

# *Divided facilities: early cottage hospitals and the provision of health care services in Natal*

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Cottage hospitals were founded in Britain and as the British engaged in empire building abroad, they were also implemented in their colonies. Dr Albert Napier erected the first cottage hospital in Cranleigh, England in 1858.<sup>1</sup> A cottage hospital was a small structure utilised as a hospital with minimal modifications. Typically, it was a detached residence containing two or three individual rooms and only a handful of beds for tending to the sick.<sup>2</sup> In Natal, these cottage hospitals were located in villages and later on also erected in urban areas. Similar to other institutions, these cottage hospitals were not immune from inequalities associated with race.<sup>3</sup> The public health care facilities to be examined are the cottage hospitals at Umsinga (erected in 1889), Newcastle (1901) and Dundee (1903).

## **Factors leading to the establishment of cottage hospitals in colonial Natal**

Studies undertaken by various academics indicate that the development of cottage hospitals was driven by the dangers posed by African and Indian healers; the significant increase in licensed doctors during the 1890s; and, last, the establishment of Responsible Government in 1893.<sup>4</sup> In the early colonial era, most Africans in the so-called reserves, and those living in and around towns, relied on either their own home remedies or traditional healers for their health care needs; visiting a Western doctor was a last resort.<sup>5</sup> Similar to Africans, Indian communities also had their own healers whom people turned to when they were ill. It is important to note when Indians started arriving in Natal in the 1860s that 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 the Colony. A number came as trained professionals and skilled workers, while others had trade or practical skills learnt from their home country. Included among 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>6</sup>

Karen Flint shows how the development of ‘hybrid’ healing cultures became so prevalent during the course of the nineteenth century that it was 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 criminalise the activities of these healers.<sup>7</sup> By the 1890s, medicine became more regulated and standardised as a profession, unlicensed medical practitioners were marginalised and criminalised, and as a result more doctors arrived in Natal.<sup>8</sup> In the late 1800s, the Colony encountered the looming danger of infectious diseases spreading, prompting colonial authorities to increase public health care services.<sup>9</sup> Increasing numbers of health care professionals, rising trends towards professionalising doctors, and doctors’ ambition to extend the influence of biomedicine also played a significant role in promoting the establishment of public health services, such as cottage hospitals.<sup>10</sup> In the second half of the 1800s, an increasing number of doctors from Britain migrated to southern Africa after receiving training in their home country. In 1856, there were only around twelve licensed practitioners in Natal, but by the late 1880s, the number had grown to about 100.<sup>11</sup> Another factor that encouraged the government to develop cottage hospitals in Natal was this Colony’s attainment of Responsible Government status. The predominantly white (male, propertied) voting public achieved this in 1893 after many years of lobbying. Responsible Government or self-government meant that Natal had its own governor, elected its own officials to its upper and lower houses of parliament, and was no longer dependent on decisions made in the Cape. 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.<sup>12</sup>

## **Cottage hospitals in colonial Natal**

In relation to pre-cottage hospital services, individuals residing in the colony of Natal could also obtain support from Christian missionary doctors and nurses. Christian missionaries played an essential role in the provision of Western health care services for black patients. From 1835, Dr Newton Adams of the Congregationalist American Board of Missions was the first medical missionary to work in the Natal region.<sup>13</sup> He established a mission station, which became known as the Adams Mission Station in the Amanzimtoti area south of Durban. Incredibly hard working and versatile, this 'teacher of three coats' (*umfundisi yamebantyi amatatu*), as local people called him, did much to lay the groundwork to spread the gospel, teach Africans on his mission to read and write and introduce many Africans to Western medicine.<sup>14</sup> 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 Natal, starting in the 1830s and 1840s, with more coming over from the United Kingdom, Europe and the United States of America in the latter half of the nineteenth century.<sup>15</sup> 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. 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>16</sup>

Numerous state-funded cottage hospitals were built across various magisterial districts in Natal from the 1880s to 1910. They were located in Richmond, Maphumulo, Umsinga (or Pomeroy), Newcastle, Dundee, Port Shepstone, Eshowe, Ixopo, Richmond, Stanger, Weenen, Avoca, Verulam, Umzinto and Isipingo.<sup>17</sup>

## **Umsinga cottage hospital**

Umsinga was one of the magisterial districts located in the north-western part of Natal. During the latter half of the nineteenth century, most of the southern part of this area was subdivided into a so-called native reserve as part of the Shepstone system, where the majority of the region's African communities were relocated.<sup>18</sup> Umsinga was a rural district, where most people made their living from farming. This included both livestock and agriculture.<sup>19</sup> By the late 1800s there were an estimated

32 000 Africans living in the Umsinga district.<sup>20</sup> These Africans comprised 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>21</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. Among African communities, the next port of call for illnesses not treatable with home remedies were traditional healers.<sup>22</sup> In terms of biomedical health care services, there were few options available for people living in this district. One option was 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 (1870).<sup>23</sup> Other than missionaries, 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 policemen, farmers, clerks and all magistrate court workers in the area; and to report on and try to stop the spread of infectious diseases.<sup>24</sup> By the late 1880s, 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.<sup>25</sup>

Towards the end of 1888, Sir Arthur Havelock, the lieutenant-governor of Natal, approved and funded the establishment of a small cottage hospital to cater for Umsinga region.<sup>26</sup> The construction work on this building began in late 1888 and was finished in four and a half months.<sup>27</sup> In March 1889, the Umsinga Native Cottage Hospital was completed at a cost of £5 000 provided by the Native Affairs Department. This tiny medical facility catered for black patients and the facility included two wards, a surgery room, a room for patient consultations, and a spacious porch. At first, the hospital had a total of twelve beds.<sup>28</sup> Furthermore, residents from the area were given permission to construct some huts on empty land close to the hospital. These were meant to house the family or friends of patients who were also responsible for bringing food to those receiving care at the hospital, as it lacked kitchen facilities.<sup>29</sup> Dr John Mavuna Nembula was appointed

as the first medical officer-in-charge of this hospital on 18 March 1889. Nembula had a lot of responsibilities placed on his shoulders, as both district surgeon and medical officer-in-charge. Indeed, the archival records discuss how Nembula worked long hours, often more than twelve a day, on a regular basis.<sup>30</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 per annum with rations.<sup>31</sup>

### **Newcastle cottage hospital**

Newcastle was also located in the north-western part of the colony of Natal. Unlike Umsinga, which remained a primarily rural district during the period covered by this study, Newcastle quickly developed into an important industrial town. This was because of the discovery of local coal deposits by settlers, who had learnt about them from local African people.<sup>32</sup> In the latter part of the 1800s, coal attracted additional residents to the area to utilise it for warmth and to fuel steam-powered machines and trains. In the late 1800s, the region saw growth in many large coal mines and related industries like iron and steel production, which utilised coal heat for smelting iron ore extracted from rock.<sup>33</sup> White settlers resided in the town or on farms nearby, while Africans were moved to segregated reserves around 80 kilometres away from the main town, mirroring the situation in Umsinga. In addition to Africans and European settlers, Newcastle also became a settlement for individuals who had moved to Natal from India. Similar to Africans from the reserves, ‘Coolies’ from India (as referred to by the colonial government) were attracted to the region to exploit job opportunities available in and around the town.<sup>34</sup> Certain indigenous individuals known as free or passenger Indians independently travelled to the region to establish trading posts to sell goods to the communities in and around Newcastle.<sup>35</sup>

Concerning the health care situation in Newcastle, as was the case in Umsinga during the latter half of the nineteenth century, 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.<sup>36</sup> Biomedical health care services in the area 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>37</sup> Moreover, despite the presence of a district surgeon in Newcastle who offered medical services for the colonial government, this physician was highly burdened with work. His attempts to stop disease outbreaks, treat government and mining personnel, and run a part-time private clinic made it challenging to assist everyone in need of his care.<sup>38</sup>

The establishment of the Newcastle Cottage Hospital came to fruition in the early 1900s, following years of advocacy from different stakeholders. Several justifications were provided for constructing this hospital. In a petition to the local government, a town resident highlighted the absence of a state hospital in the area as one of their concerns.<sup>39</sup> It took several years, but eventually the newly appointed governor of Natal agreed to this in 1898 and building started in 1900. Similar to Umsinga, the building chosen for this purpose already existed, attached to the local gaol, having been used as a mortuary before it was converted. However, unlike Umsinga 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. Newcastle Cottage Hospital was opened in June 1901. In its initial plan, it consisted of three divisions with thirteen beds in each, a surgical area, kitchen, pantry and a spot for appointments. 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>40</sup>

As was the case in Umsinga, in Newcastle the district surgeon was also appointed as the medical officer-in-charge of the Newcastle Cottage Hospital and worked closely with the resident magistrate between 1901 and 1910. Dr John M. Ormond was the first doctor appointed as medical officer-in-charge of this hospital.<sup>41</sup> He carried a heavy workload providing health care services to people needing care in the Newcastle district and provided in- and outpatient medical and surgical services at the cottage hospital. Newcastle Cottage Hospital had a larger medical staff to help treat

patients. There were likely several reasons for this. First, because of its location on the main road to and from the gold mines of the Witwatersrand it had to cater for a larger influx of people needing treatment who passed through this town. Second, it needed to cater for soldiers and civilians wounded during the South African War. Third, mining and industrial accidents were more common, due to the more industrialised nature of this town and facilities needed to be provided for these. Finally, as a segregated hospital with three wards it needed a larger staff to serve these different 'racial' groups. 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>42</sup> 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>43</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 could afford. 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. In addition, the hospital received fee payments from the owners of various coal mines in Newcastle to cover the treatment provided for sick or injured-on-the-job employees.<sup>44</sup>

### **Dundee cottage hospital**

The Dundee area is near the Biggarsberg mountain range in northern Natal.<sup>45</sup> For most of the nineteenth century the region was mainly rural, consisting of dispersed African households engaged in farming animals and plants. 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>46</sup> As had been the case in Umsinga and Newcastle, the African population of Dundee was forced to relocate into reserves as part of the Shepstone system and 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 the Dundee area experienced similar land shortages and overcrowding problems, as well as impoverishment.<sup>47</sup>

Furthermore, Indian indentured labourers were also transported to Dundee to serve as inexpensive workers in the coal mines or as labourers for Natal government railway construction. These workers typically resided on their employers' land until fulfilling their agreements.<sup>48</sup> In addition to indentured labourers, passenger and free Indians also came to the area to establish farms or sell produce and other goods in supply stores.<sup>49</sup> Similar to those residing in Umsinga and Newcastle in the late 1800s, most individuals in Dundee and its vicinity initially relied on home remedies to treat their illnesses, turning to traditional healers only as a last resort. Additionally, many individuals during that period would have turned to biomedically trained physicians as a final option, only after exhausting home remedies and the assistance of traditional healers.<sup>50</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, trying to stop the spread of infectious diseases and treating patients in his part-time private practice.<sup>51</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 coal mines.<sup>52</sup> 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 Swedish Mission.<sup>53</sup> The Swedish Mission Hospital (also known as the Betania Hospital), was officially opened in 1899 and provided accommodation for forty patients of all 'races'. The initial staff consisted of two mission doctors, a matron and three Swedish nursing sisters.<sup>54</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. First, 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 coal mining industry.<sup>55</sup>



Second, the Dundee district surgeon made repeated appeals to the government to establish a hospital to accommodate the growing numbers of patients, particularly coal miners and railway workers he was attending to.<sup>56</sup> Third, 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>57</sup>

In 1900 when permission was eventually given and funds were made available to go ahead with the construction work, 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.<sup>58</sup> In addition, again unlike Umsinga and Newcastle, the Dundee Cottage Hospital was to be constructed as a new building, not a renovation of an existing building.<sup>59</sup> The contractors appointed to complete the construction work did so in April 1901 at a cost of £500. 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, it was constructed as a simple, single-storey brick building, with a corrugated iron roof and cement floors.<sup>60</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 in 1899. This meant delays in completing the hospital because of funding shortages with money used instead for the war effort.<sup>61</sup> Eventually, after the war ended in 1902 and the government was able to procure the necessary furniture and equipment, the Dundee Cottage Hospital was opened in December 1903.<sup>62</sup> Similar to Newcastle Cottage Hospital, it was initially opened to treat black and white patients, offering two segregated wards with eleven beds.<sup>63</sup> This hospital also had kitchen facilities, a small operating theatre, a patient consultation area, and ablution facilities. It was provided with electricity in 1902, which meant that its staff and patients had the convenience of electric lights immediately upon opening.<sup>64</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 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>65</sup> In its first

few months of operation, patients were therefore accommodated on floor beds in the corridors, overwhelming its services and staff. Furthermore, white settlers in this region who sought treatment at this hospital increasingly voiced complaints about the overcrowding and poor service received.<sup>66</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 1904, African and Indian patients needing biomedical care were referred to the Swedish Mission Hospital for treatment.<sup>67</sup>

## Conclusion

This article has presented a thorough analysis of the origins of cottage hospitals and the elements that resulted in the construction of such health care facilities in the colony of Natal. In addition, this research has analysed three cottage hospitals, considering the circumstances of their establishment and the vital role of district surgeons, who acted as the medical officers overseeing these 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.

## NOTES

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