each of the three cottage hospitals. Through careful examination of archival sources, I analyse how each hospital was financed and managed, but also how they worked i.e. the services provided by their medical personnel and the patients they served. I will also consider whether racial inequalities and segregation affected the operation of these hospitals in the colonial period.

Chapter Five examines whether the change in political dispensation had an effect on the cottage hospital system in Natal. Of particular interest is whether the end of British colonial rule and the coming to power in 1910 of the Union of South Africa government influenced the provision of public health care services in the province of Natal.

Chapter Six concludes my thesis with a summary of important issues and themes that were examined in the thesis. It also considers the impact that these cottage hospitals had on the provision of health care services in the colony of Natal.

## CHAPTER TWO

### **The Pre-Cottage Hospital Era: Some Historical Background Leading to the Formation of Cottage Hospitals in Colonial Natal**

This chapter investigates the broader historical context of health care in the colony of Natal in the nineteenth century. The first half of this chapter analyses what health care services were available to the public before the creation of cottage hospitals in the colony of Natal. The second part considers what encouraged the government's decision to introduce the cottage hospital system in this colony from the mid-1880s. The latter half of the 1800s was a complicated period producing many overlapping factors that encouraged the colonial government to rollout cottage hospitals in a number of its magisterial districts.

As mentioned in the previous chapter the British colonised Natal in May 1844.<sup>96</sup> It formed one of two British colonies – the Cape colony being the other – in the region of what would become South Africa after 1910. In its first few decades, Natal operated in a close relationship with the Cape. Indeed, until 1893, when the colony of Natal received its own self-governing status, Natal's highest colonial official, the Lieutenant Governor, took his orders from, and reported to, the higher-ranking Governor, who was stationed in the Cape.<sup>97</sup> The colony of Natal was from the late 1840s, sub-divided into several magisterial districts. Percy Laidler and Michael Gelfand note in their book *South Africa: Its Medical History 1652-1898* that “in 1847 Natal was divided into the magistracies of Durban, Pietermaritzburg, Umvoti, Impapane (Mooi and Burus Rivers), Upper Tugela and Umzinyate or Buffalo River”.<sup>98</sup> Although the number of magisterial districts would change over time i.e. increase or

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<sup>96</sup> A.F. Hattersley. *The British Settlement of Natal: A Study in Imperial Migration*. (Cambridge: Cambridge University Press, 1950) 93-150.

<sup>97</sup> Charles Ballard. “Traders, Trekkers and Colonist”. *Natal and Zululand from Earliest Times to 1910: A New History*. Andrew Duminy and Bill Guest eds. (Pietermaritzburg: University of Natal Press, 1989) 123-125; B.J. Kline. “The Establishment of Responsible Government in Natal, 1887-1893: The Legacy of Apartheid”. *Journal of Natal and Zulu History* (1986, 9) 55-70.

<sup>98</sup> Percy W. Laidler and Michael Gelfand. *South Africa: Its Medical History 1652-1898*. (Cape Town: Struik, 1971) 319.

decrease in number depending on changing political circumstances, such as the addition of Inanda and Klip River, for example in the 1850s,<sup>99</sup> each magisterial district was given its own Resident Magistrate who was in charge of enforcing the laws of the colony.<sup>100</sup>

Within British imperial structures, Natal was regarded as less important and subordinate to the Cape Colony at this time.<sup>101</sup> As a result, the Natal colonial government received less financial support from the British government to run its affairs. Its development of the “Shepstone System” from the 1840s onward, developed as a key strategy by officials within the Natal administration to administer the colony’s African population cheaply.<sup>102</sup> In 1846, Sir Theophilus Shepstone, who was born in England and raised by missionary parents in the Cape, was appointed as “Diplomatic Agent of the Tribes” (he would later become Secretary of Native Affairs).<sup>103</sup> Shepstone developed a way to manage Africans politically, while also developing a way to exploit their untapped labour potential, which was needed for the development of Natal’s settler economy.<sup>104</sup>

During his time in office, Shepstone created the “Shepstone System”. This system involved the relocation of tens of thousands of Africans to a number of “reserves” in various parts of Natal.<sup>105</sup> African chiefs deemed loyal to the British colonial government, were tasked with ruling these regions and reported to Resident Magistrates located in or near to each “reserve”.<sup>106</sup> Other than serving as a system to manage politically the numerically dominant

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<sup>99</sup> Jeff Guy. *Theophilus Shepstone and the Forging of Natal: African Autonomy and Settler Colonialism in the Making of Traditional Authority*. (Pietermaritzburg: University of KwaZulu-Natal Press, 2013) 167-173.

<sup>100</sup> J. Forsyth Ingram. *The Colony of Natal*. (London: Sir Joseph and Sons, 1895) 26-28.

<sup>101</sup> Ballard, “Traders, Trekkers and Colonists”, 125.

<sup>102</sup> Jeff Guy. *The Destruction of the Zulu Kingdom: The Civil War in Zululand, 1879-1884*. (Pietermaritzburg: University of Natal Press, 1994) 4.

<sup>103</sup> Norman Etherington. “The ‘Shepstone System’ in the Colony of Natal and Beyond the Borders”. *Natal and Zululand from Earliest Times to 1910: A New History*. Andrew Duminy and Bill Guest eds. (Pietermaritzburg: University of Natal Press, 1989) 170-173.

<sup>104</sup> Guy, *Theophilus Shepstone and the Forging of Natal*, 1-2; Etherington, “The ‘Shepstone System’”, 170-171 and David Welsh. *The Roots of Segregation: Native Policy in Colonial Natal, 1845-1910*. (Cape Town: Oxford University Press, 1971) 57-58.

<sup>105</sup> Edgar Brookes and Nathan Hurwitz. *The Native Reserves of Natal*. (Cape Town: Oxford University Press, 1957) 12.

<sup>106</sup> Edgar H. Brookes and Colin De B. Webb. *A History of Natal*. (Pietermaritzburg: University of Natal Press, 1965) 55-60; Etherington, “The ‘Shepstone System’”, 174-179; Surendra Bhana and Joy Brain. *Setting down*



African population in Natal, the “reserve” system was also created to segregate Africans from white settlers. In addition, the “reserves” functioned as labour recruiting areas where settlers could source cheap labourers to work on white farms or the mines, or in the towns, and returned to these areas once their labour contracts ended.<sup>107</sup> Over time, the creation of these “reserves” produced much disruption in African lives. They caused growing hardships for African families as overcrowding led to reduced access to land for their farming and cattle grazing activities, which in turn led to collapsing “reserve” economies and poverty.<sup>108</sup> In turn, poverty and malnutrition had a negative influence on the health of people living in the “reserves”.

Another noteworthy factor to consider in the history of colonial Natal was the arrival of indentured labourers in the region from 1860.<sup>109</sup> Indentured labourers were brought to the region by the colonial government from the Indian subcontinent to address what had become a serious labour shortage needed both to help build the infrastructure of the colony and work on settler farms, especially the large sugar plantations.<sup>110</sup> The labour shortage stemmed primarily from the small number of European settlers in the colony, and the large majority of Africans on the “reserves” who – at this stage in the region’s history – still managed to maintain their independence by homestead farming, which enabled many to refuse to enter exploitative labour contracts with the settlers.<sup>111</sup>

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*Roots: Indian Immigration to South African, 1860-1911*. (Johannesburg: Witwatersrand University Press, 1990) 23.

<sup>107</sup> Welsh, *The Roots of Segregation*, 57-58.

<sup>108</sup> Etherington, “The ‘Shepstone System’”, 170-174.

<sup>109</sup> Bhana and Brain, *Setting down Roots*, 25; Ashwin Desai and Goolam Vahed. *Inside Indian Indenture. A South African Story, 1860-1914*. (Cape Town: Human Sciences Research Council, 2010) 1; and Natal Colony, *Report of the Indian Immigration Commission (Wragg Commission) 1885-7*. (Pietermaritzburg: P. Davis and Sons, 1887) 148-149.

<sup>110</sup> Joy Brian. “Indentured and Free Indians in the Economy of Colonial Natal”. *Enterprise and Exploitation in a Victorian Colony: Aspects of the Economic and Social History of Colonial Natal*. Bill Guest and John M. Sellers eds. (Pietermaritzburg: University of Natal Press, 1985) 199-209.

<sup>111</sup> Bhana and Brain, *Setting Down Roots*, 24-25.

Indentured immigrants were transported, for example, from Madras and Calcutta to Natal through an agency known as the Indian Immigration Trust Board.<sup>112</sup> Most Indians entered into indentured labour contracts because of poverty in their home territories. Indenture contracts were advertised to Indians as an opportunity to start new lives overseas. The contracts included paid passage by ship, as well as accommodation, food rations and a small wage in exchange for bonded servitude for an agreed upon period of time (usually five years), when they arrived in Natal.<sup>113</sup> The first two ships – *The Truro* and *The Belvedere* – arrived in Durban from Madras and Calcutta respectively on 16 and 26 November 1860 carrying several hundred people.<sup>114</sup> Once Indian indentured labourers arrived in Natal, they were taken to various parts of the colony to begin their work contracts, such as on the sugar plantations. After completing their contracts, “free Indians” could then choose to re-indenture themselves by signing another contract, they could stay on in the colony and make a new life for themselves by becoming farmers or doing other jobs, or they could return to India.<sup>115</sup>

Many Indians died on board the ships that crossed the Indian Ocean. For example, on the second ship, the *Belvedere*, an infectious water-borne disease – cholera – led to the deaths of 24 people.<sup>116</sup> The threat of the spread of infectious diseases was the key reason why the colonial authorities in Durban created an isolation facility at the harbour to quarantine new arrivals from India.<sup>117</sup> Furthermore, when Indians started arriving in Natal from 1860, when inspected on arrival, many were found to be malnourished and disease ridden and thus in a physically weakened state. Many of these Indians were then labelled as “chronic invalids”, had their contracts nullified, and were shipped back to India even before they started their work contracts because they were too weak physically or too unwell to do the work required

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<sup>112</sup> Bhana and Brain, *Setting Down Roots*, 22-23.

<sup>113</sup> Edmund H. Burrows. *A History of Medicine in South Africa up to the End of the Nineteenth Century*. (Cape Town: A.A. Balkema, 1958), 387.

<sup>114</sup> Bhana and Brain, *Setting Down Roots*, 28-29.

<sup>115</sup> Bhana and Brain, *Setting Down Roots*, 30-31.

<sup>116</sup> Laidler and Gelfand, *South Africa: Its Medical History*, 387.

<sup>117</sup> Laidler and Gelfand, *South Africa: Its Medical History*, 387.

of them, and the colonial government did not want to take on the extra expense of looking after them.<sup>118</sup>

When they arrived in Natal, those indentured Indians who made it through quarantine to begin their work contracts, had high expectations for their new lives. They hoped that they would live better lives in Natal than the poverty-stricken conditions they left behind in India. However, after they began their work contracts, many indentured labourers were not treated well. Indeed, many were oppressed and exploited by their employers. Common problems included restricted movement (they could not leave their place of employment without their employer's permission); they were provided with inadequate food rations, had to work long hours in hot, humid weather; and some were forced to endure beatings and abuse suffered at the hands of work supervisors or employers.<sup>119</sup>

Furthermore, many indentured labourers got sick from living in unhygienic conditions. This stemmed from the overcrowded and unsanitary barracks-type accommodation provided for them. Unhygienic conditions led to the spread of many diseases. For example, pulmonary tuberculosis became rife amongst some Indians who worked in the coalmines and/or lived in overcrowded, poorly ventilated accommodation.<sup>120</sup> Scurvy from lack of sufficient or nutritious rations became a significant problem too.<sup>121</sup> Furthermore, lack of clean drinking water and living in unhygienic conditions caused the spread of intestinal diseases, such as gastroenteritis.<sup>122</sup> Many indentured workers were injured too in accidents whilst working on the plantations, mines or doing construction work.

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<sup>118</sup> Laidler and Gelfand, *South Africa: Its Medical History*, 387.

<sup>119</sup> Bhana and Brain, *Setting Down Roots*, 29-30 and Joy Brain and P. Brain. "Nostalgia and Alligator: Morbidity and Mortality among Indian Migrants to Natal, 1884-1911". *South African Medical Journal* (1984, 65: 3), 101-102; Goolam Vahed and Ashwin Desai. "Indenture and Indianness in South Africa, 1860-1913". *Contemporary India and South Africa. Legacies, Identities and Dilemmas*. Sujata Patel and Tina Uys eds. (New Delhi: Routledge, 2012) 21-31; and Joy Brain. "Natal Indian, 1860-1919: From Co-operation, Through Competition, to Conflict". *Natal and Zululand from Earliest Times to 1910: A New History*. Andrew Duminy and Bill Guest eds. (Pietermaritzburg: University of Natal Press, 1989) 249-265.

<sup>120</sup> Brain and Brain, "Nostalgia and Alligator", 98-99.

<sup>121</sup> Brain and Brain, "Nostalgia and Alligator", 98-101.

<sup>122</sup> Brain and Brain, "Nostalgia and Alligator", 100.

Initially, the colonial government did not provide adequate health care services for Indian labourers who became sick during their periods of indenture.<sup>123</sup> Indeed, the “Coolie Agent”, appointed by the Natal colonial government to monitor any possible abuses and exploitation, did not perform his duties effectively.<sup>124</sup> In essence, the “Coolie Agent” was not able to adequately monitor the large number of workers on various plantations and other work places scattered throughout the colony, and thus could not effectively protect them or improve their working and living conditions.<sup>125</sup> Although a few proprietors on large estates or mines did provide private biomedical health care services for sick or injured workers, this was not a common practice.<sup>126</sup> These issues all provided broader context for the development of the cottage hospital system in Natal.

### **Health Care Services in the Pre-Cottage Hospital Era**

Health care services were not well organised in the years leading up to the implementation of the cottage hospital system. According to various scholars, most Africans in the “reserves”, and those living in and around towns, relied on either their own home remedies or “traditional healers” for their health care needs.<sup>127</sup> Leslie Swartz argues that home remedies fell under the “popular sector” of healing, and involved self-medication or turning to family members, friends or neighbours to assist with healing advice and remedies when a person was ill.<sup>128</sup> Within these informal social networks, people shared knowledge

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<sup>123</sup> Desai and Vahed, *Inside Indian Indenture*, 2-10 and Maureen Tayal. “Indian Indentured Labour in Natal 1890-1911”. *The Indian Economic and Social History Review*. (1977, 14: 4), 520-547.

<sup>124</sup> Natal Colony Indian Immigration Trust Board. *Extracts from Laws Governing Indian Immigration for Guidance of Employers of Indentured Indians*. (Durban: Josiah Jones, 1905), 1-24 and C.G. Henning. *The Indentured Indian in Natal, 1860-1917*. (New Delhi: Promila & Co, 1993), 56-61.

<sup>125</sup> Marcia Wright. “Public Health among the Lineaments of Colonial Natal, 1901-1910”. *Journal of Natal and Zulu History*. (2006-2007, 24:25), 136.

<sup>126</sup> Laidler and Gelfand, *South Africa: Its Medical History*, 388.

<sup>127</sup> Karen Flint. “Indian-African Encounters: Polyculturalism and African Therapeutics in Natal, South Africa, 1886-1950s”. *Journal of Southern African Studies*. (2006, 32: 2), 374-375.

<sup>128</sup> Leslie Swartz. *Culture and Mental Health: A Southern African Review*. (Cape Town: Oxford University Press), 82-83. Also see Anne Digby. “Self-Medication and the Trade in Medicine within a Multi-Ethnic

about how to make and use home remedies to treat diseases, and this knowledge was also passed down from generation to generation. Swartz argues that in most illness episodes, in diverse communities across southern Africa in the nineteenth century, the popular sector of healing would have been the first port of call for most people.

Building on from Swartz's arguments, other scholars, such as Harriet Ngubane and Anne Digby have argued that if self-medication or home remedies did not prove effective for an ill person, that person could then seek assistance from "traditional healers", or persons with special healing knowledge within their communities.<sup>129</sup> For example, within isiZulu-speaking communities in the region of Natal, "traditional healers" were made up of two main types, *izangoma* (diviners) and *izinyanga* (herbalists), though overlaps were also evident in the work of many healers.

Becoming a diviner usually involved a spiritual calling from his/her ancestors, which entailed some type of mental or physical suffering by an initiate, followed by a period of training by another diviner or diviners (*ukutwasa*) where the trainee learnt to communicate with his or her ancestors (*amadlozi*). The work of diviners involved interpreting peoples' dreams and diagnosing their illnesses, and working through ritual healing means to try to relieve psychological and social "dis-ease" plaguing individuals or families or even disharmony within wider communities.<sup>130</sup> An herbalist was a person who was very knowledgeable about the uses of different plants and animal parts for healing purposes, and usually obtained their healing knowledge from an older family member or acquaintance who passed this information to them through an apprenticeship process.<sup>131</sup>

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Context: A Case Study of South Africa from the Mid-Nineteenth to Mid-Twentieth Centuries". *Social History of Medicine*. (2005, 18: 3), 439-457.

<sup>129</sup> Harriet Ngubane. *Body and Mind in Zulu Medicine: An Ethnography of Health and Disease in Nyuswa-Zulu Thought and Practice*. (New York: Academic Press, 1977) 100 and Anne Digby. *Diversity and Division in Medicine: Health Care in South Africa from the 1800s*. (Oxford and Berne: Peter Lang, 2006), 282-283.

<sup>130</sup> Digby, *Diversity and Division*, 296-297 and Ngubane, *Body and Mind in Zulu Medicine*, 100-101.

<sup>131</sup> Digby, *Diversity and Division*, 291-294 and Ngubane, *Body and Mind in Zulu Medicine*, 100.

People trusted the services of “traditional healers” because they came from African communities and many believed that they received their special healing “powers” from the ancestors.<sup>132</sup> Furthermore, many of these healers understood both natural and supernatural causes of illnesses. They also used a wide variety of therapies, including plants and herbs, animal parts and ritualistic healing practices to make contact with their ancestors to help ease physical afflictions and broader psychosocial tensions in their communities.<sup>133</sup>

“Traditional healers” did not provide their services free of charge. Indeed, their health care services were often more expensive than western doctors were, when such services became available.<sup>134</sup> Before, and even into the colonial period, clients usually paid for their traditional therapies via a barter system, where for example, livestock was exchanged for the service provided. The amount depended on what was agreed upon by the sick person and his/her family and the “traditional healer” at the outset of a healing transaction.<sup>135</sup> Most of these healers had consultation rooms in their homes where people came to see them, while some travelled to provide services for their clients in a wide area. Other healers travelled great distances to improve their knowledge and learn about new healing therapies or herbs in other communities to help treat their clients.<sup>136</sup>

Similar to Africans, Indian communities also had their own healers whom people turned to when they were ill in the colony of Natal. It is important to note when Indians started arriving in Natal in the 1860s, the colony did not only receive indentured labourers. Other Indians also went to Natal by paying their own way with the aim of exploiting economic opportunities in this colony. A number came as trained professionals and skilled workers, while others came with trade or practical skills learnt from their home country.

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<sup>132</sup> Ngubane, *Body and Mind in Zulu Medicine*, 101.

<sup>133</sup> Annie Devenish. “Negotiating Healing: The Professionalization of Traditional Healers in KwaZulu-Natal between 1985 and 2003”. (Masters dissertation, Development Studies, University of Natal, Durban, 2003) 5.

<sup>134</sup> Ngubane, *Body and Mind in Zulu Medicine*, 100.

<sup>135</sup> Ngubane, *Body and Mind in Zulu Medicine*, 102.

<sup>136</sup> Digby, *Diversity and Division*, 279.

Included amongst these groups were Indian healers and herbalists, who immigrated to Natal and provided health care services and healing before the erection of cottage hospitals in Natal.<sup>137</sup> Karen Flint discusses how other than using home remedies to treat themselves, Indian indentured labourers also used the services offered by Indian healers. Like the services offered by African “traditional healers”, these services were not offered free of charge, and a fee was usually negotiated before the healing encounter began.<sup>138</sup> Some of these Indian healers built their practices by travelling in areas where large groups of indentured labourers worked.<sup>139</sup> Others opened “*muthi*” (medicine) shops in towns, such as Durban, where they sold medicines and gave advice to their clients.<sup>140</sup>

Unlike the meaning that their name implied to westerners, “traditional healers” were not unchanging or stuck in the past in terms of their healing approaches.<sup>141</sup> Indeed, those who have done research on “traditional healers” have noted the incredible adaptability and flexibility in their approaches in changing times. In her research, medical historian Karen Flint has shown how many African and Indian healers in colonial Natal developed a “polycultural” or “hybrid” healing culture.<sup>142</sup> In other words, as new diseases developed and as they became exposed to the healing approaches of different cultural groups, these healers would adopt and adapt different healing approaches from these different cultural groups, which they found effective in the treatment of their clients.

This is evident, for example, in colonial Natal when African healers used and sold Indian powders and spices as part of their healing therapies, and Indian “*muthi*” shop owners and street vendors would sell plant and animal parts used in African traditional healing

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<sup>137</sup> Flint, “Indian-African Encounters: Polyculturalism and African Therapeutics in Natal”, 374-375.

<sup>138</sup> Flint, “Indian-African Encounters: Polyculturalism and African Therapeutics in Natal”, 376.

<sup>139</sup> Flint, “Indian-African Encounters: Polyculturalism and African Therapeutics in Natal”, 374.

<sup>140</sup> Flint, “Indian-African Encounters: Polyculturalism and African Therapeutics in Natal”, 368.

<sup>141</sup> Catherine Burns. “Louisa Mvemve: A Woman’s Advice to the Public on the Cure of Various Diseases.” *Kronos: Journal of Cape History*. (1996, 23:1) 108-134 and Digby, *Diversity and Division*, 278.

<sup>142</sup> Flint, “Indian-African Encounters: Polyculturalism and African Therapeutics in Natal”, 382-383.

approaches.<sup>143</sup> In her book, *Healing Traditions: African Medicine, Cultural Exchange and Competition in South Africa, 1820-1948*, Karen Flint shows how the development of “hybrid” healing cultures became so prevalent during the course of the nineteenth century that it became viewed as a threat to European doctors. This led, over time, to petitions, by European doctors to ask the colonial government to introduce legal mechanisms to try to stop these activities and to criminalise the activities of these healers.<sup>144</sup> Despite these difficulties, “traditional healer” services remained popular within African and Indian communities in late nineteenth century Natal before (and indeed after) the cottage hospital services became available.

Before the 1880s, only sporadic efforts were made by the Natal colonial government to provide what Swartz has called “professional sector” or biomedical services provided by western-trained doctors, for people living in the region.<sup>145</sup> As narrated in the previous chapter, the colony of Natal had limited funds, and so spent little on the development of this professional sector. Furthermore, health care issues concerning the region’s black populations were not regarded as a priority, certainly not in the early years of the development of this colony. Indeed, during the nineteenth century, western medical services were rolled-out very slowly, and were usually developed for the region’s white settlers. They also tended to be concentrated in urban (towns) areas not rural areas. As a result, as was the case with African and Indian communities, many settlers in Natal (including both Boer and British settlers), in the early years of the colony relied on popular forms of healing, including home remedies to heal themselves when sick.<sup>146</sup> It was only when desperate, and often as a last resort, that white settler families would seek assistance from the more expensive medical services of

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<sup>143</sup> Flint, “Indian-African Encounters: Polyculturalism and African Therapeutics in Natal”, 368.

<sup>144</sup> Karen Flint. *Healing Traditions: African Medicine, Cultural Exchange and Competition in South Africa*. (Athens, OH: Ohio University Press and Pietermaritzburg: University of Natal Press, 2008) 128-135.

<sup>145</sup> Swartz, *Culture and Mental Health*, 78.

<sup>146</sup> See for example, Sandra Swart. “‘Bushveld Magic’ and ‘Miracle Doctors’: An Exploration of Eugene Marais and C. Louis Leipoldt’s Experiences in the Waterberg, South Africa, c.1906-1917”. *Journal of African History*. (2004, 45: 2) 237-255.



western-trained doctors, many of whom were in private practice, or those working from the first established public hospitals in the region.<sup>147</sup>

The quality of training of early western doctors was not uniform, which meant that people who used such services did not receive a standardised form of care. This is because in the early years, doctors developed practices with more or less formal training and because organisations, which would later develop to regulate the profession, were weakly established. Furthermore, some unlicensed doctors simply developed their practices outside of towns, or provided their services on an itinerant basis, where they had a lower chance of being caught practicing without a licence.<sup>148</sup>

Those fully qualified doctors, who were given permission to practice in the colony, usually came from Britain where they received their medical training. These early doctors also usually did “house calls”, which involved treating patients in their homes.<sup>149</sup> Depending on their area of work, this could mean a lot of travelling for these doctors. Over the years, as the medical market became more saturated with people offering medical services, serious competition developed between those with licences to practice, and those who did not. Eventually, by the 1890s, as medicine became more regulated and standardised as a profession, unlicensed medical practitioners were marginalised and criminalised, which led to the demise of such activities.<sup>150</sup>

Although early clinical facilities that developed in urban areas were usually attached to gaols, and treated paupers and prisoners, they quickly outgrew their usefulness, which led to the development of larger hospitals to accommodate more patients.<sup>151</sup> For example, in

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<sup>147</sup> Swartz, *Culture and Mental Health*, 77-79.

<sup>148</sup> E.B. van Heyningen. “Agents of Empire: The Medical Profession in the Cape Colony, 1880-1910”. *Medical History*. (1989, 33: 4) 465-466.

<sup>149</sup> Heyningen, “Agents of Empire”, 467-470.

<sup>150</sup> Heyningen, “Agents of Empire”, 460-461.

<sup>151</sup> Burrows, *A History of Medicine*, 214.

1856, the government established the colony of Natal's first public hospital.<sup>152</sup> This was opened in the town of Pietermaritzburg, which was the seat of the colonial government, and to cater for the large influx of British settlers, which occurred in the 1850s.<sup>153</sup> Grey's Hospital was named after the Governor of the Cape Colony, Sir George Grey, who had visited Natal in 1855, and had made funds available for its establishment.<sup>154</sup> Initially built in Prince Alfred Street, it opened as a large general hospital with 12 wards offering medical, surgical and maternity services to anyone who needed them.<sup>155</sup> Interestingly, in these early years, the wards were racially mixed, though they were segregated by gender. However, by the early 1880s, expanding patient numbers eventually forced the government to consider moving Grey's Hospital to a new, larger site on Town Bush Road, then on the outskirts of the town of Pietermaritzburg. This hospital was opened in June 1885 with 15 wards and 20 beds on each ward.<sup>156</sup> This new hospital also accepted patients of all races, but provided segregated wards for black and white patients. Patients also continued to be segregated according to gender.

Just a few years after Grey's was opened, Pietermaritzburg was also chosen as the site for the colony's first mental asylum. Before it opened, patients designated as "lunatics" either had to be sent to institutions in the Cape (such as Old Somerset Hospital or Robben Island) or were kept in facilities attached to the Pietermaritzburg gaol.<sup>157</sup> In addition, a few were cared for at Grey's Hospital. However, due to growing numbers of people labelled as mentally ill by the latter 1800s, the colonial government started building a new asylum in the 1870s. Also built on the outskirts of Pietermaritzburg near to where the second Grey's Hospital was built, the Natal Government Asylum (later renamed Town Hill Hospital) was opened in 1880.

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<sup>152</sup> Julie Parle. *States of Mind: Searching for Mental Health in Natal and Zululand, 1868-1918*. (Pietermaritzburg: University of KwaZulu-Natal Press, 2006) 36.

<sup>153</sup> Hanna Barbara Gorny. "Historic Hospitals in Natal". (Masters dissertation, Department of Architecture, University of Natal, Durban, 1988) 81-83.

<sup>154</sup> Gorny, "Historic Hospitals in Natal", 83 and Burrows, *A History of Medicine*, 214.

<sup>155</sup> Gorny, "Historic Hospitals in Natal", 66, 84-85.

<sup>156</sup> Jennifer G. Duckworth and Eryll Rogers. *Greys Hospital, Pietermaritzburg 1855-1985*. (Pietermaritzburg: Teeanem Printers, 1986), 9-11.

<sup>157</sup> Laidler and Gelfand, *South Africa: Its Medical History*, 386.

Initially, it accepted about 60 white patients and it was only in the 1890s that it began accommodating African and Indian patients.<sup>158</sup> However, as was the case with the second Grey's Hospital, patients were segregated into different wards based on race and gender.

The erection of Durban's first hospital (the second general hospital in the colony of Natal) followed just a few years after the establishment of the first Grey's Hospital. Durban's Bayside Hospital was conceptualised in 1858 by the Lieutenant Governor John Scott, a few years after Durban became a municipality in 1854. As had been the case with Pietermaritzburg, it became necessary for the government to build this hospital due to limited space available for the treatment of indigent patients in the facility attached to the Durban gaol. Built in the lower end of Smith Street, near to the bay, it opened its doors to patients in 1861.<sup>159</sup> Laidler and Gelfand tell us that this early hospital was a simple "brick building with an iron roof and had two wards". Furthermore, it catered "primarily for Africans", though it provided accommodation too for a few poor Europeans and Indians who needed care.<sup>160</sup> Like Grey's Hospital, patient numbers quickly outgrew this hospitals' original accommodation and the colonial authorities had to find space to build a bigger hospital. A new hospital, Addington Hospital, was eventually opened in 1879 "at a cost of £16,000 on a site near the Point and facing the Indian Ocean".<sup>161</sup> This general hospital was larger in size than the previous one with 70 to 80 beds, and accommodated African and later Indian patients.<sup>162</sup>

Other than in the above mentioned urban public hospitals, western-trained doctors were also employed as District Surgeons in the various magisterial districts scattered across the Natal colony. District Surgeons were appointed by the colonial administration and were

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<sup>158</sup> Parle, *States of Mind*, 1-2.

<sup>159</sup> Gorny, "Historic Hospitals in Natal", 108-110.

<sup>160</sup> Laidler and Gelfand, *South Africa: Its Medical History*, 386, 388.

<sup>161</sup> Laidler and Gelfand, *South Africa: Its Medical History*, 386.

<sup>162</sup> Gorny, "Historic Hospitals in Natal", 66, 114; Maurice G. Pearson. "History of Government Hospitals in Durban". *South African Medical Journal*. (1946), 451; Gorny, "Historic Hospitals in Natal", 126-127; Gelfand and Laidler, *South Africa: Its Medical History*, 214-223 and Burrows, *A History of Medicine in South Africa*, 221 and 387.

responsible for the public health of a whole district. As government employees, they were required to travel around their assigned districts to examine and treat people of all “races” at state institutions, such as gaols and schools, but also had to deal with injuries or outbreaks of illnesses affecting workers living on large estates or working in the mines.<sup>163</sup> This included treating, but also vaccinating (when vaccines became available) people to stop the spread of infectious disease outbreaks amongst those living in their district.<sup>164</sup> In addition, they were required to perform post-mortem examinations on corpses in suspicious death cases.<sup>165</sup> Although District Surgeons provided a vital health care service in their particular districts, since they were few in number, and sometimes posted in large districts, their reach was often limited. The fact that they were allowed to do part-time private practice work, to supplement their government salaries, made the situation worse. As overburdened doctors, their services often only touched the surface of the many people who needed medical care.<sup>166</sup>

Finally, in terms of pre-cottage hospital services, people living in the colony of Natal could also seek assistance from Christian missionary doctors and nurses. As was mentioned briefly in the previous chapter, Christian missionaries played an essential role in the provision of western health care services for black patients. Scholars such as Norman Etherington and Michael Gelfand have analysed some of the earliest missionaries (most of whom came from Protestant denominations) to work in the colony of Natal, starting in the 1830s and 1840s, with more coming over from the UK, Europe and the USA in the latter half of the nineteenth century.<sup>167</sup> Most established their mission stations in the rural areas to try to win converts amongst “heathen” Africans. Norman Etherington argues that although conversions initially

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<sup>163</sup> Heyningen, “Agents of Empire”, 456-458 and Laidler and Gelfand, *South Africa: Its Medical History*, 389.

<sup>164</sup> PAR Natal Colonial Publications (hereafter NCP) Vol 2/2/10 Colonial Secretary Speech, 20 June 1901, Natal Legislative Assembly Debates, 1901, Vol. XXX, 39 and Digby, *Diversity and Division*, 167.

<sup>165</sup> Digby, *Diversity and Division*, 158-166.

<sup>166</sup> Laidler and Gelfand, *South Africa: Its Medical History*, 224-232.

<sup>167</sup> Gelfand, *Christian Doctor and Nurse*, 103-111 and Norman Etherington, “Christianity and African Society in Nineteenth-Century Natal”. *Natal and Zululand from Earliest Times to 1910: A New History*. Andrew Duminy and Bill Guest eds. (Pietermaritzburg: University of Natal Press, 1989), 279-284.

took place very slowly amongst Africans because many were suspicious of their motives, by the late nineteenth century, more and more Africans in this region converted and came to live on mission stations.<sup>168</sup> This process was sped up when the British undermined African political systems and lifestyles by colonising and incorporating Zululand into their colony of Natal in the 1880s.

Missionaries with medical training served several missions. Indeed, a number of scholars, working in different regions of what would become South Africa, have argued that missionaries provided many Africans with their first contact with western forms of medicine.<sup>169</sup> During the late nineteenth and early twentieth centuries, Christian missionary doctors and nurses used medicine as a “handmaiden” to their ministry activities in their clinics and later hospitals. Indeed, they hoped that the healing powers of western medicines and surgery would win African converts to Christianity more quickly.<sup>170</sup> Although their success rates varied, depending on, for example, the charisma of the missionaries, the resources they had available, and the complex political and cultural dynamics of the African communities in which they worked, they were usually the first to build clinics and hospitals in rural areas for Africans.<sup>171</sup> They were also usually the first to train Africans in western healing methods, such as nurses and medical assistants.

Dr Newton Adams of the Congregationalist American Board of Missions was the first medical missionary to work in the Natal region from 1835.<sup>172</sup> He established a mission station, which became known as the Adams Mission Station in the Amanzimtoti area south of

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<sup>168</sup> Etherington, “Christianity and African Society in Nineteenth-Century Natal”, 275-278, 285-287.

<sup>169</sup> See for example, Helen Sweet. “Expectations, Encounters and Ecclesiastics: Mission Medicine in Zululand: South Africa”. *From Western Medicine to Global Medicine: The Hospital beyond the West*. Mark Harrison, Margaret Jones and Helen Sweet eds. (New Delhi: Orient Blackswan, 2009) 330-359; James B. McCord and John S. Douglas. *My Patients were Zulus*. (London: Frederick Muller, 1946) and David Gordon. “A Sword of Empire? Medicine and Colonialism in King William’s Town, Xhosaland, 1856-1891”. *African Studies* (2001, 60: 2) 165, 170-178.

<sup>170</sup> Gelfand, *Christian Doctor and Nurse*, 20. For similar arguments, also see John L. and Jean Comaroff. “The Medicine of God’s Word” in *Of Revelation and Revolution: The Dialectics of Modernity on a South African Frontier*. Volume 2. (Chicago and London: University of Chicago Press, 1997) 325.

<sup>171</sup> Gelfand, *Christian Doctor and Nurse*, 33-100.

<sup>172</sup> Burrows, *A History of Medicine in South Africa* and Gelfand, *Christian Doctor and Nurse*, 50.

Durban.<sup>173</sup> Incredibly hard working and versatile, this “teacher of three coats” (*umfundisi yamebantyi amatatu*), as local people called him, did much to lay the ground work to spread the gospel, to teach Africans on his mission to read and write, and introduced many Africans to western medicine.<sup>174</sup> Edmund Burrows argues in his book *A History of Medicine in South Africa up to the End of the Nineteenth Century* that he “was an exceedingly skilful physician and surgeon, and the Colonists as well as the Natives came for long distances to him and he often travelled long distances to them...”<sup>175</sup>

After he died in 1851 at the age of 45 from a condition associated with being overworked, another American Board of Missions doctor, Burt Bridgeman, replaced him, though only several decades later, in 1892.<sup>176</sup> Bridgeman worked at Adams Mission for seven years until he retired.<sup>177</sup> His successor was Dr James B. McCord who arrived in Natal in October 1899. McCord, who developed his practice with the assistance of his wife Margaret, extended health care services for Africans even further in the region.<sup>178</sup> Although they started out at Adams Mission Station, they quickly saw the limitations of this remote location and moved their practice to the city of Durban, where they built a small mission-funded cottage hospital and later large mission hospital to cater for the needs of black patients.<sup>179</sup> Their nurse training school, and later involvement in the training of black doctors, would also prove essential to the development of health care services for black communities in the region.

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<sup>173</sup> Gelfand, *Christian Doctor and Nurse*, 103. Also see Sphamandla Zondi. “African Demand and Missionary Charity: The Development of Mission Health Services in KwaZulu to 1919” (PhD dissertation, Department of History, Cambridge University, UK, 1999) 14-15.

<sup>174</sup> Burrows, *A History of Medicine in South Africa*, 199.

<sup>175</sup> Burrows, *A History of Medicine in South Africa*, 199.

<sup>176</sup> Gelfand, *Christian Doctor and Nurse*, 103-104.

<sup>177</sup> McCord and Scott, *My Patients were Zulus*, 33.

<sup>178</sup> Gelfand, *Christian Doctor and Nurse*, 104-107.

<sup>179</sup> McCord and Scott, *My Patients were Zulus*, 112-122.

Furthermore, mention should be made of Rev. Dr Lancelot Parker Booth who played an important role in the provision of health care services for Indians who settled in Durban after their indentured contracts ended. From 1876 until 1888 he was appointed by the Natal government and the Indian Immigration Department as a District Surgeon in the Natal Government Medical Services from the period of 1876 to 1888. He made a significant contribution to the Indian community as he established a medical dispensary for Indians near Alice Street in Durban, which treated a range of illnesses, conditions, and injuries.<sup>180</sup> In September 1897 when the Anglican Church's St Aidan's Mission Hospital was opened, Rev. Dr Booth was appointed its first Medical Superintendent. This hospital developed as a general hospital. Although it initially only had 9 beds, as it mostly provided health care services to out-patients, by June 1900 this hospital had treated hundreds of Indian patients.<sup>181</sup>

Although space constraints will not allow me to go into further detail in terms of discussion of the work and contributions of several early missionary doctors who worked in the Natal and Zululand area, it is important to recognise that the American Board Mission doctors were not the only ones providing health care services in this region. Other scholars have analysed in detail the work of the Anglican Church, those from Scandinavia, such as the Swedish and Norwegian missions, the Church of Scotland and the Lutheran mission, to mention just a few.<sup>182</sup> They too established important mission hospitals and clinics in different parts of the colony of Natal (or after 1910 in the province of Natal), which spread evangelism and western medicine to African communities.

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<sup>180</sup> C.G. Henning. *St Aidan's Mission 1883-1983: A Centenary Brochure*. (Durban: Standard Printing Press, 1983), 1-10.

<sup>181</sup> Henning, *St Aidan's Mission 1883-1983*, 3.

<sup>182</sup> See for example, Gelfand, *Christian Doctor and Nurse*, who provides summaries of all the major mission groups who operated in Natal; Radikobo Phillip Ntsimane. "An Historical Evaluation of the Lutheran Medical Mission Services in Southern Africa with Special Emphasis on Four Hospitals: 1930s-1978". (PhD dissertation, University of KwaZulu-Natal, Pietermaritzburg, 2012) 54-57; Sweet, "Mission Medicine in Zululand", 330-359; and Lars Berge. *The Bambatha Watershed: Swedish Missionaries, African Christians and an Evolving Zulu Church in Rural Natal and Zululand 1902-1910*. (Sweden: Elanders Gotab, 2000).

## Factors leading to the Establishment of Cottage Hospitals in Colonial Natal

The British colonial government established cottage hospitals in Natal from the 1880s for a number of reasons. A significant factor was the changing socio-political context of the late 1870s and 1880s. In 1879, growing tensions between the British and the Zulus over land as well as economic and political expansion led to the Anglo-Zulu War.<sup>183</sup> The Zulu army, which stood against British armies with superior weaponry, ultimately lost the war, which began the process of the political destruction of the Zulu kingdom.<sup>184</sup> Although the British tried, in the 1880s, to extend into Zululand its system of indirect rule through loyal African “traditional authorities”, the process led to several years of violent civil war amongst various factions within the Zulu kingdom, which ultimately led to the formal colonisation of Zululand in 1887.<sup>185</sup>

The extension of the “Shepstone System” to Zululand had a profound effect on African communities and ultimately on the roll out of state sponsored health care services. The British takeover of Zululand brought more Africans under their control. Shepstone’s segregated “reserve” system was extended into Zululand. The reduction of available land led to overcrowding, which limited the ability of African communities to sustain their “traditional” homestead farming activities. Men living in Zululand were also required to pay an annual hut tax to help subsidise the British administration in the region.<sup>186</sup> Together, land alienation and taxation pushed more Africans into the labour market to earn wages. This in turn led to changing settlement patterns as workers (usually young men in the early decades), desperate to earn wages, migrated to white farms or urban areas to find work to sustain

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<sup>183</sup> John Laband and Paul Thompson. “The Reduction of Zululand, 1878-1904”. *Natal and Zululand from Earliest Times to 1910: A New History*. Andrew Duminy and Bill Guest eds. (Pietermaritzburg: University of Natal Press, 1989) 193 and Collin Webb. “The Origins of the Anglo-Zulu War: Problems of Interpretation”. *The Anglo-Zulu War*. Andrew Duminy and Charles Ballard eds. (Pietermaritzburg: University of Natal Press, 1981) 10-11.

<sup>184</sup> Andrew Duminy and Charles Ballard. *The Anglo-Zulu War: New Perspectives*. (Pietermaritzburg: University of Natal Press, 1981) 2 and Guy, *The Destruction of the Zulu Kingdom*, 4.

<sup>185</sup> Duminy and Ballard, *The Anglo-Zulu War*, 63-71.

<sup>186</sup> Narissa Ramdhani. “Financing Colonial Rule: The Hut Tax System in Natal 1847-1898”. (Masters Dissertation, Department of History, University of Natal, Durban, 1985) 15-20.



themselves and their families in the reserves.<sup>187</sup> Over time, deteriorating conditions in the reserves, a greater presence of Africans living in impoverished slum conditions in and around towns, and the need to ensure a healthier labour force encouraged the colonial government to expand provision of its biomedical services.

Another factor that encouraged the government to develop cottage hospitals in Natal was this colony's attainment of responsible government status in the 1890s. The predominantly white (male, propertied) voting public achieved this in 1893 after many years of lobbying and campaigning.<sup>188</sup> Responsible government or self-government meant that Natal got its own governor, elected its own officials to its upper and lower Houses of Parliament, and it was no longer dependent on decisions made in the Cape.<sup>189</sup> This was important as it meant that the Natal colony did not have to follow the decisions or directives of the Cape in any matters, and could act on its own behalf and in its own interests. As a result, when it came to matters of health care, Natal government officials had greater freedom to develop the colony's own policies, including health care, in line with its own needs.

The threat of the spread of various infectious diseases in Natal in the latter 1800s was also a serious threat from this time. For example, disease outbreaks such as cholera and venereal diseases stimulated colonial officials to expand the number of health care services available for the public. The work of scholars such as Ashwin Desai and Goolam Vahed show how many Indians who arrived in Natal from the Calcutta region of India during the 1860s contracted cholera either before boarding the ship, or on the ship, which led to much ill health and deaths.<sup>190</sup> As mentioned earlier, this led the colonial health authorities to open an

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<sup>187</sup> Jeff Guy. "The Destruction and Reconstruction of Zulu Society". *Industrialisation and Social Change in South Africa: African Class Formation, Culture and Consciousness 1870-1930*. S. Marks and R. Rathbone eds. (New York: Longman, 1982) 176.

<sup>188</sup> For more on this issue, see Bill Guest. "Towards Responsible Government, 1879-93". *Natal and Zululand from Earliest Times to 1910: A New History*. Andrew Duminy and Bill Guest eds. (Pietermaritzburg: University of Natal Press, 1989) 233-248.

<sup>189</sup> J. Forsyth Ingram. *The Colony of Natal* (London: Sir Joseph and Sons, 1895) 23-28.

<sup>190</sup> Desai and Vahed, *Inside Indian Indenture*, 66-67.

isolation facility at the harbour that quarantined and monitored new arrivals for infectious diseases and only allowed them into the colony if they showed no signs of cholera infection. Another set of infectious diseases that broke out in colonial Natal in the 1880s were venereal diseases, particularly syphilis and gonorrhoea. Jeremy Martens' research has shown how colonial authorities were stimulated to take action in this period with the passage of the Contagious Diseases Act. This Act was passed to protect the public's health (namely the white population) from what colonial authorities regarded as the "threat" of sexually active African men and women, who were seen as spreaders of contagious diseases such as syphilis and gonorrhoea in the colony's major towns, such as Durban and Pietermaritzburg.<sup>191</sup> This act enabled the colonial state to arrest all African women who were suspected of being sex workers. The outbreak of infectious diseases, such as cholera and venereal diseases in the latter 1800s, thus pushed the government to take its public health care responsibilities more seriously in this period.

An expanding number of medical men, growing moves towards professionalization of doctors, and the desire by these doctors to expand the reach of biomedicine were influential too in encouraging the development of public health services, including cottage hospitals. During the latter half of the nineteenth century, more and more British born and trained doctors immigrated to southern Africa. Referring to the colony of Natal, Burrows argues that in 1856, there were "probably no more than a dozen licenced practitioners" in this region, though the numbers would increase to about 100 by the late 1880s.<sup>192</sup> These doctors came in increasing numbers to escape a saturated medical market in Britain and to find new work opportunities overseas. Anne Digby has argued that various wars, such as the Anglo-Zulu War and later the South African War enticed doctors to enter lucrative contracts as military doctors, while others came to the southern Africa region because of the discovery of

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<sup>191</sup> Jeremy C. Martens. "'Almost a Public Calamity': Prostitutes, 'Nurseboys', and Attempts to Control Venereal Diseases in Colonial Natal, 1886-1890". *South African Historical Journal*. (2001, 45) 27-36.

<sup>192</sup> Burrows, *A History of Medicine in South Africa*, 213.

diamonds and gold and hoped to cash in on medical services needed by more people living and working in these regions.<sup>193</sup>

The expanding number of medical men in Natal meant that they had greater power as a bloc to lobby the colonial government to achieve their goals. This is evident when doctors started working more closely with the government during the period when they organised themselves into a more established profession.<sup>194</sup> For example, during the latter 1800s, the Cape and Natal colonial governments, under pressure from European biomedical practitioners to protect their services from competition from others healers, contemplated legislation, which would criminalise the activities of “traditional healers”.<sup>195</sup> The Code of Native Law was passed in 1891.<sup>196</sup> Interestingly, this law allowed *izinyanga* to apply for licences to work in the Natal colony’s “Native areas”, where there were no other health care services, and because their herbalist activities most closely resembled biomedical practitioners. However, African diviners, whom colonial authorities regarded as engaging in threatening or “evil”, so-called “witchcraft” activities, were prohibited legally from practicing in the colony.<sup>197</sup> Thus, working with the colonial government, formally trained and registered doctors were able to spread the influence of western medicine, and encouraged the colonial government to take their biomedical health care responsibilities more seriously.

Finally, I would like to consider one last issue that helped explain the development of cottage hospitals in late nineteenth century in Natal. This was the pressure that the Indian government placed on those in charge of Natal’s colonial authorities that led to efforts to reform the indentured labour system. In 1871, when the first indentured labourers returned home after completing their contracts, and the Indian government heard about the horrific

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<sup>193</sup> Anne Digby. “A Medical El Dorado”, Colonial Medical Incomes and Practice at the Cape”. *Social History of Medicine*. (1995, 8: 3) 465-466.

<sup>194</sup> Burrows, *A History of Medicine in South Africa*, 212.

<sup>195</sup> Flint, *Healing Traditions*, 1-3.

<sup>196</sup> Digby, *Diversity and Division*, 298.

<sup>197</sup> Flint, *Healing Traditions*, 102-119 and Burns, “Louisa Mvemve”, 109-112.

living and working conditions in Natal, it stopped the supply of labourers leaving India for Natal until the Natal colonial government agreed to do something to improve their conditions.<sup>198</sup> As a result, in 1872, the Natal's Lieutenant-Governor Anthony Musgrave, appointed a "Coolie Commission" to investigate the issue.<sup>199</sup> When it reported on its findings, it recommended, in addition to other improvements, that the colonial government appoint a "Protector of Immigrants", whose office was to be given more staff and power to protect the interests of indentured labourers in Natal. This included provision of better medical care for indentured labourers.<sup>200</sup> When the government agreed to implement these improvements, the Indian government allowed shipments to resume once again in 1874. Indeed, Bhana and Brain have argued in their book, *Setting Down Roots* that the shipments were even larger than those in the first phase, as Indian indentured labourers were also needed to help with public works programmes, such as the Natal Government's Railway line, which was being constructed at this time.<sup>201</sup>

Thus, from the mid-1870s, the office of the Protector of Immigrants was tasked with arranging an improvement in medical services to provide for the growing number of indentured labourers and to try to stop the spread of infectious diseases amongst Indian communities in Natal. Working together with the Indian Immigration Trust Board and the colonial government, one of the Protector's first acts was to recommend the establishment of a larger number of clinic or hospital facilities where significant numbers of Indians lived and worked, and the appointment of more medical officers to cater for their health care needs.<sup>202</sup>

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<sup>198</sup> Bhana and Brain, *Setting down Roots*, 28-30.

<sup>199</sup> Bhana and Brain, *Setting down Roots*, 28-30.

<sup>200</sup> Laidler and Gelfand, *South Africa: Its Medical History*, 389.

<sup>201</sup> Bhana and Brain, *Setting down Roots*, 30. Also see D.H. Haydenrych. "Indian Railway Labour in Natal, 1879-1895: The Biggest Indian Workforce in the Colony". (Paper presented at a workshop on the development of Natal before Union held by the Department of Historical Studies, University of Natal, Pietermaritzburg in October 1984) 11-20.

<sup>202</sup> Wright, "Public Health in Natal", 137-143, 152-153 and Brain and Brain, "Nostalgia and Alligator", 30-102.

To organise things better, areas of Natal that had heavy concentrations of indentured labourers, were sub-divided into 15 areas or “circles” of territory where a doctor was appointed by the Indian Immigration Trust Board to visit regularly estates and mines and other places where Indians worked to attend to their medical needs.<sup>203</sup> Laidler and Gelfand noted that in six of the “circles” of territory corresponded to district surgeoncies’ and the medical officer appointed thus also held the post of District Surgeon, which placed a heavy workload on these doctors.<sup>204</sup> These developments pressured the colonial government to start rolling out improved public health care facilities, including small cottage hospitals in these areas, where these Indian Medical Officers/District Surgeons could provide improved services for their patients.

This chapter has considered the broader context of the pre-cottage hospital era and the provision of health care services in Natal before the 1880s. The colonial government provided a handful of hospitals in urban areas, operated a District Surgeon system, and helped organise and fund the provision of Indian Medical Officers to see to the needs of Indian indentured workers. Although it provided these services, it has argued that most people living in the colony before the 1880s either treated themselves with home remedies, or used the services of “traditional healers”. Some people also had the option of using the services provided by Christian missionary doctors and nurses. This chapter ended by considering some of the most important factors that encouraged the government to introduce the cottage hospital system in Natal from the 1880s. My next chapter considers the Natal colonial government’s establishment of three particular cottage hospitals in the late 1800s and early 1900s.

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<sup>203</sup> See Burrows, *A History of Medicine in South Africa*, 213; Laidler and Gelfand, *South Africa: Its Medical History*, 389 and Wright, “Public Health in Natal”, 138.

<sup>204</sup> Laidler and Gelfand, *South Africa: Its Medical History*, 389.

## CHAPTER THREE

### **Cottage Hospitals in Colonial Natal: Umsinga, Newcastle and Dundee**

Several government-funded cottage hospitals were erected in different magisterial districts scattered around the British colony of Natal between the period of the 1880s and 1910. These included, for example, cottage hospitals in the areas of Richmond, Maphumulo, Umsinga (or Pomeroy), Newcastle, Dundee, Port Shepstone, Eshowe, Ixopo, Richmond, Stanger, Weenen, Avoca, Verulam, Umzinto, and Isipingo.<sup>205</sup> This chapter examines the development of three of these cottage hospitals, namely Umsinga (1889), Newcastle (1901) and Dundee (1903) (See Appendix 1). Organisationally, this chapter is divided into three sections. Each section will start with a brief overview of the particular magisterial district, before moving on to discuss the establishment of the cottage hospital in that particular district. Umsinga was created to serve a rural population, while Newcastle and Dundee were opened to serve people living in and around towns.

My decision to analyse only three cottage hospitals was determined by a number of factors. Firstly, I found a large number of archival sources on these three hospitals in the Pietermaritzburg Archive Repository. Secondly, I chose this number as it was more manageable to study three hospitals in-depth than a larger number, where I would not have been able to do justice to them in terms of providing an in-depth analysis. Thirdly, I wanted to be able to bring in a comparative element in terms of provision of services for patients in rural and urban areas. Finally, since these particular cottage hospitals were created with the intention of treating black patients, or treating black and white patients on a segregated basis, I chose them to investigate what role segregation played in the establishment and operation of these facilities.

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<sup>205</sup> See Edmund H. Burrows. *A History of Medicine in South Africa up to the End of the Nineteenth Century*. (Cape Town: A.A. Balkema, 1958) 222 and Hanna Barbara Gorny. "Historic Hospitals in Natal". (Masters dissertation, Department of Architecture, University of Natal, Durban, 1988) 146-170.

## Umsinga Cottage Hospital

Umsinga was one of the magisterial districts located in the north western part of the colony of Natal. During the latter half of the nineteenth century, most of the southern part of this area was sub-divided into a so-called “Native reserve” as part of the Shepstone’s System, where the majority of the region’s African communities were relocated.<sup>206</sup> Umsinga was a rural district, where most people made their living from farming. This included both livestock and agriculture.<sup>207</sup> During the nineteenth and early twentieth centuries, the large majority of people living in this area were Africans. Before the “reserve” system came into effect, Africans lived in scattered family homesteads where they farmed crops and grazed their cattle, and belonged to larger clan units which recognised the authority of hereditary chiefs.<sup>208</sup> There were very few whites or Indians at this time living in Umsinga. For example, in 1903, the Resident Magistrate reported that there were less than 15 white families living in the whole district.<sup>209</sup> Most of the white settlers were made up of Dutch and German farmers.

Indians started arriving in the area from the 1860s in small numbers. Unlike Newcastle or Dundee districts, which drew in large numbers of indentured labourers to work, particularly on these districts’ coal mines, Indians who settled in Umsinga at this time became shop owners, farmers, or vendors/street traders. Most of these shop owners came to the Natal colony as “passenger Indians”, who had paid their own way to the colony with the intention of exploiting economic opportunities, such as setting up small businesses.<sup>210</sup> In later

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<sup>206</sup> Pietermaritzburg Archives Repository (hereafter PAR). Natal Colonial Publications (hereafter NCP) Box 6/1/1/27 *Natal Government Gazette*, No. 1580, 21 March 1876, 146.

<sup>207</sup> PAR NCP Box 7/2/1/6 *Blue Books for the Colony of Natal 1889*. Report of Henry F. Fynn, the Resident Magistrate of Umsinga Division for the year ended 31 December 1888. (Pietermaritzburg: Government Printers, 1890) B42-B54.

<sup>208</sup> Bhekuyise Isaac Mthembu. “Faction Fighting in Umsinga District from 1874-1906”. (Masters dissertation, Department of History, University of Zululand, 1994) 11-13.

<sup>209</sup> PAR NCP Box 7/2/1/7 *Blue Books for the Colony of Natal 1890-1891*. Report of Thomas Maxwell, the Resident Magistrate of Umsinga Division for the year ended 31 June 1891. (Pietermaritzburg: Government Printers, 1891) 74.

<sup>210</sup> PAR NCP Box 7/2/1/7 *Blue Books for the Colony of Natal 1890-1891*. Report of Thomas Maxwell, 31 June 1891, 74. For more on the history of ‘passenger Indians’ see J.B. Brain, *Christian Indians in Natal, 1860-1911: An Historical and Statistical Study*. (Cape Town: Oxford University Press, 1983) and Surendra Bhana and Joy

years, “free Indians”, who moved to the area after their indenture labour contracts ended, became farmers and/or street traders who sold, for example, vegetables and fruit.<sup>211</sup>

In terms of the African communities living in this area, there were an estimated 32,000 Africans living in the Umsinga district by the late 1800s.<sup>212</sup> These Africans were made up of different groups or clans each ruled by different chiefs. Bhekuyise Mthembu has shown in his research on Umsinga how the Shepstone System brought dramatic changes to African communities living there. One of the most significant outcomes was that this “reserve” system brought land shortages for these communities.<sup>213</sup> This was because many Africans who had lived in scattered homesteads throughout the Umsinga area were required to live in segregated African “reserves” from 1849, which led to disruptions to their traditional land use patterns and homestead production activities.<sup>214</sup> Indeed, the British government gave Africans far smaller portions of land to farm on and to graze their cattle. Some parts of this “reserve” land was also quite mountainous and rocky in nature, which made it harder for those living there to cultivate their crops.<sup>215</sup>

In addition, Shepstone’s “reserve” system encouraged more conflicts amongst Africans. Other than the challenges brought by a shortage of land, which produced conflicts over limited resources, the Shepstone System also brought political strife. Although the area remained ruled by chiefs, some important changes were introduced which destabilised the political landscape. Firstly, all the chiefs were expected to report to the Resident Magistrate.

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Brain. *Setting down Roots: Indian Immigration to South African, 1860-1911*. (Johannesburg: Witwatersrand University Press, 1990).

<sup>211</sup> PAR NCP Box 7/2/2/8 *Supplement to the Blue Book for the Colony of Natal 1891-1892: Departmental Reports*. Report of Thomas Maxwell, Resident Magistrate of Umsinga Division for the year ended 31 June 1892. (Pietermaritzburg: Government Printers, 1892) 32. For more on ‘free Indians’, see for example, Bhana and Brain, *Setting down Roots*, 30-44.

<sup>212</sup> Duncan Du Bois. *Settler Security, Insecurity and Solidarity in Colonial Natal with Particular Reference to the South Coast 1850-1910*. (School of Basic Sciences: North-West University, 2014) 1-19.

<sup>213</sup> Mthembu, “Faction Fighting in Umsinga District”, 5.

<sup>214</sup> Mthembu, “Faction Fighting in Umsinga District”, 1-7.

<sup>215</sup> PAR NCP Box 7/2/1/9 *Blue Books for the Colony of Natal, 1892-1893*. Report of Henry F. Fynn, the Resident Magistrate of Umsinga Division for the year ended 31 June 1893. (Pietermaritzburg: Government Printers, 1893) B14.



The Resident Magistrate outranked the individual chiefs, and was appointed by the British government as a type of manager in each district to oversee that district's affairs.<sup>216</sup> This included enforcement of laws, controlling the movement of people, responsibility for settling disputes, and collecting taxes. Secondly, as part of the British "divide and rule" political strategy, a number of new chiefs, who were regarded as loyal to the British, were appointed to serve as local rulers over groups of people in chiefdoms in different parts of the "reserve".<sup>217</sup> As a result, in the nineteenth century, the Umsinga "reserve" area was made up of a diverse array of chiefs, some hereditary, some appointed, which led to conflicts between different chiefs and their people over political power.<sup>218</sup> Although it claimed to bolster the system of chiefly rule in the "reserves", the Shepstone System actually worked to undermine the power of chiefs who increasingly became cogs in a larger colonial bureaucracy, who were required to report to the Resident Magistrate.

The shortage of land in the "reserves" meant that over time, these areas also became overcrowded and saw a decline of agricultural production, which meant that many Africans were unable to make a living out of farming alone. This pushed more people, especially young men, into the migrant labour system to earn wages.<sup>219</sup> The migrant labour system enabled these men to go and find work on commercial farms, on the mines or in towns for a certain period on a contract basis, which they would complete and then return to their rural areas with their wages to help support their families. This created a situation where young men would be away from their family homesteads for extended periods of time, which

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<sup>216</sup> Mthembu, "Faction Fighting in Umsinga District", 21.

<sup>217</sup> Norman Etherington. "The 'Shepstone System' in the Colony of Natal and Beyond the Borders". *Natal and Zululand from Earliest Times to 1910: A New History*. Andrew Duminy and Bill Guest eds. (Pietermaritzburg: University of Natal Press, 1989) 178.

<sup>218</sup> Mthembu, "Faction Fighting in Umsinga District", 3-10.

<sup>219</sup> Cherryl Walker. "Gender and the Development of the Migrant Labour System 1850-1930". *Women and Gender in Southern Africa to 1945*. Cherryl Walker ed. (Cape Town: David Philip Publishers, 1990) 168-179.

created increased burdens on women and older homestead members who were left behind to carry a heavier load that included childcare, domestic work and farming work.<sup>220</sup>

In terms of health care, most people living in the Umsinga district in the late nineteenth century would have tried to heal themselves first through use of home remedies passed down in families, or learnt from friends and neighbours. Amongst African communities, the next port of call, for illnesses not treatable with home remedies, were “traditional” healers.<sup>221</sup> In terms of biomedical health care services, there were few options available for people living in this district. One option were the small dispensary or clinic services offered by Christian missionaries at the Berlin Lutheran Mission (started in 1850) and the Church of Scotland’s Gordon Memorial Mission (started in 1870).<sup>222</sup> The provisions of small dispensary services were started a few years after these mission stations were opened. However, these facilities did not offer the services of fully trained doctors or nurses. For example, Reverend James Dalzell, who was in charge of the Gordon Memorial Mission, and was assisted, by his wife and two sisters (nuns), offered very basic first aid care from their small dispensary. As mentioned in the previous chapter, these missionaries hoped to use these services to win more converts to Christianity.<sup>223</sup>

Other than missionaries, from the time of the official creation of this district on 20 March 1876, a government appointed western-trained District Surgeon was also appointed to travel around the district to provide curative services for patients linked to state institutions, such as policeman, farmers, clerks and all magistrate workers in the area and to report on and

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<sup>220</sup> Walker, “Gender and the Development of the Migrant Labour System”, 172.

<sup>221</sup> PAR NCP Box 7/2/1/8 *Blue Books for the Colony of Natal, 1892*. Report of Henry F. Fynn, the Resident Magistrate of Umsinga Division for the year ended 31 December 1892. (Pietermaritzburg: Government Printers, 1893) B7 and B63.

<sup>222</sup> Lars Berge. *The Bambatha Watershed: Swedish Missionaries, African Christians and an Evolving Zulu Church in Rural Natal and Zululand 1902-1910*. (Sweden: Elanders Gotab, 2000) 103 and Michael Gelfand. *Christian Doctor and Nurse: The History of Medical Missions in South Africa from 1799-1976*. (Sandton, RSA: Aitken family and friends, 1984) 53-54.

<sup>223</sup> Gelfand, *Christian Doctor and Nurse*, 226-242.

try to stop the spread of infectious diseases.<sup>224</sup> The District Surgeon also provided part-time private care for people who were prepared to pay for his services.

By the late 1880s, however, the inadequate provision of public biomedical health care facilities in the Umsinga district was being reported regularly in government documents. For example, in 1887, the District Surgeon noted in his Annual Report that he experienced enormous strain from his constantly heavy workload. This report also stated that his clinical facilities were inadequate as he was forced to make small rooms next to the local gaol “for the purpose of receiving and affording sleeping accommodation to patients in cases of accidents or assault”.<sup>225</sup>

It was only in 1889 that the colonial government opened a cottage hospital in the Umsinga District.<sup>226</sup> It took about two years to motivate for its establishment. In June 1887, and then again in September 1887, the Resident Magistrate of Umsinga, Henry F. Fynn, having been in discussion with the District Surgeon about his work difficulties, wrote to the Secretary of Native Affairs about the need to erect a small “Native Hospital” to serve the district.<sup>227</sup> In his motivations, he wrote that this facility was needed to treat the large “Native population” of the colony.

He also stressed his desire to reduce the power of “traditional healers”, whose services he regarded as harmful, and noted as popular amongst African communities in his district. In

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<sup>224</sup> PAR NCP Box 7/2/1/5 *Blue Books for the Colony of Natal, 1888*. Report of Henry F. Fynn, the Resident Magistrate of Umsinga Division for the year ended 31 December 1888. (Pietermaritzburg: Government Printers, 1889) B63 and PAR NCP Box 7/2/2/9 *Supplement to the Blue Books for the Colony of Natal 1892-1893: Departmental Reports*. Report of Henry F. Fynn, the Resident Magistrate Umsinga Division for the year ended 31 June 1893. (Pietermaritzburg: Government Printers, 1893) B62.

<sup>225</sup> PAR NCP Box 7/2/2/4 *Supplement to the Blue Books for the Colony of Natal for the Year 1887: Medical Reports*. Report by Dr John Nembula, District Surgeon Umsinga Division (Pietermaritzburg: Government Printers, 1888) B42.

<sup>226</sup> PAR SNA Vol I/1/110 Ref 1888/913 Minute Paper from Henry F. Fynn (Resident Magistrate of Umsinga Division) to S.O. Saunders (Under Secretary of Native Affairs), re “Suggestion to Erect a Hospital for the Treatment of Natives in Distress through Wounds or Otherwise at the Magistrates Office Umsinga Division”, 12 March 1888; PAR SNA Vol I/1/113 Ref 1889/306 Minute Paper from Henry F. Fynn (Resident Magistrate of Umsinga Division) to S.O. Saunders (Under Secretary of Native Affairs), re “Respecting Native Cottage Hospital at Umsinga (Vide Blue Book 1887 page B42)”, 2 June, 1889.

<sup>227</sup> PAR NCP 7/2/2/5 *Supplement to the Blue Book for the Colony of Natal for the Year 1888: Departmental Reports*. Report of Henry F. Fynn, Resident Magistrate of Umsinga Division for the year ended 31 December 1888. (Pietermaritzburg: Government Printers, 1889) B42-B54.

1894, Magistrate Fynn wrote the following to the Colonial Secretary: “Such hospitals established in Native Locations would greatly benefit the Natives, and improve them, and should help do away with their malpractice in Native herbs and doctors, witchcraft practices and superstitions in charm of herbs”.<sup>228</sup> The opinion of Magistrate Fynn provides a good example of the common negative imperial attitudes Europeans held about the services provided by African healers. This led to the marginalization of African indigenous health knowledge during the colonial period. His arguments were strongly supported by the District Surgeon, who wrote the following on 17 October 1888:

I cannot think of a more important work for the benefit of the Aborigines of this country for their good civilisation and improvement from a general point of view and for the sake of their wounded and sick. The saving of lives of Native people with smashed-in skull cases in this hospital, and for a step forwards away from malpractices by Native doctors and superstition and other evils...<sup>229</sup>

Eventually, at the end of 1888, the Lieutenant Governor at the time, Sir Arthur Havelock, gave his permission and authorised funding to have a small “cottage hospital” established to serve the area.<sup>230</sup> The site chosen, in consultation with the Resident Magistrate and District Surgeon, was a house located next to the local gaol that had previously been used by the District Surgeon to consult with patients. However, because it was quite small and not well suited in terms of its original layout to accommodate and treat patients who were admitted for overnight stays, the colonial government authorised funds to be used to extend

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<sup>228</sup> PAR SNA Vol 1/1/184 Ref 1310/1894 Minute Paper from Henry F. Fynn (Resident Magistrate of Umsinga Division) to D. Erskine (Colonial Secretary of Natal), re “The Establishment of Native Cottage Hospital as the Seat of each Magistrate”, 2 May 1894.

<sup>229</sup> PAR SNA Vol 1/1/184 Ref 25//1893 Minute Paper from Dr. H.J. Platt (District Surgeon of Umsinga Division and Medical Officer of Umsinga Cottage Hospital) to S.O. Saunders (Under Secretary of Native Affairs), re “Annual Reports and Expenditure for the year ended 31 December 1892”, 9 January 1893 and PAR SNA Vol 1/1/2134 Ref 474/1894 Minute Paper from Dr H.E Fernandez (Port Shepstone, Natal) to S.O. Saunders (Under Secretary of Native Affairs), re “Suggested Plan for giving Natives the Opportunity of Obtaining Medical Advice and Treatment at a Trifling Cost”, 24 April 1894.

<sup>230</sup> PAR NCP Box 7/2/2/8 *Supplement to the Blue Book for the Colony of Natal 1891-1892: Departmental Reports*. Report of Henry F. Fynn, the Resident Magistrate of Umsinga Division for the year ended 31 June 1892. (Pietermaritzburg: Government Printers, 1892) B7 and C101.

and adapt the rooms of small building. The building renovations of this building were started at the end of 1888 and it took four and a half months to complete.<sup>231</sup>

When it opened in March 1889, the Umsinga Native Cottage Hospital had cost £5,000 to build, which had been made available by the Native Affairs Department. This small hospital consisted of two wards, a surgical room, a patients' consultation room, and a large verandah.<sup>232</sup> The hospital initially had 12 beds. Additionally, Africans from the district were allowed to build a few huts on open ground near to the hospital, to accommodate patients' family or friends, who were also tasked with providing food for those admitted to this cottage hospital since it did not have kitchen facilities.<sup>233</sup>

### **Newcastle Cottage Hospital**

Newcastle was also located in the north-western part of the colony of Natal. Like its more southern located neighbour Umsinga, Newcastle has had a complex history. Although Africans had lived there for centuries before the arrival of Europeans, the arrival of Voortrekkers from the Cape region from the late 1830s and then British settlers from the late 1840s had a huge influence on the area. Both groups of people migrated to and settled in the area to set up livestock and agricultural farms.

The British declared the area of Newcastle, which was named after the Secretary of State for the Colonies, Henry Pelham (who was also the Duke of Newcastle), as a magisterial

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<sup>231</sup> PAR NCP Box 7/2/2/5 *Supplement to the Blue Book for the Colony of Natal for the Year 1888: Departmental Reports*. Medical Report of Dr John Nembula, District Surgeon of Umsinga Division for the year ended 31 December 1888. (Pietermaritzburg: Government Printers, 1889) B42-B54.

<sup>232</sup> PAR SNA Vol I/1/110 Ref 1888/913 Minute Paper from Henry F. Fynn (Resident Magistrate of Umsinga Division) to S.O Saunders (Under Secretary of Native Affairs), re "Suggestion to Erect a Hospital for the Treatment of Natives in Distress through Wounds or Otherwise", 12 March 1888 and PAR SNA Vol I/1/130 Ref 1890/997 Minute Paper from Henry F. Fynn (Resident Magistrate of Umsinga Division) to S.O. Saunders (Under Secretary of Native Affairs), re "Dr. John Mavuma Nembula, District Surgeon and Medical Officer of Umsinga Cottage Hospital Application for Additional Accommodation, Kitchen, Storeroom and Additional Ward", 15 August 1890.

<sup>233</sup> PAR NCP Box 7/2/2/7 *Supplement to the Blue Book for the Colony of Natal 1890-1891: Departmental Reports*. Report by Henry F. Fynn, Resident Magistrate of Umsinga Division for the year 31 December 1891. (Pietermaritzburg, Government Printers, 1892) B 5-6, B100-B101.

district of the colony of Natal in December 1862.<sup>234</sup> Unlike Umsinga, which remained a primarily rural district during the period covered by this thesis, Newcastle quickly developed into an important industrial town. This was because of the discovery of local coal deposits by settlers, who had learnt about such deposits from local African people.<sup>235</sup> During the second half of the nineteenth century, coal enticed more settlers to the region to exploit its natural resources, which was used as a source of heat, as well as to power steam-operated machines and locomotives that developed during the industrial era.<sup>236</sup> By the late nineteenth century, several large coalmines had developed in the region as well as associated industries, such as the development of the iron and steel industry, which used the heat from coal to smelt iron ore from rock.<sup>237</sup>

While white settlers lived in the town or on farms close to the town, in a similar situation to Umsinga, Africans were relocated to segregated “reserves” located approximately 80 kilometres outside the main Newcastle town during the latter decades of the 1800s. As with Umsinga, their lives were disrupted enormously by their loss of land and relocation to segregated “reserves”, which also led over time, to overcrowded conditions, reduced homestead agricultural productivity, and conflicts between individual families and communities over limited resources and political power.<sup>238</sup> Over the years, as homestead production went into further decline, more and more African men joined the migrant labour work force. Indeed, many went to work in Newcastle’s coalmines or factories in town, to earn

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<sup>234</sup> PAR NCP Box 6/1/1/13 *The Natal Government Gazette* No. 735, Monday, 8 December 1862. 275 and B.C. Baylis. *A History of Newcastle*. (Newcastle: The Newcastle Advertiser, 1951), 4.

<sup>235</sup> J. J. G. Bignaut. “Coal Provinces in the Natal Coalfields”. *Journal of Geology*. (1951, 54:1) 27-32.

<sup>236</sup> Ruth Edgecombe and Bill Guest. “An introduction to the Pre-Union Natal Coal Industry”. *Enterprise and Exploitation in a Victorian Colony: Aspects of the Economic and Social History of Colonial Natal*. Bill Guest and John M. Sellers eds. (Pietermaritzburg: University of Natal Press, 1985) 312.

<sup>237</sup> Ruth Edgecombe and Bill Guest. “Labour Conditions on the Natal Collieries: The Case of the Dundee Coal Company 1908-1955”. (Unpublished Paper, University of the Witwatersrand: African Studies Seminar Paper, May 1986) 1-7.

<sup>238</sup> Bhekuyise Isaac Mthembu. “Faction Fighting in Umsinga District from 1874-1906”. (Master’s dissertation, Department of History, University of Zululand, 1994) 1-22.

wages for their families.<sup>239</sup> Whilst working in these types of jobs on a contract basis, they were usually housed temporarily on the properties of these mine or factory owners until their contracts ended and they would then return home. As with Umsinga, this forced Africans left in the “reserves”, particularly women, the elderly, and children to carry the majority of the load of homestead production in the “reserve” areas.<sup>240</sup>

Other than Africans and European settler populations, Newcastle also became home to people who had migrated to Natal from India. As was the case with Africans from the “reserves”, “Coolies” as Indians were commonly referred to by the colonial government, were drawn to the area to take advantage of various job opportunities offered in and around this town.<sup>241</sup> Some “free” or “passenger” Indians made their own way to the area as traders to open shops to sell goods to communities living in and around Newcastle. Others came to work in the iron and steel factories.<sup>242</sup> However, the majority of Indians who came to the area from the 1860s were brought as indentured labourers to work on the coalmines or for the Natal government on the railway lines.<sup>243</sup> While indentured labourers were usually accommodated in barracks-like accommodation on the properties of their employers or the government, “passenger” and “free” Indians either rented or bought property on the outskirts of the Newcastle town area. Furthermore, from 1887, those Indians living in the town area were expected to carry permits from the Resident Magistrate giving their permission to

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<sup>239</sup> Edgecombe and Guest, “Labour Conditions on the Natal Collieries”, 1-20.

<sup>240</sup> Ingrid Mary Machin. “The Levying of Forced African Labour and Military Service by the Colonial State of Natal”. (PhD dissertation, Department of Historical Studies, University of Natal, Pietermaritzburg, 1995) and Narrissa Ramdhani. “Financing Colonial Rule: The Hut Tax System in Natal 1847-1898”. (Masters dissertation, Department of History, University of Natal, Durban, 1985).

<sup>241</sup> Baylis, *A History of Newcastle*, 59.

<sup>242</sup> PAR NCP 8/1/13/2/11 *Blue Books for the Colony of Natal 1903*. Report of J.O. Jackson, the Resident Magistrate of Newcastle Division for the year ended 31 December 1903. (Pietermaritzburg: Government Printers, 1904) 30.

<sup>243</sup> Surendra Bhana and Joy Brain. *Setting down Roots: Indian Immigration to South African, 1860-1911*. (Johannesburg: Witwatersrand University Press, 1990) 178-180.

remain in the town area, and were forced to endure curfew restrictions, which limited their movements at night.<sup>244</sup>

Concerning the health care situation in Newcastle, as was the case in Umsinga during the latter half of the 1800s, most people who lived in the Newcastle area and its neighbouring African “reserve” lands used longstanding and well-tried home remedies to heal themselves. Alternatively, if such home remedies did not work, Africans and Indians sought out the services of indigenous healers whom they felt were familiar with their socio-cultural backgrounds and beliefs, and importantly could assist them with illnesses caused by natural and/or supernatural causes.<sup>245</sup> People could also consult with the District Surgeon on a private basis.

Concerning the biomedical health care services in the area, these were inadequate before the Newcastle Cottage Hospital opened. In fact, unlike Umsinga, up until the late 1800s, the Newcastle magisterial district did not have any mission dispensary or clinic facilities in the area.<sup>246</sup> Indeed, those wanting to use such services had to travel to Dundee (about 80 kilometres south) or to Umsinga (about 130 kilometres to the southeast). In addition, although the Newcastle magisterial district had a District Surgeon who provided health care services on behalf of the colonial government, this doctor was incredibly overworked. Indeed, his efforts to prevent disease outbreaks, as well as attending to illnesses, accidents or injuries of people working at government facilities and the mines, not to mention

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<sup>244</sup> Baylis, *A History of Newcastle*, 59.

<sup>245</sup> Karen Flint. *Healing Traditions: African Medicine, Cultural Exchange and Competition in South Africa*. (Athens, OH: Ohio University Press and Pietermaritzburg University of Natal Press, 2008) 95-119 and Harriet Ngubane. *Body and Mind in Zulu Medicine. Ethnography of Health and Diseases in Nyuswa-Zulu Thoughts and Practice*. (London: Academic Press, 1977) 100-101.

<sup>246</sup> PAR NCP Box 7/4/1 *Departmental Reports for the Colony of Natal, 1893-1894: Medical Reports*. Report of J.M. Ormond, District Surgeon of Newcastle Division. Newcastle Division for the year 1 July 1893 to 30 June 1894. (Pietermaritzburg: Government Printers, 1894) B7.



operating a part-time private practice made it difficult to help all the people needing his care.<sup>247</sup>

The Newcastle Cottage Hospital became a reality in the early 1900s, after several years of lobbying by various interested parties. As was the case with the Umsinga Cottage Hospital, the creation of this hospital was instigated by the Resident Magistrate (Mr. Philip Allen) and the District Surgeon (Dr J. M. Ormond), but also several Newcastle community members, who lobbied for its development.

There were a number of reasons given to build this hospital. One of the points raised by a resident of the town in a petition sent to the local government was that there was no state hospital provided in the area.<sup>248</sup> Indeed, if a person needed to be treated in a state hospital for something more serious, they had to travel great distances to Ladysmith (approximately 110 kilometres), Umsinga (approximately 130 kilometres) or Pietermaritzburg (approximately 260 kilometres) away.

Another point mentioned by the Newcastle Town Board was Newcastle's status as a "frontier town" on the main road to the gold mines of the Witwatersrand.<sup>249</sup> Those arguing this point asserted the need for a hospital to cater for the growing influx of people settling in the area and passing through the town to and from the gold fields. Other members of the community felt that Newcastle needed its own hospital to accommodate growing numbers of workers attracted to the area to work on the coalmines, railways and other related industrial enterprises. Increasing numbers of workers meant the possibility of more work related injuries and sicknesses and thus provision of facilities to treat them.<sup>250</sup> The fact that a large

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<sup>247</sup> PAR NCP Box 7/4/1 *Departmental Reports for the Colony of Natal, 1893-1894: Medical Reports*. Report of J.M. Ormond, District Surgeon, Newcastle Division, 1 July 1893 to 30 June 1894, B7.

<sup>248</sup> PAR CSO Vol 916 Ref 1883/2738 Letter from F.N. Tucker (Secretary of the Town Council) to Sir Henry Ernest Bulwer (Lieutenant-Governor of the Colony of Natal) re "Petition asking that £1000 be placed on the Estimates for a Cottage Hospital at Newcastle", 16 July 1883.

<sup>249</sup> PAR CSO Vol 916 Ref 1883/2738 Letter from Tucker to Bulwer, re "Petition", 16 July 1883.

<sup>250</sup> PAR CSO Vol 997 Ref 1884/4421 Letter from F.N. Tucker (Secretary of the Town Council) to C.B.H. Mitchell (Colonial Secretary of Natal), re "Conditions on which the Grant of £250 to the Newcastle Cottage Hospital will be made", 2 January 1884.

division of Natal's Mounted Police was stationed in the Newcastle area in the early 1890s to guard the town from attacks from Boers from the Transvaal Republic provided another incentive to build a hospital.<sup>251</sup> Those arguing for this point asserted that in times of conflict, there were inadequate health care services available to assist these police officers, and that these men suffered because of this.

As a result, in 1885, the Resident Magistrate representing the Newcastle Town Board made a formal request to the Lieutenant Governor of the colony of Natal, Sir Henry Ernest Bulwer, to get permission and the necessary funds to erect a cottage hospital in Newcastle. It took several years but eventually, the then newly appointed Governor of Natal, agreed to this in 1898. The building started in 1900. Similar to Umsinga, the building chosen for this purpose was an already existing building, which was attached to the local gaol, and had been used as a mortuary before it was converted. However, unlike Umsinga's Cottage Hospital, the renovations needed to create the Newcastle Cottage Hospital cost only £926, because the old building renovated for this purpose was larger in size and required less construction work to make it suitable for its new purpose.<sup>252</sup>

The Newcastle Cottage Hospital opened in June 1901.<sup>253</sup> In terms of its initial layout, it consisted of three wards with 13 beds, a surgery area, and a consultation area. It also had a kitchen and pantry.<sup>254</sup> Unlike Umsinga, which was developed as a "Native hospital", this cottage hospital was established to treat both black and white patients, though in segregated wards. Indeed, each of the three wards of this hospital was created with the purpose of treating the region's main "race groups" separately, namely Africans, Indians and whites.<sup>255</sup> Furthermore, unlike Umsinga, this cottage hospital did not encourage the building of huts

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<sup>251</sup> PAR NCP Box 7/4/1 *Departmental Reports for the Colony of Natal, 1893-1894*. Report from Sam L.W. Rowse, the Resident Magistrate of Newcastle Division for the year 1 July 1893 to 30 June 1894. (Government Printers: Pietermaritzburg, 1894) B7.

<sup>252</sup> Gorny, "Historic Hospitals in Natal", 171-172.

<sup>253</sup> Gorny, "Historic Hospitals in Natal", 175-177.

<sup>254</sup> Gorny, "Historic Hospitals in Natal", 149.

<sup>255</sup> Gorny, "Historic Hospitals in Natal", 149-150.

near the property to house relatives and friends of patients as it had a kitchen on site where staff could prepare food for the patients.

### **Dundee Cottage Hospital**

The area of Dundee was located in the valley of the Biggarsberg mountain range in northern Natal.<sup>256</sup> For most of the 1800s, the area was rural, made up of scattered African homesteads, with families who farmed livestock and crops. From the late 1830s, as was the case in Newcastle, the population dynamic of the area changed with the arrival of the Voortrekkers who were looking to establish farms in the area. During the 1840s, British settlers also started settling in the area and engaged in farming activities. The area was named Dundee by one of the early British farmers, who named his farm after his place of origin in Scotland.

When settlers in the area discovered the region's rich coal deposits, Dundee, as had been the case with Newcastle, quickly developed into a town from the 1860s. More settlers were attracted to the area to develop the mines, to find employment, or to set up other businesses that served or were associated with the mines.<sup>257</sup> Three of Dundee's biggest coalmines in the late 1800s were Malahleni, Hlatikulu and Burnside. Under Proclamation No. 46, the town of Dundee but also its surrounding area became a magisterial district of the British colony of Natal in 1889.<sup>258</sup>

As had been the case in Umsinga and Newcastle, the African population of Dundee were forced to relocate into "reserves" as part of the Shepstone System. These "reserves" were located outside the magisterial district of Dundee. Over time, as had been the case for those living in "Native reserves" on the outskirts of Newcastle or in Umsinga, Africans living on "reserves" near to the Dundee area experienced similar land shortages and overcrowding

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<sup>256</sup> Ruth Edgecombe and Bill Guest. *Labour Conditions of the Natal Collieries: The Case of the Dundee Coal Company 1908-1955*. (African Studies Institute, University of the Witwatersrand, 1986) 5.

<sup>257</sup> Edgecombe and Guest, "Labour Conditions on the Natal Collieries", 1.

<sup>258</sup> PAR NCP Box 7/2/2/6 *Supplement to the Blue Book for the Colony of Natal for the Year 1889*. Report from Henry F. Fynn, Resident Magistrate, Umsinga Division, B43.

problems, as well as impoverishment. During the late 1800s and early 1900s, Dundee's coalmines provided the most important employment opportunities in the area, which attracted African migrant labourers who wanted to find wage employment to help support themselves and their families.<sup>259</sup> Similar to Africans who worked in Newcastle, Africans who worked in the Dundee area usually lived in employer provided accommodation on the mines, associated industries or as labour tenants on white farms, and returned to their rural "reserve" homes after their contracts ended.<sup>260</sup>

However, as time passed, and because of the low wages paid to these migrant workers, many workers could not afford to send much in the way of wages back home to their families. As a result, many wives and their children followed their husbands to Dundee, where they settled on mine-owned land around the coalfields in shacks they had set up, while some rented rooms in these informal settlements.<sup>261</sup> The mine owners usually ignored these informal settlements, as they wanted to keep their workers' wages low, and these settlements provided a solution where wives could live close to their husbands and live cheaply on the low salaries provided. Some women were also able to find jobs, for example, as domestic workers in white homes in Dundee, which helped to supplement their husbands' incomes.<sup>262</sup>

In addition, Indian indentured labourers were also brought to Dundee to work as cheap labourers on the coalmines or as Natal government railway construction workers.<sup>263</sup> These workers usually lived on the properties of their employers until they completed their contracts.<sup>264</sup> Apart from indentured labourers, "passenger" and "free" Indians were also attracted to the region to set up farms or to sell items, such as fruit and vegetables, as well as

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<sup>259</sup> PAR NCP Box 7/2/2/6 *Supplement to the Blue Book for the Colony of Natal for the Year 1889*. Report of Maynard Matthew, the Resident Magistrate of Dundee Division. (Pietermaritzburg: Government Printers, 1890) B80.

<sup>260</sup> Ruth Edgecombe. "The Token System: Labour Acquisition and Control on the Natal Collieries, 1911-1956". (Unpublished paper presented to the University of the Witwatersrand History Workshop, 9-14 February 1987), 4.

<sup>261</sup> Edgecombe, "The Token System", 5.

<sup>262</sup> Edgecombe, "The Token System", 9.

<sup>263</sup> Edgecombe, "The Token System", 3.

<sup>264</sup> Edgecombe and Guest, "Labour Conditions on the Natal Collieries", 2.

other supply shops.<sup>265</sup> Interestingly, there is evidence to suggest that several Indian traders even set up *muthi* shops in such towns, where these traders sold herbs and other items used for “traditional healing”.<sup>266</sup> As was the case with those living in the Umsinga and Newcastle areas in the late 1800s, most people living in and around Dundee used home remedies first, to try to heal their ailments, and only consulted “traditional healers” if their home remedies failed. Furthermore, most people at the time would have resorted to the services of biomedically-trained doctors only as a last resort, if neither home remedies nor the services of “traditional healers” worked.<sup>267</sup>

During the 1800s, people living in the Dundee area could have accessed biomedical services through three main avenues: the District Surgeon, mine doctors and Christian missionaries. As was the case in Umsinga and Newcastle, a government-appointed District Surgeon also served the district of Dundee, and spent much of his time attending to the needs of various people for his government responsibilities, tried to stop the spread of infectious diseases, and treated patients in his part time private practice.<sup>268</sup>

Government records also highlight the existence of a handful of medical officers who were appointed to work on some of this district’s large coalmines.<sup>269</sup> This occurred particularly from the 1870s after the Indian government threatened to stop sending indentured labourers to Natal unless the state and employees of indentured labourers made concerted efforts to improve medical services for their labourers. Before this period, mineworkers suffered from poor health, malnutrition and other diseases, which were caused by unhygienic and overcrowded living conditions on the mine compounds, and the poor quality and quantity

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<sup>265</sup> Surendra Bhana and Joy Brain. *Setting down Roots: Indian Immigration to South African, 1860-1911*. (Johannesburg: Witwatersrand University Press, 1990) 29-44.

<sup>266</sup> Flint, *Healing Traditions*, 95-128.

<sup>267</sup> Leslie Swartz. *Culture and Mental Health: A Southern African Review*. (Cape Town: Oxford University Press, 1998) 87-89.

<sup>268</sup> PAR NCP Box 7/2/2/6 *Supplement to the Blue Book for the Colony of Natal for the Year 1889: Medical Reports*. Report from Dr A.J. Abraham, District Surgeon of Dundee Division. (Pietermaritzburg: Government Printers, 1890) B84.

<sup>269</sup> Edgcombe and Guest, “Labour Conditions on the Natal Collieries”, 13.

of food.<sup>270</sup> Thus doctors were employed by some wealthy mine owners to treat their workers' illnesses and to advise them about ways to improve their workers' living and working conditions.

Other than the District Surgeon and a few private mine doctors, people in the area could also take advantage of the medical services offered by the Church of the Swedish Mission. Although this mission had started its work in 1893 on land it had bought near the Dundee coalfields, it was only in the late 1890s that it was able to provide biomedical services.<sup>271</sup> During this period, a wealthy Swedish supporter of the mission, Countess, H. Posse, donated a piece of land in the central town area of Dundee, as well as the funds to build a small hospital. The Swedish Mission Hospital (also known as the Betania Hospital), was officially opened in 1899 and provided accommodation for 40 patients of all races. The initial staff consisted of two mission doctors, a matron and three Swedish nursing sisters.<sup>272</sup>

Although better off in terms of its supply of biomedical doctors than Newcastle had been before its cottage hospital was built, strong arguments were made for the establishment of a cottage hospital in Dundee between 1900 to 1901. Firstly, similar to the Newcastle situation, arguments were made in favour of a new hospital in Dundee to cater for the growing population, particularly of African and Indian workers, which resulted from the development of the region's coalmining industry.<sup>273</sup> Secondly, the Dundee District Surgeon made repeated appeals to the government to establish a hospital to accommodate the growing numbers of patients, particularly coalminer and railway workers that he was attending to in his district.<sup>274</sup>

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<sup>270</sup> Edgecombe and Guest, "Labour Conditions on the Natal Collieries", 3.

<sup>271</sup> Gelfand, *Christian Doctor and Nurse*, 129.

<sup>272</sup> Gelfand, *Christian Doctor and Nurse*, 130 and Gorny, "Historic Hospitals in Natal", 261.

<sup>273</sup> PAR CSO Vol 1706 Ref 1902/4791 Minute Paper from Dr Ernest Hill (Health Officer of the Colony of Natal) to Mr. John C. Bird (Principal Under Secretary), re "Completion of Dundee Cottage Hospital", 25 June 1902, 2-7.

<sup>274</sup> PAR DPH Vol 9 Ref DPH986/02 Minute Paper from Dr. Ernest Hill (Health Officer for the Colony of Natal) to Dr. A.J. Abraham (District Surgeon of Dundee Division), re "Question of the Cottage Hospital", 1 December 1902.

Thirdly, the government also recognised the burden it had placed on the Swedish Mission Hospital as the only available institution for the treatment of all race groups.<sup>275</sup> Indeed, during the South African War, this Swedish Mission Hospital had been stretched beyond its capacity as it also served as a military hospital, treating British troops and civilians injured during battles against Boer forces, such as the Battle of Talana in 1899, or when troops were ambushed on patrol.<sup>276</sup>

As was the case with the previously discussed cottage hospitals, the conceptualisation and motivation for the erection of the Dundee Cottage Hospital took some years before it was actually realised. In addition to the Resident Magistrate and District Surgeon, interested community members such as the Mayor and the Natal Mining Association were key lobbyists of the Natal colonial government to erect this hospital.<sup>277</sup>

In 1900 when permission was eventually given and funds were made available to go ahead with the construction work,<sup>278</sup> unlike the Umsinga and Newcastle cottage hospitals, which were built in central areas of their districts, the site chosen for the construction of the Dundee Cottage Hospital was on the outskirts of the town on the main road to Ladysmith. This site was chosen to accommodate the growing African and Indian population located on

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<sup>275</sup> PAR CSO Vol 1697 Ref 1902/874 Minute Paper from Rev. L.P. Norenus (Superintendent of the Swedish Church Mission Hospital) to Dr Ernest Hill (Health Officer for the Colony of Natal), re “Annual Reports for the year ending 31<sup>st</sup> December 1901”, 1 January 1902; PAR DPH Vol 8 Ref DPH754/02 Minute Paper from Dr A.J. Abraham (District Surgeon Dundee Division) to Dr Ernest Hill (Health Officer for the Colony of Natal) re “Overcrowded State of the Swedish Hospital and Completion of Dundee Cottage Hospital”, 1 October 1902; PAR DPH Vol 37 Ref DPH505/08 Minute Paper from Dr A.J. Abraham (District Surgeon of Dundee Division) to Rev. L.P. Norenus (Superintendent of the Swedish Church Mission Hospital) re “The Overcrowded State of Swedish Mission Hospital”, 8 October 1908.

<sup>276</sup> Gorny, “Historic Hospitals in Natal”, 266.

<sup>277</sup> PAR Public Works Department (hereafter PWD) Vol 2/91 Ref PWD3967/1900 Minute Paper from the Honorary Secretary of the Natal Mining Association to Mr. Barnes (Chief Engineer, Public Works Department), re “Proposed Cottage Hospital at Dundee”, 26 July 1900; PAR DPH Vol 7 Ref DPH826/02 Letter from W.H. Tatham (Mayor of Dundee) to Dr. Ernest Hill (Health Officer of the Colony of Natal) re “Incomplete condition of the Government Cottage Hospital”, 27 July 1902; PAR DPH Vol 9 Ref DPH986/02 Minute Paper from Dr. Ernest Hill to Dr. A.J. Abraham, re “Question of the Cottage Hospital”, 1 December 1902.

<sup>278</sup> PAR CSO Vol 1658 Ref 1900/7562 Minute Paper from F. J. Birkett (Town Clerk Dundee) to the Colonial Secretary re “The Government Intention to Erect a Hospital in Dundee”, 2 June 1900, 3-9.

the outskirts of the town, and to be near to the railroad, which was being constructed between Ladysmith and Dundee by a large work force at the time.<sup>279</sup>

In addition, unlike Umsinga and Newcastle, the Dundee Cottage Hospital was to be constructed as a new building, not a renovation of an existing building.<sup>280</sup> The contractors appointed to complete the construction work did so in April 1901 at a cost of £500. The cost of this cottage hospital was a lot cheaper compared to those erected in Newcastle and Umsinga as it did not need costly renovations or extensions. Rather, this new build was constructed as a simple, single-storey brick building, with a corrugated iron roof and cement floors.<sup>281</sup>

However, its opening was delayed by another two and a half years. Although the construction was completed in the early months of 1901, it did not have any furniture or equipment. The main reason for this was the outbreak of the South African War between 1899 and 1902. This meant delays in completing the hospital because of funding shortages, which were used instead for the war effort.<sup>282</sup> Furthermore, in November 1901, the colonial government allowed a few military officers from the British army, stationed in the area during the period of the South African War, to occupy temporarily the premises until June 1902.

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<sup>279</sup> Gorny, "Historic Hospitals in Natal", 175.

<sup>280</sup> Gorny, "Historic Hospitals in Natal", 175.

<sup>281</sup> PAR CSO Vol 1706 Ref 1902/4791 Minute Paper from Dr Ernest Hill to the Colonial Secretary, re "Completion of Dundee Cottage Hospital", 25 June 1902, 2-7; Gorny, "Historic Hospitals in Natal", 175-178.

<sup>282</sup> PAR Minister of Justice and Public Works (hereafter MJP) Vol 88 Ref LW5769/1901 Minute Paper from Major Hector Corbyn (Head of Royal Artillery) N.H. Hime (Minister of Land and Works) re "Permission to live in the newly erected Cottage Hospital at Dundee", 2 November 1901, 1-6; PAR DPH Vol 8 Ref DPH642/02 Minute Paper from Dr Ernest Hill (Health Officer of the Colony of Natal) to Major Hector Corbyn (Head of Royal Artillery), re "Proposal that Officers of a Battalion of Artillery should vacate the newly erected Dundee Cottage Hospital", 20 July 1902, 2-13; PAR CSO Vol 1708 Ref 1902/5697 Minute Paper from Mr. John C. Bird (Principal Under Secretary, Natal) to Dr. Ernest Hill (Health Officer of the Colony of Natal), re "Request for Mr. Leseur of the Mines Office to temporally occupy the Cottage Hospital Dundee vacated by Major Corbyn", 16 August 1902.



Eventually, after the war ended and the government was able to procure the necessary furniture and equipment, the Dundee Cottage Hospital was opened in December 1903.<sup>283</sup> Similar to Newcastle's Cottage Hospital, it was initially opened to treat black and white patients, offering two segregated wards with 11 beds.<sup>284</sup> This hospital also had kitchen facilities, a small operating theatre, a patient consultation area, and ablution facilities. This hospital was provided with electricity in 1902, which meant that its staff and patients were provided with the convenience of electric lights immediately upon opening.<sup>285</sup>

However, in 1904, just a few months after opening, the colonial government classified this hospital as a "European-only" facility. According to Dr Ernest Hill, the Health Officer of the colony of Natal, this occurred because soon after opening, this small hospital's facilities were overwhelmed by the large numbers of black patients who needed to be admitted for medical care.<sup>286</sup> In its first few months of operations, patients were therefore accommodated on floor beds, in the corridors, overwhelming its services and staff. Furthermore, white settlers in this region, who sought treated at this hospital, increasingly voiced complaints about the overcrowding and poor services received at this hospital.<sup>287</sup> Since the hospital was small and could not adequately accommodate the growing number of black patients seeking care, Dr Hill authorised its change in operational status to a whites-only hospital, and negotiated with the Swedish Mission Hospital to take its black patients. As a result, from

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<sup>283</sup> PAR PWD Vol 2/111 Ref PWD3541/1903 Minute Paper from Dr. A.J. Abraham (District Surgeon of Dundee Division and Medical Officer of Dundee Cottage Hospital) to Mr. Barnes (Chief Engineer, Public Works Department), re "List of Furniture required at the Dundee Cottage Hospital", 5 August 1903; PAR DPH Vol 11 Ref DPH439/03 Minute Paper from Dr. Ernest Hill (Health Officer of the Colony of Natal) to Mr. Barnes (Chief Engineer, Public Works Department), re "List of Furniture and other Requirements for the Cottage Hospital at Newcastle and Dundee", 3 November 1903.

<sup>284</sup> PAR PWD Vol 2/121 Ref PWD7110/1903 Minute Paper from F.J. Birkett (Town Clerk Dundee) to the Colonial Secretary, 10 January 1903.

<sup>285</sup> PAR PWD Vol 2/103 Ref PWD1594/1902 Minute Paper from Mr. Barnes to Dr Ernest Hill, re "Cottage Hospital Dundee", 12 January 1902, 1-15.

<sup>286</sup> PAR DPH Vol 2842 Ref DPH1903/1842 Minute Paper from Dr Ernest Hill (Health Officer of the Colony on Natal) to the Colonial Secretary, re "Arrangements for the Treatment of Europeans Only at Dundee Cottage Hospital", 17 March 1903, 1-9.

<sup>287</sup> PAR DPH Vol 16 Ref 194/1904 Minute Paper from Dr Ernest Hill (Health Officer of the Colony of Natal) to Dr H.J. Galbraith (Medical Attendant to the Glencoe Collieries), re "Guarantees for Hospital Patients at Dundee Cottage Hospital", 22 March 1904.

1904, African and Indian patients needing biomedical care were referred to the Swedish Mission Hospital for treatment.<sup>288</sup> Importantly, the majority of black communities living in this, as well as the Newcastle and Umsinga areas continued to rely on their own home remedies or the services of ‘traditional healers’ for their health care needs.

This chapter has considered the various factors that led to the establishment of three cottage hospitals by the colonial government in Natal. In addition to considering when and why they were built, and whether they were built as new structures or were renovated from older buildings, this chapter has also examined how these hospitals were built to serve different population groups. While Umsinga Cottage Hospital was built to serve a primarily rural African population, Newcastle and Dundee Cottage Hospitals were opened with segregated wards to serve racially mixed populations from more urbanised areas. However, analysis of this history has also shown how the original intentions for a cottage hospital could also change as was the case with the Dundee hospital, which was designated a whites-only hospital not long after it opened. The next chapter will focus on how these three cottage hospitals were financed, managed and staffed. It will also consider the influence that racial segregation had on the provision of services at these facilities.

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<sup>288</sup> PAR DPH Vol 2842 Ref DPH1903/1842 Minute Paper from Dr Ernest Hill to the Colonial Secretary, re “Arrangements for the Treatment of Europeans Only at Dundee Cottage Hospital”, 17 March 1903 1-9.

## **CHAPTER FOUR**

### **Racially Divided Institutions: The Management, Staffing and Work of Cottage**

#### **Hospitals in Colonial Natal**

This chapter analyses the operational aspects of Umsinga, Newcastle and Dundee cottage hospitals. In other words, using secondary sources, as well as sources obtained from the Pietermaritzburg Archive Repository, I investigate how these hospitals worked. This includes issues such as management and financing, as well as the medical and non-medical staff who worked at these institutions. As discussed in the previous chapter, the issue of the “race” of the patient to be treated played an important role in the establishment of these hospitals. This chapter will build on analysis of racial issues further and consider how segregation influenced the provision of services at these facilities.

#### **Umsinga Cottage Hospital**

As discussed in the previous chapter, Umsinga Cottage Hospital was opened in 1889 by the colonial government in the Umsinga District. Of the three hospitals analysed in this thesis, it was the most racially segregated institution as it was created and designated as a “Native hospital” to serve the health care needs of the African population of this district.<sup>289</sup> The Resident Magistrate, who was appointed as a local authority to oversee government affairs in this district and to safeguard the interests of the colonial government, had a close working relationship with the Secretary of Native Affairs and the Colonial Secretary and reported to the Health Officer of the Colony of Natal,. Indeed, he managed the affairs of this hospital for the colonial government.

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<sup>289</sup> Pietermaritzburg Archives Repository (hereafter PAR). Secretary of Native Affairs (hereafter SNA) Vol 1/1/120 Ref 1889/1204 Minute Paper from Henry F. Fynn, the Resident Magistrate of Umsinga Division to S.O. Saunders (Under Secretary of Native Affairs), re “Accounts due in Connection with Umsinga ‘Native’ Cottage Hospital”, 12 November 1889 and PAR SNA Vol 1/1/113 Ref 1889/306 Minute Paper from Henry F. Fynn, the Resident Magistrate of Umsinga Division to S.O. Saunders (Under Secretary of Native Affairs), re “Native Cottage Hospital at Umsinga” (Vide Blue Book 1887 page B42, 2 June 1889.

The Resident Magistrate's duties during the late 1800s and first decade of the 1900s were varied and numerous. This person was responsible for ensuring sufficient finances to fund the running of this institution. Indeed, the Resident Magistrate worked closely with the Health Officer of the Colony and Native Affairs Department, which provided a significant portion of the funds needed to cover the running costs of this hospital. The rest of the running costs were covered by patient fees, which were kept at a low level because of the poverty-stricken nature of most Africans who lived in this district.<sup>290</sup> This funding was used to pay the salaries of the staff, and to purchase the medicines, other supplies and equipment needed to run this cottage hospital.<sup>291</sup> As part of his duties, the Resident Magistrate was required for inspecting this hospital regularly (at least once a week). This enabled him to monitor the work of the Medical Officer-in-charge and his staff to ensure that they were carrying out their duties, and to ensure the "well-being of the inmates" (i.e. its patients).<sup>292</sup> He also had the right to refuse admission for patients, or to remove patients from the hospital. Furthermore, the Resident Magistrate addressed any complaints, disputes or questions related to the hospital.

The Resident Magistrate worked closely with the government-appointed District Surgeon, who was also appointed as the Medical Officer-in-charge of the Umsinga Cottage Hospital. This was because there was a lack of western trained medical staff living or working in the area to fill these positions, but it was also a financial decision by the government to keep costs low i.e. it required the payment of only one salary. Dr John

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<sup>290</sup> PAR SNA Vol 1/1/184 Ref 474/1894 Pamphlet attached to Minute Paper from H.C. Shepstone (Secretary of Native Affairs, Natal), "Rules for the Management of 'Native' Cottage Hospitals". (Pietermaritzburg: Natal Government Printers, 1 August 1890) 1-3.

<sup>291</sup> PAR SNA Vol I/1/110 Ref 1888/913 Minute Paper from Henry F. Fynn (Resident Magistrate of Umsinga division) to S.O. Saunders (Under Secretary of Native Affairs, Natal), re "Suggestion for the Erection of a Hospital for the Treatment of Natives in Distress through Wounds or Otherwise", 12 March 1888; PAR SNA Vol 1/1/123 Ref 1890/290 Minute Paper from Henry F. Fynn (Resident Magistrate of Umsinga Division) to S.O. Saunders (Under Secretary of Native Affairs, Natal), re "Furniture received for Umsinga 'Native' Cottage Hospital", 14 August 1890; and PAR SNA Vol 1/1/130 Ref 1890/998 Minute Paper from Henry F. Fynn (Resident Magistrate of Umsinga Division) to S.O. Saunders (Under Secretary of Native Affairs, Natal), re "Provisions of Stock and Other Necessities under Rule No. 12 for Umsinga 'Native' Cottage Hospital", 15 August 1890.

<sup>292</sup> PAR SNA Vol 1/1/184 Ref 474/1894 Pamphlet attached to Minute Paper from H.C. Shepstone, re "Rules for the Management of 'Native' Cottage Hospitals", 1 August 1890, 4-5.

Mavuna Nembula was appointed as the first Medical Officer-in-charge of this hospital in 18 March 1889. Dr Nembula was a special person in South Africa's medical history as he was the first African to train in the USA to become a fully qualified and licenced biomedical practitioner who practiced in Natal.<sup>293</sup>

John Nembula was born into an isiZulu-speaking family on the Adams Mission Station in 1860. His father, Ira Nembula, was one of Dr Newton Adams's earliest African converts to Christianity.<sup>294</sup> John Nembula attended school at Adams Mission. After completing high school, he was taken to the USA in 1883 by the American Board Mission to assist in the translation of the Bible into isiZulu. In addition, he did clerical work to raise money that enabled him to extend his education, which entailed studying medicine at Chicago Medical School.<sup>295</sup> When Dr John Nembula returned to Natal in 1888, a few months later, he was appointed the District Surgeon of Umsinga and Medical Officer-in-charge of Umsinga hospital with a salary of £400 per annum.<sup>296</sup> This occurred despite the opposition raised by whites living in the district, who objected to having a "Zulu doctor" appointed in this position.<sup>297</sup> Edmund Burrows highlights that the local Resident Magistrate at the time, Henry F. Fynn, played a significant role in endorsing Dr Nembula for this position, which resulted in him getting the job.<sup>298</sup>

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<sup>293</sup> PAR Natal Colonial Publications (hereafter NCP) 6/1/1/42. *The Natal Government Gazette*, no. 2371, Tuesday, 6 January 1891, 136.

<sup>294</sup> Sphamandla Zondi. "African Demand and Missionary Charity: The Development of Mission Healthcare in Kwa-Zulu Natal 1919". (PhD Thesis, Department of History, Cambridge University, 15 September 1999) 5.

<sup>295</sup> Zondi, "African Demand and Missionary Charity", 15.

<sup>296</sup> PAR NCP Box 7/2/1/6 *Blue Books for the Colony of Natal 1889*. Report of Henry F. Fynn, the Resident Magistrate of Umsinga Division for the year ended 31 December 1888. (Pietermaritzburg: Government Printers, 1890) B42-B54 and PAR SNA Vol 1/1/126 Ref 1890/697 Minute Paper from Dr. John Nembula (District Surgeon, Umsinga Division) to S.O. Saunders (Under Secretary of Native Affairs, Natal), re "Permission to appoint the Medical Officer for Umsinga 'Native' Cottage Hospital", 13 June 1890.

<sup>297</sup> Edmund H. Burrows. *A History of Medicine in South Africa up to the End of the Nineteenth Century*. (Cape Town: A.A. Balkema, 1958) 223.

<sup>298</sup> Anne Digby. *Diversity and Division in Medicine: Health Care in South Africa from the 1800s*. (Oxford and Berne: Peter Lang, 2006) 193 and Anne Digby. "Early Black Doctors in South Africa". *Journal of African History*. (2005, 46:3), 432 and 448;

Dr Nembula had a lot of responsibilities placed on his shoulders, as both the District Surgeon and Medical Officer-in-charge. Indeed, the archival records discuss how Dr Nembula worked long hours, often more than 12 hours a day, on a regular basis.<sup>299</sup> Firstly, he was responsible for carrying out the usual duties of the District Surgeon, which included travel out into the Umsinga District to attend to patients needing care, such as those at state institutions (e.g. prisoners at the local gaol), doing post-mortem work, and giving vaccinations to people to stop the spread of infectious diseases.<sup>300</sup> Secondly, he aided the staff of the dispensaries of the Church of Scotland's Gordon Memorial Mission and Berlin Lutheran Mission, when they needed his assistance with more serious cases.<sup>301</sup>

Thirdly, as Medical Officer appointed in charge of the Umsinga Cottage Hospital, Dr Nembula was also primarily responsible for the medical and surgical treatment of patients, which he or the Resident Magistrate admitted to this hospital, or those he treated in the outpatients' section. As part of his cottage hospital job, he had to record the information of all patients he admitted to this hospital in an infirmary book. This included their date of admission, their full names, place of residence, their so-called "tribe", age, sex, a brief history of their medical problems and the treatments he gave to his patients.<sup>302</sup> He was also responsible for the discharge of patients after their treatment. Furthermore, at the end of each year, Dr Nembula was required to draw up and submit a report summarising the number of patients he had treated over the year, the types of conditions and diseases treated, the number and cause of deaths of his patients, as well as provide an account of the hospital's expenses

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"Dr John Mavuma Nembula", *South African History Online*, 17 February 2011,

<http://www.sahistory.org.za/people/dr-john-mavuma-nembula> (Accessed on 15 October 2017)

<sup>299</sup> PAR SNA Vol I/1/110 Ref 1888/913 Minute Paper from Henry F. Fynn to S.O Saunders, re "Suggestion to Erect a Hospital for the Treatment of Natives in Distress through Wounds or Otherwise", 12 March 1888.

<sup>300</sup> PAR SNA Vol I/1/184 Ref 474/1894 Pamphlet attached to Minute Paper by H.C. Shepstone, re "Rules for the Management of "Native" Cottage Hospitals", 1 August 1890), 1-4.

<sup>301</sup> Zondi, "African Demand and Missionary Charity", 15-16.

<sup>302</sup> PAR SNA Vol I/1/184 Ref 474/1894 Pamphlet attached to Minute Paper by H.C. Shepstone, re "Rules for the Management of "Native" Cottage Hospitals", 1 August 1890, 1-4.

and fees received from patients.<sup>303</sup> Finally, he could also attend to patients at his home either before or after his hospital or District Surgeon work hours if patients wanted to consult him on a private basis.<sup>304</sup>

Dr Nembula left his post as District Surgeon and Medical Officer-in-charge of Umsinga Cottage Hospital in 1893. Although it is not stated in the archival records why he left, careful analysis of these records suggests it was most likely related to being overworked, as throughout his years of service, he only had one African attendant to assist him. After he left Umsinga, he returned to Amanzimtoti for a couple of years and worked at Adams Mission Station with the American Board missionary, Dr Burt Bridgman, to re-establish the hospital that had been closed after Dr Adams left.<sup>305</sup> Towards the end of 1896, he was appointed District Surgeon of Maphumulo, and moved to this region of Zululand. Burrows tell us that it was there where he died from tuberculosis “while still a young man in 1897”.<sup>306</sup>

After Nembula left Umsinga, other doctors were appointed to replace him as District Surgeon and Medical Officer-in-charge of Umsinga Cottage Hospital. Several white doctors replaced him, including Dr H.T. Platt in 1893, followed by Dr W. Black in 1895. Though Dr Black continued on with his District Surgeon duties until 1903, he only worked as the Medical Officer-in-charge of the Umsinga Cottage Hospital until 1901 when the hospital was closed during the South African War because funding restrictions halted its operations.<sup>307</sup> It

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<sup>303</sup> PAR SNA 1/1/184 Ref 474/1894 Pamphlet attached to Minute Paper by H.C. Shepstone (Secretary for Native Affairs, Natal), “Rules for the Management of “Native” Cottage Hospitals”. (Pietermaritzburg: Natal Government Printers, 1 August 1890), 5.

<sup>304</sup> PAR SNA Vol I/1/110 Ref 1888/913 Minute Paper from Henry F. Fynn (Resident Magistrate of Umsinga Division) to S.O Saunders (Under Secretary of Native Affairs, Natal), re “Suggestion for Erection of a Hospital for the Treatment of Natives in Distress through Wounds or Otherwise”, 12 March 1888.

<sup>305</sup> Zondi, “African Demand and Missionary Charity”, 16.

<sup>306</sup> Burrow, *A History of Medicine*, 223.

<sup>307</sup> PAR Colonial Secretary Office (hereafter CSO) Vol 1433 Ref 1895/2896 Minute Paper from Henry F. Fynn (Resident Magistrate of Umsinga Division) to John C. Bird (Principal Under Secretary, Natal), re “Assumption of Duties of Dr. W. Black, District Surgeon and Medical Officer of Umsinga ‘Native’ Cottage Hospital”, 20 March 1895.

was reopened in 1903, though only treated patients on an outpatients' basis.<sup>308</sup> Dr F.R.H. Potts was appointed as the District Surgeon and Medical Officer-in-charge of this outpatient's facility in 1903, a position he held until 1906 when Dr J.A. Clement was appointed to replace him. Umsinga Cottage Hospital remained an outpatients-only facility until the end of Dr Potts's time there, reverting to both an in-and outpatients facility after the appointment of Dr Clement, and remained so until it was closed in 1910.<sup>309</sup>

As had been the case with Dr Nembula, most of these doctors did not remain for long at these posts because of the difficulty of living and working in this area. For example, in 1903 Dr Potts complained to the Health Officer of the Colony about a number of things. In addition to the low salary he received for his long hours and heavy workload (he received £400 p.a. during his employment period), he objected to the strain placed on him because of the lack of adequate staff. He also complained about the strain placed on his horse, which he had to take out regularly to travel to see patients in the hilly terrain of the Umsinga district.<sup>310</sup> Furthermore, he protested against the white ant infested accommodation provided for him at the hospital; the lack of housing available for white residents outside the hospital in this predominantly "native area"; and the lack of "development" in the area, which made getting

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<sup>308</sup> PAR Department of Public Health (hereafter DPH) Vol 11 Ref DPH283/1903 Minute Paper from Dr F.R.H. Potts (District Health Officer, Umsinga) to Dr Ernest Hill (Health Officer of the Colony of Natal), re "Difficulties Connected with Existence, and Retaining Services of a District Surgeon at Pomeroy", 24 March 1903.

<sup>309</sup> PAR SNA Vol 1/1/193 Ref 1390/1894 Minute Paper from Henry F. Fynn (Resident Magistrate, Umsinga) to S.O. Saunders (Secretary of Native Affairs, Natal), re "Request for Dr. Jaynes to be appointed District Surgeon of Umsinga 'Native' Cottage Hospital", 5 November 1894; PAR CSO Vol 1433 Ref 1895/2896 Minute Paper from Henry F. Fynn (Resident Magistrate, Umsinga) to John C. Bird (Principal Under Secretary, Natal), re "Dr. W. Black assumed Duties as District Surgeon and Medical Officer of Umsinga 'Native Cottage Hospital'", 20 March 1895; PAR CSO Vol 1317 Ref 1891/6568 Minute Paper from A.G Thomson (Medical Doctor, Colony of Natal) to John C. Bird (Principal Under Secretary, Natal) re "Application for Appointment as District Surgeon, Umsinga Division and Medical Officer of Umsinga Native Cottage Hospital", 6 September 1891.

<sup>310</sup> PAR DPH Vol 11 Ref DPH283/1903 Minute Paper from Dr F.R.H. Potts to Dr Ernest Hill, re "Difficulties Connected with Existence, and Retaining Services of a District Surgeon at Pomeroy", 24 March 1903, 1-5.



medical supplies, and even food difficult. Initially, when he arrived in this district, Umsinga did not even have a butchery, bakery and very few fresh vegetable and fruit shops.<sup>311</sup>

In 1906, when Dr Clement took over, in addition to mentioning similar problems, he also made repeated arguments to expand the size of the hospital. In a letter to the Resident Magistrate on 4 February 1907, Dr Clement expressed his frustration at the small size of his operating facilities, the limited medical equipment available to him, such as his need for an operational steam steriliser, and the hospital's inadequate medical supplies, such as dressings and medicines.<sup>312</sup> Moreover, he made repeated requests to the Resident Magistrate to appoint more staff, including two nurses, to assist him during operations and to help oversee the care of patients when he was out working in the district, as well as an Indian and African attendants in the hospital to help cater for the growing numbers of patients.<sup>313</sup>

In terms of staff, it is important to note that when the Umsinga Cottage Hospital was opened in 1889, other than the Medical Officer, the only other staff member appointed by the Resident Magistrate to work at this small hospital was an untrained male African hospital guard/attendant, who lived at the hospital and was paid £18 p.a. with rations.<sup>314</sup> In addition to guarding and cleaning the property, he was also required to assist the doctor with other tasks he deemed necessary. Since this hospital did not have kitchen facilities, and patients' families

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<sup>311</sup> PAR DPH Vol 11 Ref DPH283/1903 Minute Paper from Dr F.R.H. Potts to Dr Ernest Hill, re "Difficulties Connected with Existence, and Retaining Services of a District Surgeon at Pomeroy", 24 March 1903, 1-5.

<sup>312</sup> PAR SNA Vol 1/1/381 Ref 1907/3012 Minute Paper from Dr J.A. Clement (District Surgeon, Pomeroy Umsinga Division and Medical Officer of Umsinga 'Native' Cottage Hospital) to S.O. Saunders (Under Secretary of Native Affairs, Natal), re "Patients treated at Umsinga 'Native' Cottage Hospital", 8 October 1907 and PAR CSO Vol 1828 Ref 1907/1212 Minute Paper from Dr Ernest Hill (Health Officer of the Colony of Natal) to Dr J.A. Clement (District Surgeon Umsinga Division and Medical Officer of Umsinga 'Native' Cottage Hospital), re "Drugs for Umsinga 'Native' Cottage Hospital", 26 November 1907.

<sup>313</sup> PAR CSO Vol 1825 Ref 1906/9567 Minute Paper from Dr J.A. Clement (District Surgeon Umsinga Division and Medical Officer of Umsinga 'Native' Cottage Hospital) to John C. Bird (Principal Under Secretary) re "Repair of Umsinga 'Native' Cottage Hospital and the Allotment of Two Indian Attendants", 30 December 1906 and PAR SNA Vol 1/1/360 Ref 1907/95 Minute Paper from Dr J.A. Clement (District Surgeon, Umsinga) to S.O. Saunders (Under Secretary of Native Affairs, Natal) re "Request for the Continuance of the Allowance of £50 a year for the Native Hospital and £18 for a Native Attendant", 23 March 1907.

<sup>314</sup> PAR SNA Vol I/1/113 Ref 1889/306 Minute Paper from Henry F. Fynn to S.O. Saunders, re "Native Cottage Hospital at Umsinga" (Vide Blue Book 1887 page B42), 2 June 1889.

cooked for them in the nearby outdoor huts to feed them, this attendant did not have kitchen duties. This inadequate staffing situation remained in place until 1901 when the hospital closed, but also when it reopened in 1903, and continued into Dr Clement's period, despite their repeated requests to get the Resident Magistrate to appoint additional staff.<sup>315</sup>

This poor staffing situation remained in effect in spite of the growing numbers of "native" male and female patients over the years, primarily people living in the Umsinga District, who received treatment in the two wards (12 beds) of this small health care facility. Indeed, although 29 in-patients were only recorded in 1889, soon after opening, this small hospital experienced a serious shortage of accommodation as was reported by Dr Nembula during a five months period between 1 July 1890 and 30 November 1890. In his report to the Resident Magistrate, he recorded having treated 99 patients during this period. While he could squeeze 18 patients into beds or onto floor beds inside the hospital and down its corridors, he was forced to accommodate 81 patients outdoors or in outdoor huts on mats as the hospital had no more room for them inside its main building.<sup>316</sup> Many of these patients were seriously ill and had travelled long distances to get medical care in this institution.

In addition to highlighting the problems of overcrowding on the hospital's wards, which produced unhygienic treatment conditions because patients often came to hospital with "their bodies greased their carryings dirty and full of lice",<sup>317</sup> he also noted the problems related to patients being treated outdoors. While he did recognise that many of his patients preferred staying outdoors or in huts constructed near the hospital to be close to their loved

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<sup>315</sup> PAR CSO Vol 1825 Ref 1906/9567 Minute Paper from Dr J.A. Clement to John C. Bird. Re "Repair of Umsinga 'Native' Cottage Hospital and the Allotment of Two Indian Attendants", 30 December 1906.

<sup>316</sup> PAR SNA Vol 1/1/13 Ref 1890/997 Minute Paper from Henry F. Fynn (Resident Magistrate, Umsinga Division) to S.O. Saunders (Under Secretary of Native Affairs), "Dr. John Mavuma Nembula, District Surgeon and Medical Officer of Umsinga Cottage Hospital Application for Additional Accommodation, Kitchen, Storeroom and Additional Ward", 15 August 1890.

<sup>317</sup> PAR SNA Vol 1/1/130 Ref 1890/997 Minute Paper from Henry F. Fynn to S.O. Saunders re "Dr. John Mavuma Nembula... Umsinga Cottage Hospital Application for Additional Accommodation", 15 August 1890.

ones, this situation did not ensure the best quality of biomedical care because he could not control the cleanliness of these huts.<sup>318</sup>

Between 1889 and 1910, Umsinga Cottage Hospital records show that this hospital attracted many African patients from different parts of the district. This hospital accommodated male and female African patients separately in two different wards. The staff at this hospital treated the following common health problems/conditions: fractures and wounds (of all kinds), spinal and skin conditions/diseases, infectious diseases such as pneumonia, flu, smallpox, tuberculosis, enteric fever, but also ulcers, diarrhoea, otitis, scrofula, bronchitis, dyspepsia and rheumatism. It also treated patients suffering from psychological conditions such as hysteria. Furthermore, this hospital accommodated maternity cases, as well as treated children for a variety of conditions.<sup>319</sup> Numerous minor and major surgical cases were also dealt with, such as removal of cancerous tumours and limb amputations.<sup>320</sup>

Dr Nembula played an important role in attracting African patients to what would have been to them an unfamiliar biomedical institution. The fact that he was an isiZulu-speaking doctor, whose family originated from the Amanzimtoti area, meant that they would

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<sup>318</sup> PAR SNA Vol I/1/130 Ref 1890/997 Minute Paper from Henry F. Fynn to S.O. Saunders, re “Dr. John Mavuma Nembula... Umsinga Cottage Hospital Application for Additional Accommodation”, 15 August 1890.

<sup>319</sup> PAR SNA Vol I/1/110 Ref 1888/913 Minute Paper from Henry F. Fynn to S.O. Saunders re “Suggestion to Erect a Hospital for the Treatment of Natives in Distress through Wounds or Otherwise”, 12 March 1888; PAR SNA Vol I/1/113 Ref 1889/306 Minute Paper from Henry F. Fynn to S.O. Saunders, re “Native Cottage Hospital at Umsinga” (Vide Blue Book 1887 page B42), 2 June 1889; PAR NCP 7/2/2/9 *Supplement to the Blue Books for the Colony of Natal 1892-1893: Medical Reports*. Report from Dr. H. T. Platt (District Surgeon Umsinga Division, and Medical Officer, Umsinga Cottage Hospital) for the year ended June 1893 (Pietermaritzburg: Government Printers 1893) B26-B27; PAR SNA Vol I/1/185 Ref 530/1894 Minute Paper from S.O. Saunders (Under Secretary of Native Affairs, Natal) to Henry F. Fynn (Resident Magistrate, Umsinga Division) re “Request that the Annual Report (TO31/12/93) on the Native Cottage Hospital be Forwarded to him”, 30 April 1894; PAR CSO Vol 1433 Ref 1895/2896 Minute Paper from Henry F. Fynn to John C. Bird, re “Assumption of Duties of Dr. W. Black”, 20 March 1895; PAR SNA Vol I/1/381 Ref 1907/3012 Minute Paper from Dr J.A. Clement to S.O. Saunders, re “Patients treated at Umsinga ‘Native’ Cottage Hospital”, 8 October 1907; and PAR CSO Vol 1828 Ref 1907/1212 Minute Paper from Dr Ernest Hill to Dr J.A. Clement, re “Drugs for Umsinga ‘Native’ Cottage Hospital”, 26 November 1907.

<sup>320</sup> PAR NCP 7/2/2/9 *Supplement to the Blue Books for the Colony of Natal 1892-1893: Medical Reports*. Report from Dr. H. T. Platt (District Surgeon Umsinga Division, and Medical Officer, Umsinga Cottage Hospital) for the year ended June 1893 (Pietermaritzburg: Government Printers 1893) M14.

have felt more relaxed about being treated in this facility because he would have been familiar with their customs and would have been able to communicate well with them because he knew their language. He would also have been aware that most of his patients would have tried other means to heal themselves, such as the services of “traditional healers” before coming to his hospital for treatment. In addition, many of his patients would have preferred the treatment he provided as although the nearby mission dispensary offered clinical services for patients, these services were more basic in nature, and some patients did not like being preached to about Christianity during their treatment at this institution.<sup>321</sup>

The decision by Dr Nembula (having received permission from the Resident Magistrate) to allow Africans to build huts outside the main building where family members of patients could stay, but also prepare food for their sick loved ones, shows that he understood the importance of wider family and community support in healing African patients.<sup>322</sup> This was very different to the situation at most other hospitals in the colony at the time, where patients were usually separated from their families during treatment in hospitals, and their family or friends were only allowed to visit during certain hours specified by the hospital. In addition, as patient numbers expanded over the years, as Medical Officer-in-charge, Dr Nembula was forced, when the wards were too full, to accommodate some patients in these huts too.

Although the doctors who worked at this cottage hospital were not successful in terms of getting funds to appoint more staff, some were successful in pressuring the Resident Magistrate and Native Affairs Department to provide additional money to expand the size of this hospital to accommodate growing patient numbers. For example, at the end of 1890, Dr

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<sup>321</sup> PAR NCP Box 7/2/2/5 *Supplement to the Blue Book for the Colony of Natal 1888: Departmental Reports*. Medical Report from Dr John Nembula, District Surgeon Umsinga Division for the year ended 31 December 1888. (Government Printers: Pietermaritzburg, 1889) B42-B54.

<sup>322</sup> PAR SNA Vol I/1/110 Ref 1888/913 Minute Paper from Henry F. Fynn to S.O. Saunders re “Suggestion to Erect a Hospital for the Treatment of Natives in Distress through Wounds or Otherwise”, 12 March 1888.

Nembula submitted a proposal to the Resident Magistrate suggesting various additions to the hospital. This included an additional large ward to accommodate more patients, kitchen facilities to enable the preparation of food for patients, and a storeroom.<sup>323</sup> This request was forwarded to the Secretary of Native Affairs who approved in 1890 all the additions proposed by Dr Nembula at a cost of £177. After these extensions were made, this hospital had a total of 18 beds. It is likely that the government approved these extensions because of space limitations and thus was necessary, but also because a once-off payment to expand this facility was cheaper than approving the appointment of more staff on a continuous basis. Indeed, we can see in the archival records that the Colonial Secretary instructed the use of prisoners held in the nearby Umsinga gaol to make bricks for these additions to keep the costs down.<sup>324</sup>

In the years after Umsinga Cottage Hospital's closure in 1901 during the South African War and then its reopening after the war in 1903, it was only in 1906 that additional small repair work, such as fixing leaks in walls and the roof, and repairing broken doors, windows and floors, was done at the hospital. Dr Clement, who was appointed Medical Officer-in-charge of this hospital from 1903, played an important role in urging this repair work as he complained regularly to government officials about the hospital's deteriorating and "inhabitable" physical condition.<sup>325</sup> However, this repair work was delayed until 1906. Although one might surmise that this was because it was a "Native hospital" treating African patients and thus was not seen as a priority in the eyes of government officials, the colony

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<sup>323</sup> PAR SNA Vol 1/1/130 Ref 1890/997 Minute Paper from Henry F. Fynn to S.O. Saunders re "Dr. John Mavuma Nembula... Umsinga Cottage Hospital Application for Additional Accommodation", 15 August 1890.

<sup>324</sup> PAR SNA Vol 1/1/130 Ref 1890/997 Minute Paper from Henry F. Fynn to S.O. Saunders, re "Dr. John Mavuma Nembula... Umsinga Cottage Hospital Application for Additional Accommodation", 15 August 1890.

<sup>325</sup> PAR CSO Vol 1825 Ref 1906/9567 Minute Paper from Dr J.A. Clement to John C. Bird, re "Repair of Umsinga 'Native' Cottage Hospital and the Allotment of Two Indian Attendants", 30 December 1906 and PAR SNA Vol 1/1/381 Ref 1907/3012 Minute Paper from Dr J.A. Clement to S.O. Saunders, re "Patients Treated at Umsinga 'Native' Cottage Hospital", 8 October 1907.

was also negatively affected by an economic depression after the war, which would have limited funds for such projects.<sup>326</sup>

### **Newcastle Cottage Hospital**

Opened in 1901 by the colonial government, the Newcastle Cottage Hospital, unlike Umsinga, was established in an area without other biomedical services. It was thus created with the purpose of treating both black and white patients, though on a segregated ward basis. Yet, in a similar manner to the case of the Umsinga Cottage Hospital, the Resident Magistrate of the Newcastle District was appointed to manage the affairs of this hospital, which included this hospital's finances and staffing.

Since Newcastle Cottage Hospital catered for patients of all "races", funding for this hospital came from a number of different sources in the first decade of the twentieth century. This included the white colonial government (via the office of the Health Officer of the Colony), the Native Affairs Department, Newcastle Town Council authorities, and patients' fees.<sup>327</sup> At this hospital, a patient's designated "racial group" influenced the fees paid. Indeed, a graded structure of payment was introduced based on what authorities thought patients

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<sup>326</sup> PAR CSO Vol 1828 Ref 1907/1212 Minute Paper from Dr Ernest Hill to Dr J.A. Clement, re "Drugs for Umsinga 'Native' Cottage Hospital", 26 November 1907; PAR CSO Vol 1825 Ref 1906/9567 Minute Paper from Dr J.A. Clement to John C. Bird, re "Repair of Umsinga 'Native' Cottage Hospital and the Allotment of Two Indian Attendants", 30 December 1906; PAR SNA Vol 1/1/360 Ref 1907/95 Minute Paper from Dr J.A. Clement to S.O. Saunders, re "Request for Continuance of the Allowance of £50 a year for the Native Hospital and £18 for a Native Attendant", 23 March 1907.

<sup>327</sup> PAR CSO Vol 916 Ref 1883/2738 Letter from F.N. Tucker (Secretary of the Town Council) to Sir Henry Ernest Bulwer (Lieutenant-Governor to the Colony of Natal) re "Petition asking that £1000 may be placed on the Estimates for a Cottage Hospital at Newcastle", 16 July 1883; PAR CSO Vol 997 Ref 1884/4421 Letter from F.N. Tucker (Secretary of the Town Council) to the Colonial Secretary re "Conditions on which the Grant of £250 to the Newcastle Cottage Hospital will be made", 2 January 1884; PAR Survey General Office (hereafter SGO) Vol III/1/126 Ref SG1758/1898 Minute Paper from J.G. Kemp (Mayor of Newcastle) to N.H. Hime (Minister of Land and Works), re "Request that the Corporation may be given ERF no 11, Church Street, in Exchange for the Four Acres to be given by the Corporation of the Proposed Cottage Hospital", 24 March 1894; and PAR SGO Vol III/1/126 Ref SG2483/1898 Minute Paper from J.G. Kemp (Mayor of Newcastle) to N.H. Hime (Minister of Land and Works) re "Enquiries upon what terms Government would be Prepared to Dispose of the Erf No 9, Church Street, Newcastle", 8 February 1898.

could afford to pay.<sup>328</sup> For example, Africans and Indians were in 1901 expected to pay 2 shillings per day for in-patient treatment at this hospital while whites were expected to pay 9 shillings per day.<sup>329</sup> In addition, the hospital received fee payments from the owners of various coalmines in Newcastle, to cover the treatment provided for sick or injured-on-the-job employees.<sup>330</sup> Although many of the larger mines had their own doctors on staff who were responsible for maintaining the health of their workers, these doctors could refer patients to the Newcastle hospital in more serious cases. As was the case with Umsinga, Newcastle's Resident Magistrate used this funding to pay for staff salaries, medicines and other supplies needed to run the Newcastle Cottage Hospital.

Interestingly, unlike Umsinga Cottage Hospital, which was forced to close for a period during the South African War, Newcastle's Cottage Hospital did not close during these war years. There are a number of possible reasons for this. Firstly, it was the only hospital in the Newcastle area; a much larger town than Umsinga, so closing it would have closed the only biomedical facility for people in and around the town. Secondly, closing it would have negatively affected both black and white residents. Thirdly, because of its location near to areas where numerous battles took place between the British and Boers during the South African War, it also helped treat wounded soldiers loyal to the British cause.<sup>331</sup>

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<sup>328</sup> PAR DPH Vol 16 Ref 194/1904 Minute Paper from Dr Ernest Hill (Health Officer for the Colony of Natal) to Dr H.J. Galbraith (District Health Officer of Dundee Division and Medical Officer of Dundee Cottage Hospital), re "Guarantees for Hospital Patients at Dundee Cottage Hospital", 22 March 1904.

<sup>329</sup> PAR DPH Vol 16 Ref 194/1904 Minute Paper from Dr Ernest Hill to Dr H.J. Galbraith, re "Guarantees for Hospital Patients at Dundee Cottage Hospital", 22 March 1904.

<sup>330</sup> PAR DPH Box 8/1/12/4/1 Reports of the Health Officer for the Colony of Natal for the year 1904. Report by Dr Ernest Hill. (Pietermaritzburg: Times Printing and Publishing, 1905); PAR DPH Vol 16 Ref 194/1904 Minute Paper from Dr Ernest Hill to Dr H.J. Galbraith, re "Guarantees for Hospital Patients at Dundee Cottage Hospital", 22 March 1904.

<sup>331</sup> PAR DPH Box 8/1/12/4/1. Reports of the Health Officer for the Colony of Natal for the year 1904. Report by Dr Ernest Hill; PAR NCP Box 7/4/7 Departmental Reports, 1900. Medical Report from Dr. Ormond, Medical Officer, Newcastle Cottage Hospital (Government Printers: Pietermaritzburg, 1901) 75.

The only time the hospital actually stopped operating as a general hospital in the period up to 1910 was for a year in 1904 when it was used as an isolation facility for the treatment of white smallpox patients.<sup>332</sup> The records highlight that because of its small size and due to the large numbers of patients (both black and white) who sought treatment for smallpox at this time, the hospital authorities decided to limit treatment to white patients only to alleviate overcrowding, and sent black smallpox patients to the larger, though more distant, Ladysmith Government Hospital during this time. 19 deaths were reported in the Newcastle region during this smallpox outbreak.<sup>333</sup>

The Resident Magistrate of Newcastle had similar duties at the Newcastle Cottage Hospital compared to those who worked in Umsinga. He was required to inspect the hospital weekly to ensure that it functioned well, oversaw the staff to ensure that they carried out their required duties, and kept a close eye on the hospital's expenses, fee collection and accounts. In addition, the Resident Magistrate was responsible, twice a year, for drawing up "a scale of charges for food and maintenance to be paid... by inmates of the hospital during the ensuing six months", which was then given to the Medical Officer to use as his guide in the collection of fees.<sup>334</sup> The Newcastle Resident Magistrate also had the right to admit patients to the Newcastle Cottage Hospital and to refuse the admission of patients.<sup>335</sup>

As was the case in Umsinga, in Newcastle, the District Surgeon, who was also appointed as the Medical Officer-in-charge of the Newcastle Cottage Hospital, worked closely with the Resident Magistrate between 1901 and 1910. Dr John M. Ormond was the

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<sup>332</sup> PAR DPH Vol 17 Ref DPH899/1904 Minute Paper from J. Hastie (Councilor of Ward 1, Newcastle) to Dr. Ernest Hill (Health Officer of the Colony of Natal), re "Request to Use Cottage Hospital for the Outbreak of Smallpox", 8 February 1904 and PAR DPH Box 8/1/12/4/1 Reports of the Health Officer for the Colony of Natal for the year 1904. Report by Dr Ernest Hill. (Pietermaritzburg: Printing and Publishing, 1905) 35-40.

<sup>333</sup> PAR DPH Vol 17 Ref DPH899/1904 Minute Paper from J. Hastie to Dr. Ernest Hill, re "Request to use Cottage Hospital in Connection with Outbreak of Smallpox", 8 February 1904.

<sup>334</sup> PAR DPH Vol 11 Ref DPH546/03 Minute Paper from Dr. Ernest Hill (Health Officer of the Colony of Natal) to Sir Albert Henry Hime (Prime Minister) re "Rules for Cottage Hospitals", 28 April 1903.

<sup>335</sup> PAR DPH Vol 11 Ref DPH546/03 Minute Paper from Dr. Ernest Hill to Sir Albert Henry Hime re "Rules for Cottage Hospitals", 28 April 1903.



first doctor appointed as Medical Officer-in-charge of this hospital.<sup>336</sup> Before this appointment, he had worked for the government in the 1890s as a Public Vaccinator, but also as the District Surgeon for the Newcastle region, which he continued to do when he was appointed as head the Newcastle Cottage Hospital.<sup>337</sup>

As had been the case of the Medical Officers employed at the Umsinga Cottage Hospital, he played an important role in the daily operations of this hospital. He carried a heavy workload providing health care services to people needing care in the Newcastle district and provided in- and out-patient medical and surgical services at the cottage hospital. As was the case with Medical Officers at Umsinga, this Medical Officer had to record all patients' family, disease and treatment histories when they were admitted in an infirmary book, as well as record their dates of discharge or death. In addition, at the end of the year, he had to submit a summary of the work he had done at this hospital in an annual report, which was given to the Resident Magistrate to review. Moreover, he was allowed to treat patients privately, after hospital and district surgeon duty work hours, to supplement his government salary.

After Dr Ormond left his post as District Surgeon and Medical Officer-in-charge at the Newcastle Cottage Hospital at the end of 1905, other doctors was appointed to replace him. This included Dr William Black; the same Dr Black who had worked in Umsinga, who was appointed in Newcastle between 1906 and 1907. He was followed by Dr J.A. Nolan, who served in these positions during 1908, and he was replaced by Dr H.A. Edwards in 1909.<sup>338</sup> As a result, unlike Umsinga Cottage Hospital who had at least one black Medical Officer on its staff, Newcastle Cottage Hospital only appointed white Medical Officers to run this

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<sup>336</sup> PAR NCP Box 6/1/1/45 *The Natal Government Gazette*, no. 2371, Tuesday, 6 January 1891, 159.

<sup>337</sup> B.C. Baylis. *A History of Newcastle*. (Newcastle, Natal: The Newcastle Advertiser, 1951) 49.

<sup>338</sup> PAR CSO Vol 1871 Ref 1909/2302 Minute Paper from J. Hannetous Laffe (Medical Director, Government Cottage Hospitals, Durban) to the Assistant Under Secretary, re "Six months leave granted to Dr. Nolan and Dr. H. A. Edwards", 23 March 1909.

facility. Yet, in a similar manner to Umsinga Cottage Hospital, most of these doctors did not stay for long periods working in these positions. This was because of the stress and huge demands on their time. As had been the case with Umsinga, many of these doctors also voiced various complaints, such as shortage of staff, lack of equipment and medicines to treat patients, and the overcrowded state of the hospital because of inadequate accommodation.<sup>339</sup>

In terms of other medical staff who worked at this hospital, unlike Umsinga, doctors who worked at some of the large coalmines in the Newcastle area were also allowed to treat their seriously sick or injured patients at the Newcastle Cottage Hospital. However, this could only occur after a particular mine doctor had obtained the necessary permission to do so from the Resident Magistrate and Medical Officer-in-charge to admit their patients.<sup>340</sup> Additionally, once these patients were admitted, the doctors from the mines were fully responsible for the treatment and wellbeing of their patients while they were in hospital and the mine bore the cost of any medical, surgical and other sundry expenses incurred while their patients were in hospital.

Another difference between Newcastle and Umsinga cottage hospitals was that Newcastle Cottage Hospital had a larger medical staff to help treat patients. There were likely several reasons for this. Firstly, because of its location on the main road to and from the gold mines of the Witwatersrand, it had more staff to cater for a larger influx of people needing treatment who passed through this town. Secondly, it needed a larger staff contingent to cater for soldiers and civilians wounded during the South African War. Thirdly, mining and industrial accidents were more common, due to the more industrialised nature of this town,

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<sup>339</sup> PAR DPH Vol 12 Ref DPH822/03 Minute Paper from Dr Ormond (District Surgeon Newcastle Division and Medical Officer, Newcastle Cottage Hospital) to Dr. Ernest Hill (Health Officer of the Colony of Natal), re “Cook and Indian Attendant had Resignations”, 1 July 1903 and PAR DPH Vol 12 Ref DPH1133/1903 Minute Paper from Dr. Ormond (District Surgeon Newcastle Division, and Medical Officer Newcastle Cottage Hospital) to Dr. Ernest Hill (Health Officer of the Colony of Natal), re “Resignation of Matron”, 1 October 1903.

<sup>340</sup> PAR DPH Vol 16 Ref 194/1904 Minute Paper from Dr Ernest Hill to Dr H.J. Galbraith, re “Guarantees for Hospital Patients at Dundee Cottage Hospital”, 22 March 1904.

and facilities needed to be provided for this. Finally, as a segregated hospital, with three wards catering for whites, Indians and Africans, it needed a larger staff to serve these different “racial” groups. Whereas Umsinga’s staff situation was restricted by a government determined to provide health care services for “Natives” as cheaply as possible, in Newcastle, which had a larger and more demanding white population, and as the only public hospital in the area, it was under more pressure to provide better quality services.

Other than the Medical Officer and occasional practice rights given to mine doctors, by early 1903, the hospital had appointed a matron, a professional nurse, a probationer nurse, one Indian cook and two Indian ward attendants.<sup>341</sup> In this same year, in addition, its non-medical support staff consisted of an Indian cook to prepare food for the patients and staff, and a “Native” servant who was responsible for keeping the hospital clean.<sup>342</sup> The matron earned a salary of £70 p.a., the professional nurse earned £40 p.a., and the probationer nurse earned £20 p.a. The Indian ward attendants earned £5 p.a. each and the Indian cook and African cleaner earned £4 p.a. each plus food rations.<sup>343</sup> Although the female nurses, who were all white, earned much more than the hospital’s black ward attendants, cook and cleaner because of their advanced professional qualifications, racial differences also played a role.

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<sup>341</sup> PAR DPH Vol 12 Ref DPH1133/1903 Minute Paper from Dr. Ormond to Dr. Ernest Hill, re “Resignation of Matron”, 1 October 1903; PAR DPH Vol 11 Ref DPH440/03 Minute Paper from Dr Ernest Hill (Health Officer of the Colony of Natal) to Dr Ormond (District Surgeon, Newcastle Division, and Medical Officer of Newcastle Cottage Hospital), re “Letter of Appointment for Mrs N. Harker as Matron of the Newcastle Hospital”, 26 March 1903, 1-7; PAR DPH Vol 20 Ref DPH63/1905 Minute Paper from Dr. Ormond (District Surgeon, Newcastle Division and Medical Officer of Newcastle Cottage Hospital) to Dr. Ernest Hill (Health Officer of the Colony of Natal), re “Miss Dorothy North (Probationer Nurse) Seeking Transfer to Addington Hospital”, 18 January 1905, 2-10; and PAR CSO Vol 1813 Ref 1906/4651 Letter from Miss Constance Rowse (Qualified Nurse, Durban) to H. Albert Hime (Assistant Under Secretary), re “Application for Post of Matron of the Newcastle Cottage Hospital”, 27 April 1906.

<sup>342</sup> PAR Indian Immigration (hereafter II) Vol 1/119 Ref II458/1903 Letter from Dr. Ernest Hill (Health Officer of the Colony of Natal) to the Protector of Indian Immigrants, re “Cook of the Newcastle Cottage Hospital”, 4 October 1903; PAR DPH Vol 12 Ref DPH822/03 Minute Paper from Dr Ormond (District Surgeon Newcastle Division and Medical Officer, Newcastle Cottage Hospital) to Dr. Ernest Hill (Health Officer of the Colony of Natal), re “Cook and Indian Attendant Resignation and Arrangement for their Replacement”, 1 July 1903; and PAR DPH Vol 12 Ref DPH924/1903 Minute Paper from Dr. Ormond (District Surgeon, Newcastle Cottage Hospital) to Dr. Ernest Hill (Health Officer of the Colony of Natal), re “Indian Employees’ Requests for Rations to buy Vegetables and Other Things”, 29 July 1903.

<sup>343</sup> PAR II Vol 1/119 Ref II458/1903 Letter from Dr. Ernest Hill (Health Officer of the Colony of Natal) to the Protector of Indian Immigrants, re “Cook of the Newcastle Cottage Hospital”, 4 October 1903.

Indeed, the white staffs were given higher salaries as colonial authorities believed they had higher standards of living to provide for. However, the white nursing staff earned much less than the Medical Officer-in-charge, who earned £400 p.a. This highlighted the nurses' professionally inferior work position and gender status at the time compared to doctors, even though they did much of the caring work in the hospital. In 1909, the permanent staff contingent for this hospital had increased from 9 to 11.<sup>344</sup>

Although I was not able to learn much about most of the staff in the archival records, interestingly, I was able to discover that the Indian ward attendants were usually men who had received first aid and other medical training in India.<sup>345</sup> In 1903, we also learn in the archival records about grievances raised by the Indian ward attendants who were dissatisfied with the food rations provided for them by the hospital. As vegetarians, they did not eat meat and petitioned the colonial government to give them a monthly allowance of £25 to buy additional vegetables, which was granted to them.<sup>346</sup> While white and Indian staff occasionally expressed their grievances, which are evident in the archival records, I could not find any cases of grievance lodged by this hospital's African workers.

In terms of patients treated at Newcastle Cottage Hospital, as mentioned earlier, the records highlight that staff treated patients from different "racial groups" in three segregated wards at this general hospital. It also used partitions to separate men and women being treated in these wards. Between 1901 and 1910 patients admitted into this hospital were treated for similar conditions to those at Umsinga Cottage Hospital, including various infectious

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<sup>344</sup> PAR NCP Box 7/3/16 *Colony of Natal Statistical Year Book for the Year 1909*. Medical Report from Dr. J. A. Nolan, District Surgeon, Newcastle Division and Medical Officer of Newcastle Cottage Hospital. (Pietermaritzburg: Government Printers, 1910) 277.

<sup>345</sup> PAR DPH Vol 12 Ref DPH822/03 Minute Paper from Dr Ormond to Dr. Ernest Hill, re "Cook and Indian Attendant Resignation and Arrangement for their Replacement", 1 July 1903 and PAR DPH Vol 12 Ref DPH924/1903 Minute Paper from Dr. Ormond (District Surgeon and Medical Officer of Newcastle Cottage Hospital) to Dr. Ernest Hill (Health Officer of the Colony of Natal), re "Indian Employees' Requests for Rations to buy Vegetables and Other Things", 29 July 1903.

<sup>346</sup> PAR DPH Vol 12 Ref DPH552/1903 Minute Paper from Dr Ormond to Dr Ernest Hill, re "Indian Attendant at Newcastle Cottage Hospital Request for Allowance in lieu of Rations", 27 April 1903, 1-3.

diseases, such as smallpox, pneumonia, tuberculosis and dysentery. Moreover, this hospital performed numerous major and minor surgical operations, such as excisions of tumours and amputations and provided maternity services for women. Different to Umsinga which did not have mines, this hospital also treated patients who suffered from coalmining/industry or railway accidents such as burns and wounds from explosions and roof collapses.<sup>347</sup>

Although during this period, most of these patients would have come for treatment having tried to heal themselves at home or having sought the assistance of other non-western trained healers who practiced within or outside the district, as was the case with Umsinga, patient numbers increased over the years at Newcastle Cottage Hospital. The Medical Officer's annual reports highlighted this increase clearly. For example, in-patient numbers increased from 64 in 1904 to 79 in 1905, 88 in 1906 and 212 in 1907.<sup>348</sup> Furthermore, it was recorded in archival documents that African and Indian patients increased faster than whites, whose numbers were fewer, and who preferred being treated privately by the District Surgeon.<sup>349</sup> As a result, overcrowding and limited accommodation for patients was a frequent complaint noted by the medical staff, particularly in the hospital's black wards. Though nothing was stated specifically in the records to this effect, one can assume that a limited

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<sup>347</sup> PAR NCP Box 7/3/8 *Colony of Natal Statistical Year Book for the Year 1901*. Medical Report from Dr Ormond, District Surgeon, and Medical Officer of Newcastle Cottage Hospital. (Pietermaritzburg; Government Printers, 1902) 38; PAR NCP Box 7/3/9 *Colony of Natal Statistical Year Book for the Year 1902*. Medical Report from Dr Ormond (Pietermaritzburg; Government Printers, 1903) 19-22; PAR NCP Box 7/3/10 *Colony of Natal Statistical Year Book for the Year 1903*. Medical Report from Dr Ormond. (Pietermaritzburg; Government Printers, 1904) 66; PAR NCP Box 7/3/11 *Colony of Natal Statistical Year Book for the Year 1904*. Medical Report from Dr Ormond, 22; PAR NCP Box 7/3/12 *Colony of Natal Statistical Year Book for the Year 1905*. Medical Report from Dr Ormond, 221; PAR NCP Box 7/3/13 *Colony of Natal Statistical Year Book for the Year 1906*. Medical Report from Dr. William Black, District Surgeon, and Medical Officer of Newcastle Cottage Hospital, 242; PAR NCP Box 7/3/14 *Colony of Natal Statistical Year Book for the Year 1907*. Medical Report from Dr William Black, 252; and .PAR NCP Box 7/3/16 *Colony of Natal Statistical Year Book for the Year 1909*. Medical Report from Dr. J.A. Nolan, District Surgeon Newcastle Division, and Medical Officer of Newcastle Cottage Hospital, 277.

<sup>348</sup> PAR NCP Box 7/3/11 *Colony of Natal Statistical Year Book for the Year 1904*. Medical Report from Dr Ormond, 389; PAR NCP Box 7/3/12 *Colony of Natal Statistical Year Book for the Year 1905*. Medical Report from Dr Ormond, 221; PAR NCP Box 7/3/13 *Colony of Natal Statistical Year Book for the Year 1906*. Medical Report from Dr William Black, 242 and PAR NCP Box 7/3/14 *Colony of Natal Statistical Year Book for the Year 1907*. Medical Report from Dr William Black, 252.

<sup>349</sup> PAR DPH Vol 16 Ref 194/1904 Minute Paper from Dr Ernest Hill to Dr H.J. Galbraith, re "Guarantees for Hospital Patients at Dundee Cottage Hospital", 22 March 1904.

number of beds also meant the need to improvise temporary accommodation when needed, such as floor beds when hospital beds were full.

The accommodation for patients at Newcastle Cottage Hospital was different from that provided at Umsinga. Although Umsinga authorities enabled the erection of huts to accommodate families of the sick, and allowed patients to stay with families in these huts when overcrowded, Newcastle Cottage Hospital did not make similar provisions for its patients. Only patients were accommodated on hospital property, and family members or friends could only visit them at established visiting times determined by the hospital.<sup>350</sup> This was in keeping with other hospitals provided in South Africa at the time.

Because of the growing patient numbers during the first decade of the 1900s, further extensions were made to the Newcastle Cottage Hospital after it opened. For example, in 1904, a government inspection of this institution revealed the need, for example, for nurses' and servants' quarters, a larger operating theatre, improved ablution facilities for the wards, and an additional ward.<sup>351</sup> As a result, funds were made available later in 1904 for extensions to be made, which addressed all of the inspector's suggestions.<sup>352</sup>

On 1 January 1906, the control of Newcastle's Cottage Hospital was removed from the Resident Magistrate who reported to the Health Officer of the Colony, and placed under the control of a local Hospital Board.<sup>353</sup> This was done to ease the work burden of the Health

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<sup>350</sup> PAR DPH Vol 16 Ref 194/1904 Minute Paper from Dr Ernest Hill to Dr H.J. Galbraith, re "Guarantees for Hospital Patients at Dundee Cottage Hospital", 22 March 1904.

<sup>351</sup> PAR DPH Vol 21 Ref DPH83/1904 Minute Paper from Dr Ernest Hill to Albert H. Hime, re "Reports on Inspection of the Newcastle and Dundee Hospitals", 27 April 1903, 1-10; PAR PWD Vol 2/126 Ref PWD289/1904 Minute Paper from Dr Ernest Hill (Health Officer of the Colony of Natal) to J. F. E. Barnes (Chief Engineer, Public Works Department), re "Question as to Additions to the Newcastle and Dundee Cottage Hospitals", 28 May 1904.

<sup>352</sup> PAR PWD Vol 2/137 Ref PWD4987/1904 Minute Paper from J. Burnes (Secretary Tender Board) to Mr. Barnes (Chief Engineer, Public Works Department), re "Tender for Additions and Alterations to the Hospital at Newcastle", 13 August 1904, 2-6.

<sup>353</sup> PAR CSO Vol 1828 Ref 1907/1375 Letter from B. Lazarus (Matron, Newcastle Cottage Hospital) to Mr. John C. Bird (Principal Under Secretary), re "Application for One Month's Leave of Absence from 1<sup>st</sup> March 1907", 11 February 1907.

Officer and, it was hoped, to aid the hospital to function better. Further, the rapid growth of this hospital and increased expense of running a larger hospital also would have provided a good reason to explain why the colonial government was prepared to give up its control. As a result, the Medical Officer-in-charge no longer reported exclusively to the Resident Magistrate, but to a Hospital Board, which was made up of himself, the Resident Magistrate (who was also the chairperson of the Board), and a few influential mine owners and/or managers, and local men such as representatives on the Town Council and business people.<sup>354</sup> The Hospital Board as a collective then made decisions about the hospital and oversaw the hospital's operational activities and accounts. It was also responsible for raising the necessary money via patient fees and other means to cover the running expenses of the hospital.<sup>355</sup>

As had been the case in earlier years, when this Hospital Board took over in 1906, it was also required to deal with the growing number of patients.<sup>356</sup> However, because of difficulties in raising sufficient capital to expand the hospital, in 1906 this Hospital Board approved the erection of a tent outside the hospital to provide additional space to accommodate more patients.<sup>357</sup> No further extensions were made to this hospital up to 1910, the period covered by this thesis.

### **Dundee Cottage Hospital**

As discussed in the last chapter, Dundee Cottage Hospital was opened at the end of 1903 after the South African War. It was created initially as a hospital that catered for patients of all "races", though like Newcastle Cottage Hospital, on a segregated basis. However, in March 1904, just a few months after it had opened, the status of this hospital

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<sup>354</sup> PAR NCP Box 6/1/1/61 *The Natal Government Gazette*, No. 838, Monday, 11 December 1905, 116.

<sup>355</sup> PAR DPH Vol 1-2. Board of Health Natal Meetings, 1904-1911.

<sup>356</sup> PAR DPH Vol 3-5. Minutes of Meetings of a Committee Appointed by Board of Health Natal to Investigate Newcastle and Dundee Cottage Hospital, 1904-1910.

<sup>357</sup> PAR NCP Box 7/3/13 *Colony of Natal Statistical Year Book for the Year 1906*. Medical Report from Dr William Black, 221 and PAR NCP Box 7/3/14 *Colony of Natal Statistical Year Book for the Year 1907*. Medical Report from Dr William Black, 252.

changed dramatically. Unlike Umsinga and Newcastle Cottage Hospitals, Dundee Cottage Hospital was re-designated a “Europeans only” hospital by the Health Officer of the Colony.<sup>358</sup> This occurred because of the large increase in black patients in the months after this hospital’s opening and growing numbers of complaints by white residents in the town who objected to the overcrowding of facilities, including the housing of patients in the corridors that resulted soon after its opening.

As a result, this hospital’s Medical Officer-in-charge, in line with the new policy, had to refuse admission to African and Indian patients. All black patients seeking biomedical treatment were then sent to the Swedish Mission Hospital in Dundee.<sup>359</sup> As an incentive, the Health Officer for the Colony agreed to grant this mission hospital an annual subsidy, which started initially at £100 and came from “Public Funds”, to accommodate and treat black patients.<sup>360</sup> This hospital thus experienced increasing black patient numbers over the years, which put growing pressure on its staff and its facilities.<sup>361</sup>

In terms of the management of Dundee’s Cottage Hospital, this was initially provided through a close working relationship between the Resident Magistrate of this area and the Medical Officer-in-charge of this hospital. Indeed, as was the case with Umsinga and

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<sup>358</sup> PAR DPH Vol 2842 Ref DPH1903/1842 Minute Paper from Dr Ernest Hill (Health Officer of the Colony of Natal) to the Colonial Secretary, re “Arrangements for the Treatment of Europeans Only at Dundee Cottage Hospital”, 17 March 1903, 1-9; PAR DPH Vol 16 Ref 194/1904 Minute Paper from Dr Ernest Hill to Dr H.J. Galbraith, re “Guarantees for Hospital Patients at Dundee Cottage Hospital”, 22 March 1904 and PAR PWD Vol 2/121 Ref PWD7110/1903 Minute Paper from F. J. Birkett (Town Clerk Dundee) to Dr. Ernest Hill (Health Officer of the Colony of Natal), re “Request Clarity on what lines the Dundee Cottage Hospital is to be run”, 10 January 1903.

<sup>359</sup> PAR DPH Vol 2842 Ref 1903/1842 Minute Paper from Dr Ernest Hill to the Colonial Secretary, re “Arrangements for the treatment of Europeans Only at Dundee Cottage Hospital”, 17 March 1903; 1-9; PAR DPH Vol 16 Ref 194/1904 Minute Paper from Dr Ernest Hill to Dr H.J. Galbraith, re “Guarantees for Hospital Patients at Dundee Cottage Hospital”, 22 March 1904 and PAR DPH Box 8/1/12/4/1 Reports of the Health Officer for the Colony of Natal for the year 1904. Report from Dr Ernest Hill, 50.

<sup>360</sup> PAR DPH 2842 Vol Ref DPH1903/1842 Minute Paper from Dr Ernest Hill (Health Officer of the Colony of Natal) to Reverend L.P. Norenius (Superintendent of the Swedish Mission Hospital, Dundee), re “Annual Subsidy of £100 to be given by the Colonial Government to the Swedish Mission Hospital for Accommodating ‘Native’ Patients”, 12 July 1903.

<sup>361</sup> PAR DPH Vol 37 Ref DPH505/08 Minute Paper from Dr A.J. Abraham (District Surgeon of Dundee, Medical Officer-in-Charge, Dundee Cottage Hospital) to Rev. L.P. Norenius (Superintendent of the Swedish Mission Hospital, Dundee), re “The Overcrowded State of the Swedish Mission Hospital”, 8 October 1908.



Newcastle, Dundee's Medical Officer reported directly to the Resident Magistrate, who had similar duties, which included management of the hospital's staff, operations (including regular inspections), and oversaw the hospital's accounts and patients' fee scales. Initially, funding to run this segregated hospital was obtained from the colonial government and the Department of Native Affairs, as well as patient fees, which like Newcastle's Cottage Hospital, were set at 9 shillings per day for white patients admitted, and 2 shillings per day for Africans and Indians.<sup>362</sup> In addition, similar to Newcastle, Dundee Cottage Hospital, which served the labourers of large coalmines and other industrial firms, received payments from various employers for the treatment of sick or injured employees.<sup>363</sup> However, after the hospital became a "Europeans only" hospital, its funding was no longer obtained from the Department of Native Affairs.

In terms of staffing at Dundee Cottage Hospital, similar to Newcastle and Umsinga the Medical Officer-in-charge at this hospital was also the District Surgeon. Interestingly, Dundee Cottage Hospital only had one Medical Officer-in-charge of the hospital and District Surgeon during the period covered by this thesis. He was a white medical practitioner, Dr Alva J. Abraham, who served in this position from 1903 until 1910, whereas the other two hospitals discussed had several doctors who were appointed to fill this role over the years.<sup>364</sup> Before accepting this job at Dundee Cottage Hospital, Dr Abraham had served as the District Surgeon of Dundee from 1890.

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<sup>362</sup> PAR DPH Vol 16 Ref 194/1904 Minute Paper from Dr Ernest Hill to Dr H.J. Galbraith, re "Guarantees for Hospital Patients at Dundee Cottage Hospital", 22 March 1904.

<sup>363</sup> PAR DPH Vol 1-2 Board of Health Natal Meetings, 1904-1911 and PAR DPH Vol 3-5. Minutes of Meetings of a Committee Appointed by Board of Health Natal to Investigate Dundee and Newcastle Cottage Hospitals, 1904-1910.

<sup>364</sup> PAR DPH Vol 9 Ref DPH986/02 Minute Paper from Dr. Ernest Hill (Health Officer of the Colony of Natal) to Dr Abraham (District Surgeon Dundee Division, and Medical Officer Dundee Cottage Hospital), re "The Question of Dundee Cottage Hospital", 12 November 1902, 1-3 and PAR NCP Box 7/2/2/7 *Supplement to the Blue Book for the Colony of Natal, 1890-1891: Medical Reports*. Report by Dr John M. Abraham, District Surgeon Dundee Division. (Pietermaritzburg: Government Printers, 1891) B84.

The duties carried out by the Medical Officer-in-charge at Dundee's Cottage Hospital were similar to those of the Medical Officers who worked at Umsinga and Newcastle cottage hospitals. This included treating in- and out-patients, as well as managing the staff and hospital accounts, and ensuring a smooth functioning of this institution on a daily basis. He also recorded patients' histories, documented their conditions and treatments, and wrote an annual report summarising the hospital's activities at the end of each year for the Resident Magistrate.

Similar to the work of the District Surgeons and Medical Officers-in-charge of the Newcastle Cottage Hospital, Dr Abrahams was also responsible for providing health care services for the region's (white) mineworkers, when called upon by mine managers to treat their sick employees, but also to assist those who were injured on the job.<sup>365</sup> In this work, Dr R.A. Mate, another qualified doctor who worked on the staff at Dundee Cottage Hospital, assisted him between 1903 and 1910.

Although the archival records do not explain why these doctors worked for longer periods at this hospital compared to those employed at Newcastle and Umsinga cottage hospitals, they did receive additional financial incentives whilst working there, which might account for this. In addition to being allowed to do private practice to supplement their government incomes, both doctors receive an annual "Club Remuneration" of £500 p.a. each, supplied by a consortium of mine owners.<sup>366</sup>

Besides these two medical doctors, the Dundee Cottage Hospital employed a number of other staff too. Indeed, like the Newcastle Cottage Hospital, this hospital was allowed to employ a larger staff contingent than at Umsinga. The first matron of this hospital was

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<sup>365</sup> PAR DPH Vol 16 Ref 194/1904 Minute Paper from Dr Ernest Hill to Dr H.J. Galbraith, re "Guarantees for Hospital Patients at Dundee Cottage Hospital", 22 March 1904.

<sup>366</sup> PAR DPH Vol 16 Ref DPH194/1904 Minute Paper from Dr Ernest Hill to Dr H.J. Galbraith, re "Guarantees for Hospital Patients at Dundee Cottage Hospital", 22 March 1904.

appointed in January 1903 to help get the facility ready for the reception of patients.<sup>367</sup> By 1903, it was reported that this hospital employed a matron, a trained nurse and a probationer nurse and that they were all white.<sup>368</sup> The 1903 archival records highlight that the matron received a salary of £70 p.a. (which was scheduled to increase to £75 p.a. in her second year and £80 p.a. in her third year), the qualified nurse received £40, and the probationer nurse received £20.<sup>369</sup> They were accommodated on the property of the hospital in areas designated as “European”, which offered better quality, fully furnished accommodation with a kitchen, dining and bathroom facilities. Furthermore, this hospital employed a “European cook”, who received a salary of £5 p.a. plus rations, as well as an Indian cook, and two “Native” servants, who were responsible for cleaning and other housekeeping duties.<sup>370</sup> They also all received salaries of £5 p.a. plus rations. However, unlike the black support staff who were housed in inferior, cramped accommodation in an outside building, the white cook was housed in her own room in the main hospital building to maintain racial segregation.<sup>371</sup>

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<sup>367</sup> PAR CSO Vol 1706 Ref 1902/4791 Minute Paper from Dr Ernest Hill (Health Officer of the Colony of Natal) to the Colonial Secretary, re “Completion of Dundee Cottage Hospital”, 25 January 1902 and PAR DPH Vol 07 Ref DPH126/1902 Minute Paper from the Colonial Secretary to Dr. Ernest Hill (Health Officer of the Colony of Natal), re “Completion of Cottage Hospital at Dundee: Proposed Opening and Appointment of Staff”, 12 October 1902.

<sup>368</sup> PAR DPH Vol 11 Ref DPH447/03 Letter from Nurse Norenuis (Matron Dundee Cottage Hospital) to Dr. Ernest Hill (Health Officer of the Colony of Natal), re “Payment of Salary”, 26 March 1903; PAR DPH Vol 12 Ref DPH863/1903 Minute Paper from Dr. Abraham (District Surgeon Dundee Division, and Medical Officer of Dundee Cottage Hospital) to Dr. Ernest Hill (Health Officer of the Colony of Natal), re “Increment of the Salary of Matron Nurse, and Question to Obtain a Cook”, 13 July 1903; PAR CSO Vol 1791 Ref 1905/4899 Minute Paper from Dr. Abraham (District Surgeon Dundee Division, Medical officer of Dundee Cottage Hospital) to Dr. Ernest Hill (Health Officer for the Colony of Natal), re Staffing Matters, 16 March 1905 and PAR DPH Vol 13 Ref DPH89/1904 Minute Paper from Dr. Abraham (District Surgeon Dundee Division, and Medical Officer of Dundee Cottage Hospital) to Dr. Ernest Hill (Health Officer of the Colony of Natal), re Staffing Matters, 30 January 1904.

<sup>369</sup> PAR DPH Vol 12 Ref DPH863/1903 Minute Paper from Dr. Abraham (District Surgeon Dundee Division, and Medical Officer of Dundee Cottage Hospital) to Dr. Ernest Hill (Health Officer of the Colony of Natal), re “Increment of the Salary of Matron Nurse and Request to Obtain a Cook”, 13 July 1903.

<sup>370</sup> PAR DPH Vol 11 Ref DPH447/03 Letter from Nurse Norenuis to Dr. Ernest Hill, re “Payment of Salary”, 26 March 1903.

<sup>371</sup> PAR DPH Vol 58 Ref DPH/156/1902 Minute Paper from Dr Abraham (District Surgeon Dundee Division, and Medical Officer, Dundee Cottage Hospital) to Dr Ernest Hill (Health Officer of the Colony of Natal, 19 December 1902 and PAR DPH Vol 11 Ref DPH/331/1903 Minute Paper from Dr Ernest Hill (Health Officer of the Colony of Natal) to Dr Abraham (District Surgeon Dundee Division, and Medical Officer Dundee Cottage Hospital), re “Dundee Cottage Hospital”, 6 July 1903; and PAR DPH Vol 11 Ref DPH447/03 Letter from Nurse Norenuis to Dr. Ernest Hill, re “Payment of Salary”, 26 March 1903.

By the end of 1906, the number of servants had increased to five with the employment of three additional Indian employees who were paid £5 p.a. each, and the hospital employed an additional probationer nurse.<sup>372</sup> The number of staff remained at about the same level until 1910. Thus, after this hospital changed to a whites-only hospital, although its medical and nursing staff continued to be white, most of its support staff remained black as African and Indian employees were expected to do the manual types of labour in this racially discriminatory environment.

In terms of its patients, Dundee Cottage Hospital, like Newcastle and Umsinga hospitals also treated increasing numbers of patients admitted from 1903 when it opened to the end period covered by this thesis (i.e. 1910). Although the number of in-patients dropped a bit from the recorded figure of 54 patients in 1904 (the year its status changed to a whites-only hospital),<sup>373</sup> to 43 admissions in 1905 when it offered treatment exclusively to white patients,<sup>374</sup> this hospital too showed an increase in patients admitted as the years went on. For example in 1907, the hospital recorded 66 admissions in 1907,<sup>375</sup> 79 admissions in 1908,<sup>376</sup> and 146 admissions by 1909.<sup>377</sup> As a result, its facilities became overcrowded from 1904 by white patients who increasingly sought treatment at this hospital. By late 1904, overcrowding

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<sup>372</sup> PAR NCP Box 7/3/13 *Colony of Natal Statistical Year Book for the Year 1906*. Medical Report from Dr Abraham, 221 and PAR NCP 7/3/16 *Colony of Natal Statistical Year Book for the Year 1909*. Medical Report from Dr Abraham, 277.

<sup>373</sup> Dr Ernest Hill noted in his 1903 report that the hospital was “extremely full” and that there were a number of patients who were treated in the opening months, which were not recorded. See PAR DPH Vol 2842 Ref 1903/1842 Minute Paper from Dr Ernest Hill to the Colonial Secretary, re “Arrangements for the Treatment of Europeans Only at Dundee Cottage Hospital”, 17 March 1903, 1-9 and PAR NCP Box 7/3/11. *Colony of Natal Statistical Year Book for the Year 1904*. Medical Report from Dr Abraham, 389.

<sup>374</sup> PAR NCP Box 7/3/12 *Colony of Natal Statistical Year Book for the Year 1905*. Medical Report from Dr Abraham, 221.

<sup>375</sup> PAR NCP Box 7/3/14 *Colony of Natal Statistical Year Book for the Year 1907*. Medical Report from Dr Abraham, 252.

<sup>376</sup> PAR NCP Box 7/3/15 *Colony of Natal Statistical Year Book for the Year 1908*. Medical Report from Dr Abraham, 250.

<sup>377</sup> PAR NCP Box 7/3/16 *Colony of Natal Statistical Year Book for the Year 1909*. Medical Report from Dr Abraham, 277.

became such a problem that the Medical Officer informed the Resident Magistrate and Health Officer of the Colony that he was unable to admit patients because the hospital was full.<sup>378</sup>

Between 1904 and 1910, Dundee Cottage Hospital treated white patients who got sick or injured while working on the mines, or on the railways, or in other industries that operated in and around Dundee. This hospital has treated some of the mines/railways/industries sicknesses or injuries/accidents, namely burns and wounds, but also hip joint dislocations, internal bleeding, pelvic fractures from explosions and roof cave ins.<sup>379</sup> Furthermore, it also treated their families. Like Umsinga and Newcastle, pregnancy related conditions and child birth were handled at this hospital, as were conditions affecting children. And, as was the case at the previously discussed cottage hospitals, a wide range of illnesses/conditions were treated over these years, such as intestinal and respiratory diseases, infectious diseases, including tuberculosis.<sup>380</sup> Moreover, surgeries commonly performed at this hospital were similar to those done at Newcastle.

However, from 1905, the archival records report increasing numbers of complaints about the 9 shillings per day costs charged to white patients for in-patient hospital treatment. For example, in 1905, a Mr Field, who was employed by the Natal Government Railway, removed his daughter (whom the records claim was suffering from “poisoning”) from the hospital before she was officially discharged because he could not afford to pay the hospital

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<sup>378</sup> PAR DPH Vol 13 Ref DPH22/1904 Minute Paper from Maynard Matthew (Resident Magistrate Dundee) to Dr. Ernest Hill (Health Officer of the Colony of Natal), re “Urgent Case (Poor woman) Pressing for Admission to the Cottage Hospital”, 29 January 1904.

<sup>379</sup> Ruth Edgcombe and Bill Guest. “Labour conditions on the Natal Collieries: The case of the Dundee Coal Company 1908-1955”. (University of the Witwatersrand: African Studies Seminar Paper, May 1986), 26-30.

<sup>380</sup> PAR NCP Box 8/1/13/2/12 *Blue Book for the Colony of Natal for the year 1904*. Medical Report from Dr Abraham, 21; PAR NCP Box 7/3/10 *Colony of Natal Statistical Year Book for the Year 1903*. Medical Report from Dr AJ Abraham, 66; PAR NCP Box 7/3/11 *Colony of Natal Statistical Year Book for the Year 1904*. Medical Report from Dr AJ Abraham, 22; PAR NCP Box 7/3/12 *Colony of Natal Statistical Year Book for the Year 1905*. Medical Report from Dr. AJ Abraham, 221; PAR NCP Box 7/3/13 *Colony of Natal Statistical Year Book for the Year 1906*. Medical Report from Dr. A.J. Abraham, 242; PAR NCP Box 7/3/14 *Colony of Natal Statistical Year Book for the Year 1907*, 252 and PAR NCP Box 7/3/16 *Colony of Natal Statistical Year Book for the Year 1909*. Medical Report from Dr. A.J. Abraham, 277.

charges.<sup>381</sup> In another example from the same year, a Mr Thomas Nicol, employed at the Navigation Collieries, was unable to pay his son's hospital fees, which amounted to £101.5.0 for treatment of an unstated but serious sickness. Because of the seriousness of the case, his son was later transferred to Addington Hospital in Durban, where the records state he was "unlikely to recover".<sup>382</sup> After Mr Nicol's son was transferred from Dundee hospital, he appealed to the hospital to reduce his son's fees on the basis of poverty. The hospital eventually agreed to assist him, and reduced his fees to £30.<sup>383</sup>

In a similar way to Newcastle Cottage Hospital, Dundee Cottage Hospital was taken over by a Hospital Board. In fact, this Board assumed control of this hospital on 1 January 1906, the same date as Newcastle Cottage Hospital. The archival records suggest that several cottage hospitals in Natal such as Richmond, Eshowe and Port Shepstone were handed over by the colonial government to hospital boards at this time.<sup>384</sup> Like Newcastle Cottage Hospital, it was hoped that the transfer of the control of Dundee Cottage Hospital to a Hospital Board would relieve the heavy workload of the Health Officer of the Colony and facilitate the management and funding of the hospital locally.

As a result, the line of management no longer extended down from the Health Officer of the Colony to the Resident Magistrate and then the Medical Officer-in-charge of the hospital. Instead, as was the case for the Newcastle Cottage Hospital, the Medical Officer had to report to a set of Board members, who were made up of the Resident Magistrate and other influential local business and Town Council people, and this Board made collective decisions

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<sup>381</sup> PAR DPH Vol 21 Ref DPH345/1905 Minute Paper from Maynard Matthew (Resident Magistrate Dundee) to Dr Ernest Hill (Health Officer of the Colony of Natal), re "Suggestion for a Reduction of Hospital Fees at the Government Hospital Dundee in Certain Cases", 29 April 1905.

<sup>382</sup> PAR DPH Vol 20 Ref DPH249/1905 Minute Paper from Dr. Abraham (District Surgeon, and Medical Officer of Dundee Cottage Hospital) to Dr Ernest Hill (Health Officer of the Colony of Natal), re "Request about Account Owing by S. Nicol £101.5.0", 31 March 1905.

<sup>383</sup> PAR DPH Vol 20 Ref DPH249/1905 Minute Paper from Dr. Abraham to Dr Ernest Hill, re "Request about Account Owing by S. Nicol £101.5.0", 31 March 1905.

<sup>384</sup> PAR National Treasury (hereafter NT) Vol 149 Ref T3188/1909 Document attached "Government Notice No. 153, 1906" By Mr C. Bird, Principal Under Secretary, Colonial Secretary's Office, Natal. 7<sup>th</sup> March, 1906.

about staff appointments and salaries, renovations and the general operations of this hospital.<sup>385</sup> The Dundee Cottage Hospital Board was also responsible for raising the necessary funds by setting patients' fees and appealing to various funders, such as wealthy local businesses and the government, to cover its operating costs or building projects. After the Board took control of this hospital, fees increased from 9 shillings a day to 12/6 a day, which made it even more difficult for many white patients to pay the fees.<sup>386</sup>

To cater for the growing number of patients, the managers of this hospital – both in the pre-1906 and post-1906 periods, sought to extend the facilities offered to its patients, and to improve the facilities provided for its staff. For example, towards the end of 1904, an additional six beds were added to the hospital together with small nurses' quarters, two servants' rooms, a mortuary, a boiler room, kitchen facilities, a laundry block and additional ablution facilities.<sup>387</sup> In 1905, more extensions were made including the addition of three bedrooms to the nurses' quarters, a washhouse (for black workers and patients), and another servant's room.<sup>388</sup>

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<sup>385</sup> PAR CSO Vol 1577 Ref 2322/1907 Minute Paper from A. L. Griffin (Chief Accountant, Colonial Secretary's Office Natal) to Maynard Matthew (Resident Magistrate Dundee Division, and Chairman of the Dundee Hospital Board), re "Amount Allotted to Dundee Hospital for 1907 Financial Year", 12 March 1907; PAR Indian Immigration (hereafter II) Vol 1/151 Ref 1953/1907 Letter from Thomas M. E Donal (Secretary, Cottage Hospital Board Dundee) to the Protector Indian Immigrants, Durban, "Resolution by Board asking for the Allotment of two Indentured Indians to the Dundee Cottage Hospital", 12 April 1907; PAR DPH Vol 31 Ref DPH487(B)/1908 Minute Paper from Maynard Matthew (Resident Magistrate Dundee and Chairman of the Cottage Hospital Board Dundee) to Dr. Ernest Hill (Health Officer for the Colony of Natal), re "Conduct of Cottage Hospitals", 10 October 1908; PAR CSO Vol 1867 Ref 1909/844 Minute Paper from Maynard Matthew (Resident Magistrate Dundee and the Chairman of Dundee Hospital Board) to Mr. John C. Bird (Principal Under Secretary), re "Erection of an Infectious Ward at the Dundee Government Hospital", 9 February 1909.

<sup>386</sup> PAR DPH Vol 1-2 Board of Health Natal Meetings, 1904-1911 and PAR DPH Vol 3-5 Minutes of Meetings of a Committee Appointed by Board of Health Natal to Investigate Dundee and Newcastle Cottage Hospitals, 1904-1910.

<sup>387</sup> PAR DPH Vol 21 Ref DPH83/1904 Minute Paper from Dr Ernest Hill to Albert H. Hime, "Reports on Inspection of the Newcastle and Dundee Hospitals", 27 April 1904, 1-10.

<sup>388</sup> PAR PWD Vol 2/128 Ref PWD893/1904 Minute Paper from Dr Ernest Hill (Health Officer of the Colony of Natal to J.F.S. Barnes (Chief Engineer, Public Works Department), re "Newcastle and Dundee Cottage Hospitals need of Increased Accommodation", 2 February 1904, 8-12; PAR DPH Vol 21 Ref DPH83/1904 Minute Paper from Dr Ernest Hill to Albert H. Hime, re "Reports on Inspection of the Newcastle and Dundee Hospitals", 27 April 1904, 1-10; PAR PWD Vol 2/147. Ref PWD2914/1905 Minute Paper from J. E. Barnes (Secretary Tender Board) to J. F.S. Barnes (Chief Engineer, Public Works Department), re "Additions and Alteration at Newcastle Hospital", 14 June 1905; and PAR PWD Vol 2/128 Ref PWD893/1904 Minute Paper

However, not all extensions requested were granted during the period covered by this thesis. In 1909 the Resident Magistrate and the Medical Officer-in-charge wrote at length to the Colonial Secretary requesting that funds be raised to build an infectious diseases ward behind the main building of the hospital.<sup>389</sup> They argued that people found to be suffering from an infectious disease could not be accommodated at Dundee Cottage Hospital, as they did not have the isolation facilities or the beds to house such patients for the extended periods necessary for their treatment.<sup>390</sup> These patients thus had to be sent back home, or had to be referred to other hospitals capable of accommodating them, such as Grey's Hospital in Pietermaritzburg, which was located far from Dundee. However, in the period leading up to the end of this thesis (1910), funding for such a project was not forthcoming as the government claimed it did not have the funds for such a large extension project.<sup>391</sup>

This chapter has focused on the management, staffing and work of the Umsinga, Newcastle and Dundee cottage hospitals. It also analysed the role that various employees played in enabling these institutions to operate. In addition, although more difficult to analyse because the colonial records used were written from the perspective of those in charge at these hospitals, I have tried to consider some information about the support staff and patients. Other than examining how racial segregation influenced the operations of these hospitals and their patient's experiences in these institutions, I also considered how patient numbers expanded over the years at these institutions. This created more pressure on the staff and the structures of these institutions, which in turn led to changes or expansions to accommodate

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from Dr Ernest Hill to J.F.S. Barnes, re "Newcastle and Dundee Cottage Hospitals Need of Increased Accommodation", 2 February 1904, 8-12.

<sup>389</sup> Gorny, "Historic Hospitals in Natal", 186.

<sup>390</sup> PAR CSO Vol 1867 Ref 1909/844 Minute Paper from Maynard Matthew to Mr. John C. Bird, re "Erection of an Infectious Ward at the Dundee Government Hospital", 9 February 1909.

<sup>391</sup> PAR CSO Vol 1867 Ref 1909/844 Minute Paper from Maynard Matthew to Mr. John C. Bird, re "Erection of an Infectious Ward at the Dundee Government Hospital", 9 February 1909.



these growing pressures. The next chapter will investigate what effect the creation of the Union of South Africa had on cottage hospitals in Natal.

## CHAPTER FIVE

### **The Decline of Cottage Hospitals in Natal**

This chapter analyses developments affecting the cottage hospital system in and a few years after 1910. A major factor that will be considered was the influence played by the major political and socio-economic transition that led to the formation of the Union of South Africa in 1910. The first half of this chapter considers some of the broader historical context factors that help explain this transition. This includes analysis of what was going on in the area of public health. The second half of this chapter examines what impact these broader transitions had on the cottage hospital system in Natal and how they affected Umsinga, Newcastle and Dundee cottage hospitals particularly.

### **The Historical Context leading to Union**

Several historians have written about the broader historical factors that facilitated the formation of the Union of South Africa in 1910, which had a significant influence on the country's public health history and by extension, Natal's cottage hospitals. An important factor to consider was the changing context in the years after the South African War. After the war ended in 1902, the British who emerged victorious over the Boers in this war, gained another two colonies from the Boers in the southern African region – the Zuid Afrikaanse Republiek (ZAR or the Transvaal) and the Orange Free State.<sup>392</sup> The post-war years were difficult however as reconstruction to war-ravaged communities was time consuming and expensive. The colony of Natal had also experienced fighting, particularly in its north western region, in towns such as Ladysmith, Newcastle and Dundee.<sup>393</sup> Economic disruptions to businesses and trade, destruction of farms, and military expenses during the war caused an

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<sup>392</sup> Andrew Duminy and Bill Guest. "The Anglo-Boer War and its Economic Aftermath, 1899-1910". *Natal and Zululand from Earliest Times to 1910*. Andrew Duminy and Bill Guest eds. (Pietermaritzburg: University of Natal Press, 1989) 345, 350.

<sup>393</sup> Duminy and Guest, "The Anglo-Boer War and its Economic Aftermath", 345, 350.

economic recession after the war, which led to much suffering in both white and black communities.<sup>394</sup> The activities of the British during the war, including the implementation of its scorched earth policy that led to the destruction of many Boer homes and formation of large concentration camps (where many Boer women and children were imprisoned and died from malnutrition and disease), had increased tensions and distrust between the British and Afrikaners.<sup>395</sup> This made it more difficult for the British to rule its four colonies in the post-war years.

In terms of “race” relations, the post-war British administration (between 1902 and 1910), in an attempt to win over the support of the Boers, encouraged recognition of a hierarchy of “races” in the reconstruction years. This meant that English and Afrikaans speaking whites were viewed at a higher civilizational level compared to its black populations of these colonies and given greater recognition and privileges as a result.<sup>396</sup> For example, in 1903, Lord Alfred Milner, Governor of the Transvaal, delivered a speech where he asserted: “political equality of white and black is impossible”.<sup>397</sup> This meant voting privileges for the English and Afrikaners, and financial advantages, as the government was prepared to give loans and grants to some white farmers to help with their reconstruction efforts. In Milner’s administration, blacks were to remain subordinate to whites, were not given similar assistance to rebuild their lives, and continued to be viewed as a source of cheap, exploited labour for white colonists.

In the reconstruction years, the British government continued to encourage policies that promoted racial segregation and discrimination. This included the continuation of the

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<sup>394</sup> Duminy and Guest, “The Anglo-Boer War and its Economic Aftermath”, 357, 361, 366 and William Beinart. *Twentieth-Century South Africa* (Oxford and New York: Oxford University Press, 2001) 66.

<sup>395</sup> Duminy and Guest, “The Anglo-Boer War and its Economic Aftermath”, 348-349, 355.

<sup>396</sup> Susan Parnell. “Creating Racial Privilege: The Origins of South African Public Health and Town Planning Legislation”, *Journal of Southern African Studies*. (1993, 19: 3) 21.

<sup>397</sup> Readers Digest, *Illustrated History of South Africa*. (Cape Town: Readers Association of South Africa, 1994) 266.

African rural “reserve” system and the creation of separate “locations” for Africans, and segregated living areas for Indians in urban areas where more people migrated to find work. This approach aimed to undermine what it saw, for Africans anyway, as the threat posed by the “Native Question”.<sup>398</sup> Although European colonisers had crushed most African resistance by the late 1800s, the more numerous African population living in its four colonies still posed a threat to the British as the Bambatha Rebellion in Natal had demonstrated. This uprising, which occurred in 1906 and led to the deaths of between 3,000 and 4,000 Africans, highlighted the anger amongst African populations in the Greytown area and surrounds, to the government’s discriminatory policies, including its many taxes on Africans.<sup>399</sup> The rebellion cost the colony an estimated £700 000 to quell using military force, which prolonged the financial problems of the Natal colony in the years after the war.<sup>400</sup> The financial problems faced by Natal and the continuing threat posed by its large African population was an important factor that pushed this colony to consider a political union with the Transvaal, Cape and Orange Free State colonies by the end of the first decade of the twentieth century.<sup>401</sup>

During the late nineteenth and early twentieth centuries, the Natal colonial administration also increasingly viewed people of Indian descent who had migrated and settled in colonial Natal as a threat. Labelled the “Asiatic Menace”, they were viewed as a danger because of their growing numbers and the economic competition many “free” and “passenger” Indians who settled in the region posed to white settlers by their successful

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<sup>398</sup> Bill Guest and John M. Sellers. “Introduction”. *Receded Tides of Empire: Aspects of the Economic and Social History of Natal and Zululand since 1910*. (Pietermaritzburg: University of Natal Press, 1994) 18.

<sup>399</sup> Jeff Guy. *Remembering the Rebellion the Zulu Uprising of 1906*. (Scottsville: University of KwaZulu-Natal Press, 2006) 6-11.

<sup>400</sup> Andrew Duminy. “Towards Union, 1900-10”. *Natal and Zululand from earliest times to 1910: A New History*. Andrew Duminy and Bill Guest eds. (Pietermaritzburg: University of Natal Press, 1989) 412.

<sup>401</sup> Duminy, “Towards Union, 1900-10”, 414.

business activities.<sup>402</sup> Indeed, in colonies such as Natal, by the 1890s, there was a total population of about 41,000 Indians in Natal, a population that almost equalled whites.<sup>403</sup> Furthermore, both “free” and “passenger” Indians posed a threat because of their involvement in trade, market gardening and commercial farming activities, while some owned or managed shops, and owned or rented property.<sup>404</sup> Many “passenger” Indians, who had paid their own way to Natal from the 1870s, were also highly educated compared to most indentured Indians, and some became influential leaders amongst Indian communities in Natal and the Transvaal, such as Mohandas Karamchand Mahatma Gandhi, who voiced publicly “Indian” opposition to the colonial government’s policies that limited their political and economic rights.<sup>405</sup>

Furthermore, during this period, British colonial administrators in many of its southern African colonies, linked “race” issues to sanitary concerns, as reasons to segregate different communities living in their colonies. During the first decade of the twentieth century, more Africans and Indians began settling and working in urban areas, close to or amongst white communities, to find jobs and to make a living. Numerous scholars, such as Maynard Swanson, Paul Maylam and Susan Parnell have researched how lack of adequate infrastructural development (such as housing and sanitation services) and overcrowding forced many black people to settle in unhygienic informal slums or shack settlements, which led to the outbreak and spread of diseases, such as cholera and plague.<sup>406</sup> Although many whites wanted to maintain access to cheap labour provided by black workers, they did not want to take responsibility or cover the costs of providing expanded services for such

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<sup>402</sup> Maynard W. Swanson. “The Asiatic Menace”: Creating Segregation in Durban, 1870-1900. *The International Journal of African Historical Studies*. (1983, 16:3) 401-403.

<sup>403</sup> Swanson, “The Asiatic Menace”, 404-406.

<sup>404</sup> Swanson, “The Asiatic Menace”, 405-406, 411-412.

<sup>405</sup> Guest and Sellers, “Introduction”, 14 and Swanson, “The Asiatic Menace”, 401-404, 414-415.

<sup>406</sup> Swanson, “The Asiatic Menace”, 406-408; Paul Maylam and Iain Edwards. *The Peoples City: African Life in Twentieth-Century Durban*. (Scottsville: University of Natal Press, 1996) 4-5; and Susan Parnell. “Creating Racial Privilege: The Origins of South African Public Health and Town Planning Legislation”, *Journal of Southern African Studies* (1993, 19:3) 1-2.

communities. The growing presence of black communities in urban areas also produced fears amongst white communities about being “overrun” in terms of their number, which sharpened racial prejudices.

As a result, white public health officials worked increasingly with local authorities in the first decade of the twentieth century to adopt legislation to control urban black populations. This legislation led to the demolition of slum settlements and removal and restriction of Africans and Indians to living in segregated municipal locations, usually on the outskirts of towns.<sup>407</sup> This is evident, for example, in the Cape colony, with the spread of bubonic plague. Public health authorities, working together with local officials, blamed this outbreak on unsanitary black urban slum conditions and used this to justify the passage of the 1902 Native Reserve Location Act that led to their forcible removal to segregated “locations” on the outskirts of towns.<sup>408</sup> In 1904, the passage the Native Locations Act by Durban local authorities paved the way for the establishment of similar segregated locations for Africans and Indians in this municipality too.<sup>409</sup> This local authority also required African men to carry identity passes with permits that gave them permission to live and work in an urban area.<sup>410</sup> Those found without a valid pass were arrested and forcibly removed from urban areas.

The tumultuous years of reconstruction eventually led to the formation of the Union of South Africa in 1910. This took place after lengthy political negotiations between representatives of the four British colonies, most of whom wanted to reduce British imperial influence in South Africa, which began in 1908. This eventually led to the end of British control and the creation of a new “South African” government headed by former Boer generals Louis Botha and Jan Smuts from the region’s economically powerful Transvaal

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<sup>407</sup> Parnell, “Creating Racial Privilege”, 471-473 and Swanson. “The Asiatic Menace”, 403, 407-408.

<sup>408</sup> Maynard Swanson. “The Sanitation Syndrome: Bubonic Plague and urban Native Policy in the Cape Colony 1900-1909”. *Journal of African History*. (1977, 8:3) 388, 397-401.

<sup>409</sup> Guest and Sellers, “Introduction”, 18.

<sup>410</sup> Guest and Sellers, “Introduction”, 16-17.

delegation.<sup>411</sup> Although strongly pro-British representatives from the colony of Natal were not keen to break formal ties with the United Kingdom for fears of the growing influence of Afrikaner nationalism in the country, this colony was forced reluctantly to join the Union, as it could not afford to go it alone financially.<sup>412</sup> This led to the creation of a new politically unified South Africa made up of four provinces.

Botha and Smuts worked hard to promote a new South African national identity amongst its citizens and to encourage equality and reconciliation between English and Afrikaans-speaking (male) white South Africans who obtained the vote.<sup>413</sup> However, these leaders denied voting privileges to most black residents of this country.<sup>414</sup> Indeed, the formation of the Union of South Africa in 1910 was founded based on white rule that excluded black South Africans politically and economically.<sup>415</sup> Although black activists would organise to challenge the status quo in later years, such as the South African Native National Congress in 1912 (later renamed the African National Congress), black South Africans continued to experience, and indeed, experienced increased forms of racial discrimination and segregation in the country after 1910.<sup>416</sup>

### **The Union of South Africa and its Effects on Public Health Care Services**

The unification of the four colonies into the country of South Africa did not lead to major changes in the country's public health care system. In most situations, the services

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<sup>411</sup> Beinart, *Twentieth-Century South Africa*, 78.

<sup>412</sup> Duminy, "Towards Union, 1900-10", 419, 422-423 and Guest and Sellers, "Introduction", 2-5, 10-11.

<sup>413</sup> Beinart, *Twentieth-Century South Africa*, 79.

<sup>414</sup> For several years, the Cape Province maintained a qualified franchise for a few educated and property-owning "coloured" voters though this right was removed too in 1936. See Richard John Haines. "The Opposition to General J.B.M Hertzog's Segregation Bills, 1925-1936: A Study in Extra-Parliamentary Protest". (Master of Art Thesis, Department of History and Political Science, University of Natal, Durban, 1978).

<sup>415</sup> Readers Digest, *Illustrated History of South Africa*, 263, 271.

<sup>416</sup> Readers Digest, *Illustrated History of South Africa*, 263-264 and Beinart, *Twentieth-Century South Africa*, 20.

remained the same or were only slightly altered. One main reason for this was that although the country saw a significant change in its leadership and the promotion of different political priorities after 1910, political transitions do not always go smoothly nor do they usually lead to immediate changes on the ground as it takes time for those in power to garner the necessary support to alter or reform things. Another important reason is that it usually takes time to secure the necessary finances by the state to introduce major changes or reforms. Indeed, many laws and policies, including those within the arena of public health care, were carried over largely unchanged into the new political dispensation.<sup>417</sup>

As a result, as had been the case in the pre-1910 years, firstly, health care provisions in the decade after Union tended to be curative (not preventive) in nature and concentrated in urban areas, which left rural populations poorly serviced.<sup>418</sup> Secondly, initially, the new Union government did little to improve the health care services provided by the state for black South Africans, most of whom still lived in rural areas, which continued to be left largely in the hands of missionary clinics or hospitals.<sup>419</sup> As had been the case in the pre-Union years, responses to the spread of infectious diseases were developed only when they threatened to affect the lives of white citizens, such as the outbreak of the Influenza pandemic of 1918 and the Typhus epidemic in 1923.<sup>420</sup> Thirdly, a lack of public health facilities and shortage of adequately trained health care workers remained major problems.<sup>421</sup> Furthermore, the outbreak of World War 1 in 1914, also limited funds for health and other social services,

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<sup>417</sup> H.C.J. van Rensburg, J.E. Ataguba, S.R. Benator, J.E. Doherty, M.C. Engelbrecht. "A History of Health and Health Care in South Africa: 1652-1994". *Health and Health Care in South Africa* (Pretoria: Van Schaik, 2012) 69-72 and Shula Marks and Neil Andersson, "Typhus and Social Control: South Africa, 1917-50". *Disease, Medicine and Enquire: Perspectives on Western Medicine and Experiences of European Expansion*. Roy MacLeod and Milton Lewis eds. (London, New York: Routledge, 1988) 261.

<sup>418</sup> H.C.J. van Rensburg, A. Fourie and E. Pretorius. "The Early History of Health Care in South Africa: 1652-1910". *Health Care in South Africa: Structure and Dynamics* (Pretoria: Academica, 1992) 54.

<sup>419</sup> Michael Gelfand. *Christian Doctor and Nurse: The History of Medical Missions in South Africa from 1799-1976* (Sandton, RSA: Aitken family and friends, 1984) 145-160.

<sup>420</sup> Marks and Andersson. "Typhus and Social Control: South African, 1917-50", 260, 278.

<sup>421</sup> Van Rensburg, Ataguba, Benator, Doherty, Engelbrecht, *Health and Health Care in South Africa*, 75 and Howard Phillips. "The Local State and Public Health Reform in South Africa: Bloemfontein and the Consequences of the Spanish 'Flu Epidemic of 1918". *Journal of Southern African Studies*. (1987, 13:2) 213-217.



which restricted the availability of funds to roll out major changes, including those needed in the area of public health care.

Another important factor to consider is that initially, the Union government did not develop a centralised Department of Health to oversee and coordinate the country's public health care services into an organised system. As a result, there was no proper planning to improve public health care services. This led to confusion and lack of coordination among various levels of Union authorities (e.g. local, provincial and national government bodies) as to their duties and responsibilities.<sup>422</sup> For example, under the Union Act, general hospitals were the responsibility of provincial authorities, infectious disease control services were placed in the hands of officials working for the central government, and preventive and sanitation control services remained under the control of the municipalities.<sup>423</sup> Public health care services in the era of the 1910s were thus described as decentralised, disorganised and fragmented, and they did not meet the needs of all South Africans.

In fact, the Union government did not have a Department of Public Health responsible for overseeing public health matters in the four provinces at the national level for several years after Union. It was only after the outbreak of a serious influenza pandemic in 1918, brought by troop movements at the end of World War 1 that spurred the government into action, which included the passage of the 1919 Public Health Act.<sup>424</sup> This Act was important in that it created a Public Health Department at the national level, as well as a Ministry of Health to oversee public health care issues in the country, and lay the way for the development of more public health care facilities and health worker training. However, it did not significantly alter the unequal provision of health care services provided for black and white South Africans, nor did it improve the confusing organisation of public health care

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<sup>422</sup> Marks and Andersson, "Typhus and Social Control: South African, 1917-50", 261 and Van Rensburg, Ataguba, Benator, Doherty, Engelbrecht, *Health and Health Care in South Africa*, 71-72.

<sup>423</sup> E. H. Cluver. *Public Health in South Africa*. (Johannesburg: Central News Agency, 1994) 141.

<sup>424</sup> E. H. Cluver. *Medical and Health Legislation in the Union of South Africa*. (Cape Town: Central News Agency, 1960) 5-7 and Phillips, "The Local State and Public Health Reform in South Africa", 210-211.

services. Indeed, public health care services provided by the government after 1919 remained disjointed or fragmented as public health care responsibilities continued to be carried out by officials working in different levels of government and were poorly coordinated.<sup>425</sup>

Turning to the issue of Natal's cottage hospital system specifically in this 1910s period, it is difficult to generalise about how they were affected. Indeed, diverse things happened to various cottage hospitals, also at different times, depending on their particular circumstances. For example, some of these cottage hospitals were required to close their doors, while others continued on with their public health care work, though were usually altered in some way.

Analysis of archival records highlight that cottage hospitals established in Ixopo and Port Shepstone, for example, faced several challenges, and were ultimately closed.<sup>426</sup> The Ixopo Cottage Hospital, which opened in 1902, and served rural African patients, faced such severe funding shortages in the first decade of the twentieth century that it was forced to close its doors just a short while later in 1905.<sup>427</sup> By 1908, the archival records also highlight that after its closure, some of this cottage hospital's furniture had been sent to the local gaol for use in this state facility.<sup>428</sup> Another example of hospital closure was that of Port Shepstone Cottage Hospital. Opened in 1902, this cottage hospital, which was built about 120 kilometres south of Durban, was closed in 1911 for funding shortages too.<sup>429</sup>

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<sup>425</sup> Marks and Andersson, "Typhus and Social Control: South African, 1917-50", 261.

<sup>426</sup> PAR Natal Colonial Publications (hereafter NCP) Box 8/2/6 Reports of the Health Officer for the Colony for the year ended 1905. Report by Dr Ernest Hill. (Pietermaritzburg: Times Printing and Publishing, 1906). Also see boxes 8/2/7, 8/2/8 and 8/2/9 for the Reports by Dr Ernest Hill in 1906, 1907 and 1908. In addition, see PAR Secretary of Native Affairs (hereafter SNA) Vol 1/1/470 Ref 2653/1910 Minute Paper from Major Gardener (Audit Office) to S.O. Saunders (Under Secretary of Native Affairs) re "Report on an Inspection of the Cottage Hospitals Richmond, Charlestown, Newcastle and Dundee", 1 March 1910.

<sup>427</sup> Barbara Hanna Gorny. "Historic Hospitals in Natal". Vol 1 (M.A Thesis, Department of Architecture, University of Natal, 1988), 179.

<sup>428</sup> PAR Public Works Department (hereafter PWD) Vol 2/129 Ref 491/1908 Minute Paper from Mr. C. Barnes (Chief Engineer, Public Works Department) to Mr C. Bird (Principal Under Secretary), re "Proposed handing over two of the Bedside Lockers to the Gaoler for the Safe Keeping of Medicine in the Gaol Hospital", 17 February 1908.

<sup>429</sup> Gorny, *Historic Hospitals of Natal*, 181.

There were several reasons for these hospitals' closures. As highlighted above, an important set of factors related to financial problems faced by these hospitals. Indeed, these cottage hospitals, as well as several others, were already facing serious financial challenges in the years leading up to 1910. After the South African War, because of changing funding priorities and debts incurred in the reconstruction years, the Natal colonial government did not have enough funds to keep the majority of its cottage hospitals operational. This resulted in several of these hospitals falling into disrepair. The fact that many of these hospitals were built to serve black communities, or were built to serve communities in less developed rural areas, or provided services for communities also served by Christian missionary health care services, also meant that they were likely less of a priority for this government.

As mentioned in the previous chapter, in an attempt to solve these financial problems, in January 1906, the control of all cottage hospitals were transferred from the Health Officer of the Colony to local bodies, such as hospital boards of management.<sup>430</sup> However, this did not solve the budgetary problems for many cottage hospitals. When placed under the authority of these hospital boards, many of these cottage hospitals were still not able to balance their budgets. Not able to rely on the large government subsidies they had received in previous years for their building and operational expenses, they were no longer viable financially. Faced with rising operational costs in the early twentieth century, many hospital managers found that reliance on patients' fees was insufficient to cover their running costs. This was particularly problematic where these hospitals treated indigent patients who could not afford to pay their fees.

Moreover, the mismanagement of hospital finances by some cottage hospital boards during these years led to budgetary deficits too. Between 1908 and 1909, the Board of Health in Natal, the central body that was appointed to oversee all health matters concerning the

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<sup>430</sup> PAR NCP 6/1/1/61 *The Natal Government Gazette*, No. 838, 11 December 1905, 80.

colony, appointed a Committee to investigate the cause of financial problems that were worsening the services provided by several local board-controlled cottage hospitals, such as Dundee, Newcastle and Eshowe. The Committee found that several hospital boards were misusing hospital funds in terms of expenditure, as these boards permitted their Medical Officers-in-charge too much latitude in terms of ordering things for their hospitals. For example, the Committee found that Medical Officers-in-charge of the above three hospitals purchased much larger quantities of food items, such as fruit, eggs, butter and jam, than would have been necessary to feed their staff or patients.<sup>431</sup>

### **The Closure of Umsinga ‘Native’ Cottage Hospital**

There were several factors that caused the closure of Umsinga “Native” Cottage Hospital in 1910. One important reason for this hospital’s closure was because of its location and its racial designation as a “Native hospital”. Built in a “Native reserve”, arguably, it did not receive the same level of priority as other hospitals that were erected in urban areas, and which served white populations. As narrated in the previous chapter, this cottage hospital had, since its establishment in 1890, been woefully understaffed, it had always lacked adequate medicines and supplies, and many of its Medical Officers’ requests to renovate or expand the hospital had not been approved.<sup>432</sup> Furthermore, it had been forced to close several times during its history.

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<sup>431</sup> PAR Department of Public Health (hereafter DPH) Vol 1-2 Board of Health Natal Meetings, 1904-1911 and PAR DPH Vol 3-5 Minutes of Meetings of a Committee Appointed by Board of Health Natal to Investigate Dundee and Newcastle Cottage Hospitals, 1904-1910.

<sup>432</sup> PAR SNA Vol 1/1/381 Ref 1907/3012 Minute Paper from Dr JA Clement (District Surgeon Pomeroy Umsinga Division and Medical Officer of Umsinga ‘Native’ Cottage Hospital) to S.O. Saunders (Under Secretary of Native Affairs), re “Patients treated at Umsinga ‘Native’ Cottage Hospital”, 8 October 1907; PAR Colonial Secretary Office (hereafter CSO) Vol 1828 Ref 1907/1212 Minute Paper from Dr Ernest Hill (Health Officer for the Colony of Natal) to Dr J.A. Clement (District Surgeon Umsinga Division and Medical Officer of Umsinga ‘Native’ Cottage Hospital), re “Drugs for Umsinga ‘Native’ Cottage Hospital”, 26 November 1907; PAR CSO Vol 1825 Ref 1906/9567 Minute Paper from Dr J.A. Clement (District Surgeon Umsinga Division, and Medical Officer of Umsinga ‘Native’ Cottage Hospital) to John C. Bird (Principal Under Secretary), re “Repair of Umsinga ‘Native’ Cottage Hospital and the Allotment of two Indian attendants”, 30 December 1906; PAR DPH Vol 11 Ref DPH283/1903 Minute Paper from Dr F.R.H. Potts (District Health Officer Umsinga) to

Other than financial difficulties and expenditure mismanagement issues, Umsinga Cottage Hospital was also negatively affected by the shift in political priorities that came with a change in government in 1910. Unification led to the entrenchment of racial segregation in this magisterial area, which affected this hospital. The major change that occurred was the political decision by the Union government to abolish, on 19 May 1910, the British-created Umsinga Magisterial District and to establish two new magisterial districts: Mpofana and Helpmakaar.<sup>433</sup> This move was the direct outcome of an earlier petition made in 1906 by white farmers based in the Helpmakaar area who called for the magistracy to be relocated from the Umsinga (Pomeroy village) area, where few whites lived, to the Helpmakaar area so that it would be situated more favourably to this larger white farming community.<sup>434</sup> This political reconfiguration aided in the permanent closure of the Umsinga Cottage Hospital because the government did not have the funds to finance two public hospitals in these two new magistracies. In the years immediately following 1910, Christian missionary hospitals (i.e. the Gordon Memorial and the Church of Scotland hospitals) continued to serve the African populations of these two newly established magistracies, while white patients living in the Mpofana Magistracy could seek assistance from the District Surgeon of the Kranskop District.<sup>435</sup>

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Dr Ernest Hill (Health Officer of the Colony of Natal), re “Difficulties connected with Existence, and Retaining Services of a District Surgeon at Pomeroy”, 24 March 1903, 1-5

<sup>433</sup> PAR CSO Vol 1903 Ref 1912/30 Minute Paper from Secretary for the Interior, Pretoria to Assistant Under Secretary of Interior, Pietermaritzburg, re “Request for Papers dealing with the Abolition of the Umsinga Magistracy”, 13 March 1912.

<sup>434</sup> PAR PWD Vol 2/170 Ref PWD487/1907 Letter from G.S. Saunders, (Farmers Association, Helpmakaar) to J.F. Carter (Minister of Lands and Works, Pietermaritzburg), re “Suggestion that the Umsinga Magistracy be Removed from the Village of Pomeroy to a Site nearer Helpmakaar”, 30 January 1907.

<sup>435</sup> PAR NCP Box 6/1/1/70 *The Natal Government Gazette Extraordinary*, No. 3833, Friday, 20 May 1910, Proclamation No. 47/1910; PAR CSO Vol 1903 Ref 1912/30 Minute Paper from Secretary for the Interior to the Assistant Under Secretary of Interior, re “Request for Papers dealing with the Abolition of the Umsinga Magistracy”, 13 March 1912; and PAR Kranskop Magistrate (hereafter KRK) Vol 3/3/11 Ref KK362/1910 Minute Paper from Acting Under Secretary for Justice, Pietermaritzburg to Resident Magistrate, Kranskop, re “District Surgeon of Kranskop to take up Additional Duties at Mpofana Division”, 29 July 1910.

Of course, not all cottage hospitals were closed in the 1910s period. Indeed, many continued on with their public health care functions after 1910. In addition to Newcastle and Dundee Cottage Hospitals, which I will discuss below in more detail, two other Natal cottage hospitals, which continued after 1910, were the Queen Victoria Cottage Hospital in Eshowe and Richmond's Cottage Hospital.<sup>436</sup> Queen Victoria Cottage Hospital was erected in 1898 with donations that were contributed by both Europeans and Africans for the Jubilee of Queen Victoria and opened in February 1899 with a total of twelve beds. This hospital was established in a rural, inland area where no Christian mission facilities existed, and it accommodated both black and white patients, though on a segregated basis.<sup>437</sup> Similar to Queen Victoria Cottage Hospital, Richmond Cottage Hospital was erected in 1902 in a rural midlands area that had no other hospital facilities. Its eight beds were set up to accommodate black and white patients on a segregated basis.<sup>438</sup>

There were three main reasons why these cottage hospitals continued operating as public health care facilities after 1910. Firstly, they were the only health care institutions available in their areas. Secondly, they served both black and white patients, and thus their removal would have negatively affected white patients, which the new South African government wanted to avoid. Thirdly, the archival records suggest that these two hospitals

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<sup>436</sup> PAR PWD Vol 2/195 Ref PWD307/1910 Minute Paper from Director Government Cottage Hospitals, Durban to Mr Barnes (Chief Engineer Public Works Department), re "Queen Victoria Cottage Hospital Eshowe Water supply", 28 July 1910; PAR Attorney General's Office (hereafter AGO) Vol 1/8/142 Ref 54A/1913 7327 Minute Paper from Dr A E. Carte (District Surgeon of Richmond Division) to John C. Bird (Principal Under Secretary, Natal), re "Payment of Account by Mr. Percival to Eshowe Cottage Hospital", 3 March 1913; PAR AGO Vol 1/8/140. Ref 309A/1912 Letter from G. Lord (Provincial Secretary Natal) to J.W.F Bird (Attorney General, Pietermaritzburg), re "Outstanding fees of Harris, and 'Native' Makala at Richmond Cottage Hospital", 16 August 1912; and PAR CSO Vol 1882 Ref 1909/7327 Minute Paper from Dr A.E. Carte (District Surgeon of Richmond Division) to John C. Bird (Principal Under Secretary, Natal), re "Application for the Use Richmond Cottage Hospital for the Purpose of a Private Hospital", 28 December 1909.

<sup>437</sup> Gorny, "Historic Hospitals in Natal", 182-184.

<sup>438</sup> Gorny, "Historic Hospitals in Natal", 180.

did not experience the same financial mismanagement or debt problems faced by other cottage hospitals, making them more viable economically.<sup>439</sup>

Although several cottage hospitals continued with their public health care functions after 1910, most of these facilities were altered in some way. A major area of change related to the size of these institutions. Indeed, the idea of having several small cottage hospitals was dropped in a changing context that saw the steady expansion of patient demand for biomedical services after 1910, and especially during and after World War 1.<sup>440</sup> For example, Richmond and Queen Victoria Cottage Hospitals were expanded in size to become larger general hospitals, to accommodate growing patient numbers. Indeed, at Richmond, soon after 1910, an additional “Native ward” was built together to accommodate twelve additional patients and additional living quarters to accommodate “Native” staff.<sup>441</sup>

Another major change after 1910 related to who controlled these Natal public hospitals. In this period, these hospitals were placed under the control of the Natal Provincial Administration. Indeed, in 1910 when the Union Government came to power, the local hospital board authorities fell away, and all matters concerning what had previously been cottage hospitals were now left in the hands of the Provincial Administration. However, the Provincial Administration did not ensure the day-to-day functioning of these hospitals. This was left to medically-qualified superintendents or Medical Officers-in-charge who were responsible for handling the daily affairs of their hospitals and who liaised with the Provincial Administration on pertinent matters. As the managing body, the Provincial Administration controlled the overall admission and treatment policies of these hospitals, and administered

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<sup>439</sup> PAR DPH Vol 1-2 Board of Health Natal Meetings, 1904-1911 and PAR DPH Vol 3-5 Minutes of Meetings of a Committee Appointed by Board of Health Natal to Investigate Dundee and Newcastle Cottage Hospitals, 1904-1910.

<sup>440</sup> Cluver, *Medical and Health Legislation in the Union of South Africa*, 5.

<sup>441</sup> Gorny, “Historic Hospitals in Natal”, 186-87.

subsidies to enable these institutions to function.<sup>442</sup> The Provincial Administration was also responsible for funding any maintenance costs and additions that needed to be made at these hospitals.

### **Newcastle Cottage Hospital**

Newcastle Cottage Hospital continued to exist as a public health care facility after 1910. Although this hospital had to navigate its way through some funding mismanagement issues, in the post-1910 period, the newly appointed Medical Officer-in-charge of this hospital was responsible for the day-to-day operation of this institution, working in close association with the Provincial Administration. And as such, this cottage hospital continued to thrive as a public health care facility serving patients in its expanding urban area. The sustained development of its coal mining and related industries ensured the continued migration and settlement of people in and around this area for work opportunities. Since the area in the 1910s had no other hospital facilities serving its growing, racially diverse population, closing this hospital would have had a negative effect on the health of the whole population of this area. Apart from the funding that this hospital received from the government, it also received a part of its funding from the mines as it accommodated mine patients, and such funds helped keep the hospital financially stable.<sup>443</sup>

Another area of change that influenced the Newcastle Cottage Hospital in the period after 1910 was the enlargement in size of this institution to accommodate expanding staff

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<sup>442</sup> Michael Gelfand. *Christian Doctor and Nurse: The History of Medical Missions in South Africa from 1799-1976*. (Sandton, RSA: Aitken family and friends, 1984) 262-267; Phillips, *The Local State and Public Health Reform in South Africa*, 210; PAR Chief Native Commissioner (hereafter CNC) Vol 90 Ref 1752/1912 Letter from G. Dourman (Provincial Secretary Natal) to Resident Magistrate, Newcastle Division, re “Request for Authority for Free Treatment of ‘Natives’ in Cottage Hospitals”, 5 September 1912.

<sup>443</sup> PAR DPH Box 8/1/12/4/1 Reports of the Health Officer for the Colony of Natal for the year 1904. Report by Dr Ernest Hill. (Pietermaritzburg: Times Printing and Publishing, 1905); PAR DPH Vol 16 Ref 194/1904 Minute Paper from Dr Ernest Hill to Dr H.J. Galbraith, re “Guarantees for Hospital Patients at Dundee Cottage Hospital”, 22 March 1904.



numbers, but also patient numbers, which continued to be treated on a segregated basis.<sup>444</sup> To accommodate the expansion of staff and patient numbers, soon after Union, two sets of additions were made to this hospital to cope with growing patient numbers. The first set of additions were made in 1913 and cost £2155-3-0, which included the building and supply of a whole new ward that would accommodate an additional twenty people, a new coal shed, improvement of the hospital's drainage system, and general repairs and painting.<sup>445</sup> A second set of additions were completed in the early months of 1915 at a lower cost of £362-1-4, including the building, wiring and equipping of a new addition to the hospital to be used as a dispensary and other general repairs to the coach house, the hospital's kitchen, the stable, and nurses' quarters. This set of additions also included provision of a hot water supply for the whole hospital and nurses' home.<sup>446</sup>

### **Dundee Cottage Hospital**

Dundee Cottage Hospital also continued its work as a public health care institution in the post-1910 period. This occurred for several reasons. Firstly, although this cottage hospital was not the only existing public health care facility in the Dundee area (the Swedish Mission Hospital also existed and treated black patients from the area), by 1910, it was the only hospital that served the white population of this area. Over the years, more whites settled in the area to open and run various businesses that were beneficial to the region's economy.

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<sup>444</sup> PAR SNA 1/1/470.2653/1910 Minute Paper from Major Gardener (Audit Office) to S.O. Saunders (Under Secretary of Native Affairs), re "Report on an Inspection of Cottage Hospitals: Richmond, Charlestown, Newcastle and Dundee", 1 March, 1910; PAR CNC Vol 90 Ref 1752/1912 Letter from G. Dourman (Provincial Secretary Natal) to the Resident Magistrate, Newcastle Division, re "Request for Authority for Free Treatment of 'Natives' in Cottage Hospitals", 5 September 1912.

<sup>445</sup> PAR CNC Vol 82 Ref 1248/1912 Minute Paper from Resident Magistrate, Newcastle Division to the Acting Chief Native Commissioner, Pietermaritzburg, re "Admission of Native Girl Laga to Hospital", 15 July 1912; PAR CNC Vol 176 Ref 1914/1095 Letter from the Resident Magistrate, Newcastle Division to Chief Native Commissioner, Natal, re "Admission to Newcastle Cottage Hospital of a Native Woman named Tukwase Kumalo", 4 July 1914; and PAR CNC Vol 238B Ref 1916/758 Letter from the Resident Magistrate, Newcastle Division to Chief Native Commissioner, Natal, re "Makhutla Manashila Admission to Newcastle Cottage Hospital", 18 May 1916.

<sup>446</sup> National Archives Repository (hereafter NAR) PWD Vol 2546 Ref 9144 Contractors Bill Mr Walton (District Engineer, Department of Public Works, Ladysmith) to Mr. W. A. Ross (Contractor for the Newcastle Cottage Hospital) re "Additions at Newcastle Cottage Hospital", 23 May 1913.

Therefore, because of the prioritised needs and demands of the white population in this area, this hospital was able to continue with its work after 1910 due to continued government subsidisation.<sup>447</sup> Secondly, this hospital continued to exist because like Newcastle, Dundee Cottage Hospital was located in an urban location where most of the post-1910 public health care resources were channelled. Furthermore, because this hospital had a larger number of fee paying white patients who received treatment at this facility, the hospital received more money from patient fees towards its budget. Such funds helped kept this institution afloat compared to other cottage hospitals.<sup>448</sup>

Similar to the Newcastle Cottage Hospital, Dundee Cottage Hospital underwent changes in the post-1910 period too. Dundee Cottage Hospital was also taken over by the Natal Provincial Administration and the local hospital board control fell away in 1910. The Natal Provincial Administration also worked together with the Medical Officer-in-charge who remained in charge of the day-to-day running of this hospital.<sup>449</sup>

Dundee Cottage Hospital in the immediate post-1910 period did not see any changes made in terms of the race demographic of patients admitted, and this hospital continued to accommodate white patients exclusively, while black patients continued to be sent to the Swedish Mission Hospital. However, like Newcastle, it did see a rise in patient numbers and staff. To accommodate the expansion of patients, in the early months of 1913, additions were made to this hospital to cope with growing patient numbers. These were completed in May 1913 at a cost of £ 574.16.0.<sup>450</sup> These renovations included an additional ward to

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<sup>447</sup> Gorny, "Historic Hospitals in Natal", 185.

<sup>448</sup> PAR DPH Vol 1-2 Board of Health Natal Meetings, 1904-1911 and PAR DPH Vol 3-5 Minutes of Meetings of a Committee Appointed by Board of Health Natal to Investigate Dundee and Newcastle Cottage Hospitals, 1904-1910.

<sup>449</sup> PAR DPH Vol 1-2 Board of Health Natal Meetings, 1904-1911 and PAR DPH Vol 3-5 Minutes of Meetings of a Committee Appointed by Board of Health Natal to Investigate Dundee and Newcastle Cottage Hospitals, 1904-1910.

<sup>450</sup> NAR PWD Vol 2874 Ref 10693 Contractors Bill Mr Walton (District Engineer, Department of Public Works, Ladysmith) to Messrs Johnstone and Keith (Contractor for the Dundee Cottage Hospital), re "Additions at Dundee Cottage Hospital", 14 July 1913.

accommodate an extra twenty people, as well as an infectious diseases ward wing of this hospital.

This chapter has examined the reconstruction period after the South African War, the period that saw the formation of the Union of South Africa in 1910, and the first few years after Union. It has highlighted that the political transition that led to the creation of the Union of South Africa led to the demise of Britain's cottage hospital system in Natal. It also examined some of the negative effects that the years immediately after Union had on public health care services in South Africa, including its Natal province. Moreover, the last section of this chapter investigated how the formation of the Union government influenced the functioning and the management of the three hospitals under investigation in this study, namely Umsinga, Newcastle and Dundee cottage hospitals. The next chapter will provide a few concluding remarks about these three cottage hospitals, and consider the impact that these cottage hospitals had on the provision of health care services in the colony of Natal.

## **CHAPTER SIX**

### **Conclusion**

This thesis has focused on the history of the development and operation of three cottage hospitals: Umsinga, Newcastle and Dundee in colonial Natal between the 1880s and 1910. Divided into six chapters, this thesis started in Chapter One (the Introduction chapter) with an outline of the key research issues and questions, it examined some of the most significant literature published on or around my topic, and laid out the theoretical framework and methodologies. It also defined what a cottage hospital was in the context of its original conception in nineteenth century Britain and then discussed how it spread to other parts of the world, including Natal, through the activities of the British Empire.

I then moved on to provide some broader historical background in Chapter Two. This chapter was designed to help the reader understand the pre-cottage hospital era in the colony of Natal. It highlighted what health and healing options were available to people living in the colony in the years before the 1880s. In the biomedical tradition, the public health care services available included a few larger public hospitals built in larger cities such as Durban and Pietermaritzburg, but also the services provided by state employed District Surgeons in several magisterial districts, who provided mobile health care services for state employees and other people living in smaller or less densely populated communities. Other than these state provided services, this chapter also noted the important role played by Christian missionary doctors and nurses, particularly those living in rural areas, who provided health care services, particularly for many black communities. Furthermore, this chapter reflected on the fact that during the nineteenth century, many sick people usually only used these biomedical facilities as last resort, having first tried to heal themselves or having sought the services of “traditional healers”. Finally, the last part of this chapter ponders several factors

that led the British colonial government to eventually establish cottage hospitals in Natal from the 1880s.

Chapter Three shifted the focus from the broader Natal context and zoomed into analysis of three particular magisterial districts where the British government established three cottage hospitals. This included the magisterial districts of Umsinga (or Pomeroy), Newcastle and Dundee. Umsinga Cottage Hospital was opened in 1889, Newcastle followed in 1901 and Dundee in 1903. There were several reasons why I chose to focus on these three cottage hospitals. Firstly, I wanted to provide a more in-depth qualitative analysis of these facilities, which a focus on many institutions would not have enabled. Secondly, the archival records for these three particular hospitals were more detailed and extensive, which made it easier to investigate the history of these institutions. Thirdly, I wanted to examine cottage hospitals that provided services for black patients, and so chose facilities that were either specifically created for this purpose, such as Umsinga, or those that were created to treat black patients on a segregated basis, such as Newcastle and Dundee. Fourthly, I was interested to compare the services provided at cottage hospitals in rural and urban areas.

Having analysed the establishment of the three cottage hospitals in Chapter Three, Chapter Four, which drew mostly on archival material, went into greater detail about the operations of Umsinga, Newcastle and Dundee cottage hospitals. This chapter was particularly interested in how these institutions functioned. This included analysis of who financed these facilities, who managed them, as well as their staffing situations. Although most of the archival records were written by, or focused on, the perspectives of political or medical elites, such as the Health Officer of the Colony, the Resident Magistrates or the Medical officers-in-charge of these cottage hospitals, I have tried to use these records to also determine something about the patients, particularly the conditions they were treated in, and

have included statistical information where possible to highlight how more patients sought out biomedical services at these institutions as the years went on.

Chapter Five examined what role the end of British colonial rule and the coming to power in 1910 of the Union of South Africa government had on the cottage hospital system. It started by focusing on some historical background to explain the political transition in 1910. It then went on to consider the effects this transition had on public health care services in the country more generally, and then on Natal's cottage hospital system in particular. Lack of funds, financial mismanagement by certain local hospital boards, and less concern for small hospitals located in black and rural areas were major factors that led to the closing of some cottage hospitals, such as Umsinga. Others, however, were able to survive, due to a variety of factors, such as their location in economically more important urban areas, and the greater priority given to facilities that treated white patients, such as in Newcastle and Dundee. Although several cottage hospitals were able to survive into the 1910s era and beyond, they would all undergo transformations in their physical size, staffing, patient numbers, management and funding arrangements, to mention just a few issues. Indeed, most of these institutions would quickly become unrecognisable from their humble beginnings in the late colonial period as they were altered to meet the challenges of the twentieth century.

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In the last part of this conclusion chapter, I would like to reflect on the significance of cottage hospitals in colonial Natal. In the introduction of this thesis, I noted a couple of broader research issues I wanted to investigate in this thesis. The first related to the impact that these government-sponsored biomedical facilities had on the provision of public health care services in this colony. The second related to what role "race" issues played in the provision of public health care services in this colony.

Let me start with some concluding reflections remarks to the first issue. This thesis has helped expand the available literature that focuses on health care services in the late nineteenth and early twentieth centuries. This literature has tended to concentrate either on the health care services provided by large urban public hospitals, or the important work done by Christian missionary doctors and nurses who struggled over many decades, to provide most of the biomedical services in rural areas, particularly for black patients. Instead, this thesis has contributed to this existing literature by analysing other smaller public health care institutions that were started and funded by the British colonial government, which worked in conjunction with the District Surgeoncy system, and was developed to serve communities in different magisterial districts during this period.

However, can we speak of these Natal cottage hospital facilities as “tools of empire”, as argued by Daniel Headrick in his book *The Tools of Empire: Technology and European Imperialism in the Nineteenth Century*?<sup>451</sup> By “tool” he meant how something introduced by the British, for example, a drug therapy (such as quinine for the treatment of malaria), or an institution with power to socially control a population, or a form of transport that enabled the British to infiltrate a new area, could serve as an instrument or mechanism to help the British expand or stamp its influence or authority on a particular population or in a particular area. From my analysis of the three cottage hospitals I focused on in this thesis, the answer is complex, and would be both yes and no.

These cottage hospitals certainly provided an important service to communities living in magisterial districts which before they were constructed, did not have government funded small hospital services available to them. This was evident in both the Newcastle and Dundee examples, as before these biomedical facilities were built, these magisterial districts only had the service of an overstretched District Surgeon in each of these particular areas to treat all

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<sup>451</sup> Daniel R. Headrick. *The Tools of Empire: Technology and European Imperialism in the Nineteenth Century*. (New York: Oxford University Press, 1981).

those needing health care in their whole districts. As a result, for conditions needing hospitalisation, patients had to travel great distances to reach the nearest hospitals in other magisterial districts or in the larger towns or cities to receive treatment.

Cottage hospitals also helped introduce more people – particularly those built for Africans living in isolated rural districts – to the healing world of western biomedicine, much like early missionary doctors and nurses did where they established their first biomedical facilities. Moreover, in areas where other missionary clinics or dispensaries already existed, such as at Umsinga, these cottage hospitals provided an additional biomedical health care option for people living in those communities. This was particularly important for indigent patients as different facilities often charged different fees, and some charged no fees at all, which gave poor patients the possibility of seeking care if they had little or no money for fees. However, different options were also significant for people who preferred not to go to mission hospitals because they wanted to avoid efforts made in these hospitals to convert them to Christianity.

These cottage hospitals might also be regarded as “tools of empire” in that over time, their ability to promote western cultural forms (in this case a biomedical healing approach) and to encourage more people, particularly Africans to seek health care from biomedical health care providers, over time competed with, if not undermined, the services provided by “traditional healers” in these areas. Indeed, the archival records highlight that in remote African “reserve” areas like Umsinga, its cottage hospital was able to treat African patients who had never been exposed to western medicine before, and the growing number of patients demonstrated its increasing popularity over the years.<sup>452</sup>

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<sup>452</sup> Pietermaritzburg Archives Repository (hereafter PAR) Secretary of Native Affairs (hereafter SNA) Vol 1/1/185 Ref 30/1894 Minute Paper from S.O. Saunders (Under Secretary of Native Affairs) to Henry F. Fynn (Resident Magistrate Umsinga), re “Request for the Annual Report on the ‘Native’ Cottage Hospital”, 30 April 1894.



However, in other ways, these cottage hospitals did not operate nor could they be seen as “tools of empire” because they were not as powerful, influential or far-reaching as this phrase suggests. These hospitals were not the types of “disciplinary institutions”, with the large degree of power or social control – “the medical gaze” – that Foucault imagined hospitals and their doctors to have.<sup>453</sup> Firstly, a number of cottage hospitals erected in Natal were limited as they were not found in all the magisterial districts of the colony. This severely limited their reach. Secondly, due to their limited number, these health care institutions proved difficult to access for many people, especially those built in remote rural areas, where public transport facilities were poorly developed.

Thirdly, because of the small size of these facilities and small number of its staff, they could not treat a huge numbers of patients like the larger urban hospitals such as Greys and Addington hospitals. Since the Medical Officers-in-charge were also the District Surgeons of their magistracies, these individuals, who were very few in numbers, could only treat a limited number of patients. In addition, many of these hospitals also faced the challenge of severely limited resources, which impacted on the medicines they had at their disposal and equipment to treat patients. At times, as we have seen in this thesis, some of these hospitals found it difficult to even find enough beds for patients, forcing hospital staff to turn patients away or to accommodate them on the hospital’s floor or outside. We should not forget that the biomedical knowledge of doctors and nurses during the late nineteenth and early twentieth centuries was much more limited than the knowledge of medical and nursing practitioners today.

Many people, particularly Africans, continued to remain sceptical of western healing approaches in the late nineteenth and early twentieth centuries. This is evidenced by their continued use of “traditional healers” services and efforts to treat themselves before seeking

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<sup>453</sup> Michel Foucault. *The Birth of the Clinic: An Archaeology of Medical Perception*. Translated from French by A.M Sheridan Smith. (London: Routledge, 2012) 30-32.

assistance. Indeed, seeking assistance from biomedical practitioners was usually done as a last resort. Umsinga 'Native' Cottage Hospital opened with the aim of eradicating the need for "traditional healers" amongst African patients, but that did not take place because of limitations of the services it offered. Its continuous shortage of funds, equipment, staff and accommodation, and several shut downs between 1890 and 1910 made it an unreliable service for African patients. Arguably, its services remained culturally alien to many living in this rural district. As a result, Africans did not simply abandon their previous health seeking behaviours or beliefs when biomedical services options became available. At best, it remained one of many healing options that Africans would consider using depending on their availability and nature of their illnesses.<sup>454</sup>

Finally, I would like to provide a few concluding remarks about the role that "race" played in the provision of public health care services in the colony of Natal. One of my research questions at the start of this thesis was to ask whether the issue of racial inequalities played a significant role. The answer is a resounding yes. Analysis of the history of Umsinga, Newcastle and Dundee cottage hospitals shows that each of these facilities were created by colonial administrators who promoted policies and practices that led to people being treated differently because of the colour of their skins. Indeed, Umsinga was created as a racially separate hospital in a "Native reserve" area for the exclusive use of African patients, while both Newcastle and Dundee, though initially created to provide public health care services for patients of all races did so in racially segregated wards. Furthermore, when Dundee Cottage Hospital's managers, just a few months after their hospital opened, decided to make this hospital a "Europeans-only" hospital, ostensibly to deal with overcrowding problems, it

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<sup>454</sup> Karen Flint. *Healing Traditions: African Medicine, Cultural Exchange and Competition in South Africa*. (Athens, OH: Ohio University Press and Pietermaritzburg University of Natal Press, 2008) 95-128.

reflected once again an effort by those in power to use race as a pivotal factor that determined how this hospital functioned and which patients it could treat.

Other than the fact that staff who worked in cottage hospitals was paid differently for the same work done because of their race and housed separately, treatment in racially segregated facilities and wards also led to unequal treatment for black and white patients. At black hospitals, such as Umsinga Cottage Hospital, its facilities always lacked staff, as well as the best quality equipment and medicines compared to better staffing and more medicines and equipment for those serving white patients. As discussed in this thesis, when black wards at segregated hospitals, such as Newcastle and Dundee (at least for Dundee's first year) became overcrowded, the hospital administrators did not accommodate the overflow of black patients in empty white wards. Such experiences led to sub-standard treatment conditions for black patients who were either turned away or accommodated on floor beds or in the corridors.

The archival records also highlight unequal treatment in terms of food provided for patients of different "race groups". In effect, a dietary scale operated in these hospitals for different patients. For example, African patients were only given porridge and bread in these hospitals, while European patients did not receive dietary restrictions in terms of the meals they were provided with.<sup>455</sup> Moreover, in some of these cottage hospitals, such as the facility in Newcastle, white patients with more money, could be treated as private patients in separate rooms at a higher fee, whereas such practice was not permitted for other race groups.<sup>456</sup>

The coming to power of the Union Government in 1910 came with little in the way of changes to the race policy aspects of these institutions. In hindsight, it could be argued that

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<sup>455</sup> PAR DPH Vol 1-2 Board of Health Natal Meetings, 1904-1911 and PAR DPH Vol 3-5 Minutes of Meetings of a Committee Appointed by Board of Health Natal to Investigate Dundee and Newcastle Cottage Hospitals, 1904-1910.

<sup>456</sup> PAR DPH Vol 1-2 Board of Health Natal Meetings, 1904-1911 and PAR DPH Vol 3-5 Minutes of Meetings of a Committee Appointed by Board of Health Natal to Investigate Dundee and Newcastle Cottage Hospitals, 1904-1910.

these British-created cottage hospitals provided a significant model and played an important role in socialising people – policy makers, but also the medical and nursing staff and patients – into accepting a system that promoted segregated and sub-standard treatment for black and white patients at public health facilities. Indeed, racial segregation policies that were developed in Natal's colonial cottage hospital system were used as a blueprint for policy makers moving forward into the Union period, and continued to negatively affect public health care services in South Africa in the twentieth century.

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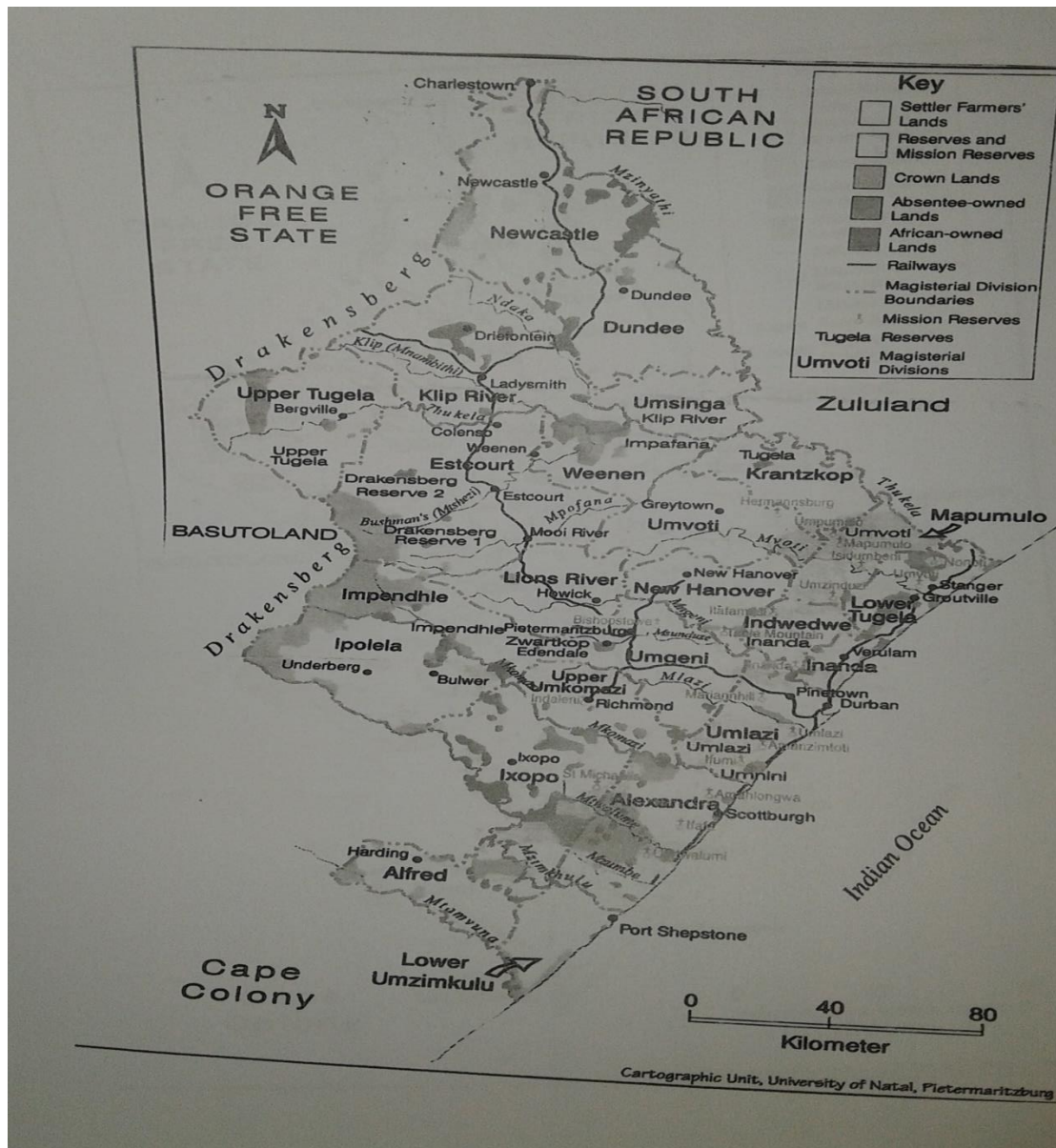
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## Appendix 1 – Map of Colonial Natal in 1900



John Lambert. *Betrayed Trust, Africans and State in Colonial Natal*. (Scottsville: University of Natal Press, 1995)

## Appendix 2 – Population according to Race for the Newcastle and Dundee areas in 1904

Dundee Race Group	Population	Newcastle Race Group	Population
Africans	1,041	Africans	1,172
Asiatic	408	Asiatic	515
Coloureds	143	Coloureds	129
Whites	1,312	Whites	1,166

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