

Health Care, Hospitals and Racial Hygiene in German Colonial Windhoek (1890-1915)

Q Wessels¹, AM Taylor³, C Correia², BC Brock⁴

1,4. Department of Anatomy, School of Medicine, University of Namibia, Windhoek, Namibia.

2. Department of Medical BioScience, University of the Western Cape, Bellville, South Africa.

3. Lancaster Medical School, Faculty of Health and Medicine, Lancaster University, United Kingdom.

Corresponding author:

Dr Quenton Wessels

School of Medicine

Faculty of Health and Medicine

University of Namibia

Windhoek

Namibia

0000

Email: qwessels@unam.na

Health Care, Hospitals and Racial Hygiene in German Colonial Windhoek

Abstract

The gradual progress of health care within Namibia (formerly known as German South-West Africa), coincided with the three major historic periods: colonial settlement, the Herero-Nama genocide (1904-1907), and the transition of administration of the colony after the First World War. Here the authors draw upon primary and secondary sources to provide insights on the development of hospitals, health care and racial hygiene in in the colony with specific reference to Windhoek. The aim here is to contribute towards the lacking historiography of the medical landscape of Windhoek. Health care during the period of German colonial rule was centralised and segregated, and this trend prevailed when South Africa undertook administration of the colony. The initial strategy under German rule was to increase the formal treatment facilities within Swakopmund and Windhoek during the 1890s. The early growth of health care and hospitals was chiefly aimed at the needs of the white Europeans and driven by principles of racial hygiene.

Keywords: Health care, hospitals, racial hygiene, German South-West Africa, colony

Introduction

Health care within Namibia evolved over time and the country's history is as colourful as the country's landscapes and cultural diversity. Namibia, formerly known as German South-West Africa (GSWA), was a German colony from 1884 until 1915. Formal health services in GSWA came into existence in the 1890s. This period was marked with the establishment of field hospitals for German soldiers in Windhoek, the capital at the time, and the coastal town of Swakopmund. The first health services in Windhoek had were military-based and came as a result of European settlement of the town and its fringes.¹ Wallace in 1997 aptly pointed that the established health care system during this period was centralised and segregated by the end of the German rule.²

The great majority of the indigenes at the time lacked proper and equal health care upon the onset of the twentieth-century due to racial segregation and this would continue until the 1980s. However, this fortunately changed over time after the country gained independence in 1990.³

Four major trends dominate the historiography of health and medicine in GSWA and Namibia. The existing work is limited to a specific health profession, linked to missionary work, or very immersed in health politics and health reform after German colonial rule. The publications by Gottschalk (1988), Kotze (1991), Van Dyk (1997), Wallace (1997) and more recently Nord

1. N. Mossolow, *Windhoek Damals – This was old Windhoek* (Windhoek: John Meinert (Pty) Ltd, 1974), 59-99.

2. M.E. Wallace, 'Health and society in Windhoek, Namibia, 1915-1945' (unpublished PhD thesis, University of London, 1997), 229-230.

3. Ministry of Health and Social Services, 'Preliminary report: Namibia Demographic and Health Survey' (Windhoek: Namibia, and analyses of unpublished data collected during this survey, 2000), 7.

(2014) serve as examples.⁴ The work presented here is the first extensive attempt to highlight the progress of the health systems, specifically the rise of hospital medicine and the medical market, in Windhoek during the period of Namibia's German colonial rule (1890 to 1915). It includes the transition from basic health services and the rise of the initial military hospitals, despite the loss of almost all documentary evidence from this period.⁵ Furthermore, the authors also discuss the influence of racial hygiene on the growing medical market at the time.

The Rise of Military Hospitals and Conflict in the Colony

Germany annexed Namibia in 1884 in an attempt to claim the so-called left-over colonies during the Scramble for Africa and Windhoek was subsequently rediscovered by Major Curt von François (1852-1931) from the German Imperial Army in 1890.⁶ The Europeans arrived via the Woermann-line (formally known as the German East Africa Line) at Walvis Bay (a

4. K. Gottschalk, 'The political economy of health care: Colonial Namibia 1915-1961', *Social Science & Medicine*, 1988, 26(6), 577-582; C.E. Kotze, 'Sanitation and health conditions in Windhoek, South West Africa, under South African Rule between 1915 and 1939', *CONTREE: Journal for South African urban and regional history*, 1991, 30, 23-30; A. Van Dyk, *The history of nursing in Namibia. Windhoek*, (Windhoek: Gamsberg Macmillan Publishers, 1997); Wallace, *op. sic.* (note 2); C. Nord, 'Health care and Warfare: Medical space, mission and apartheid in 20th century northern Namibia', *Medical History*, 2014, (58), 03, 422-446.

5. W. Hartmann, 'Urges in the colony. Men and women in colonial Windhoek, 1890 – 1905', *Journal of Namibian Studies*, 2007, 1, 39-71.

6. H. Vedder, *South West Africa*, 30-37, 507; H. Bley, *South West Africa Under German Rule, 1894-1914*, (London: Heinemann, 1971), 150-151. Windhoek was first occupied by the Oorlam, a subtribe of the Nama (also known as Namaqua), under the leadership of Jonker Afrikaner (1785-1861) in 1840. The Nama are of mixed-race and descendants of the indigenous Khoikhoi (nomadic pastoralists of the Cape Colony), Europeans and slaves from Indonesia, Madagascar and India.

coastal town under British rule) and had to travel inland by wagon to reach *Windhuk* as it was later known by the German colonists. The Woermann-line was thus indirectly instrumental in the establishment of the first colony and formal health care facilities subsequently followed. The following sections aim to capture these events.

The *Carl Woermann I* would set sail from Hamburg for Walvis Bay and docked on 16 March 1883.⁷ The passengers included 212 military reinforcements (*Schutztruppe* or protection force), Lt. Kurt Schwade (1866-1920), Dr. August Louis Alexander Richter (1863-?) (a military doctor or *Stabsarzt* in German), civilians including Dr. G. Gadow (a physician), and hospital orderlies.⁸ The arrival of the first settlers from Germany during the 1890s was followed by a rise in conflict between the collective Nama and Herero tribes and the colonialists.⁹ The Herero and Nama uprising followed as a result of the abuse, enslavement and the confiscation of the land of the indigenes by the German military forces. Some of the Nama tribes, under the leadership of Hendrik Witbooi (1830-1905), would later stage a revolt in 1903. They were joined by the Herero under the leadership of the Paramount Chief, Samuel Maharero (1856-1923) and around 60 German settlers were killed. Reinforcements were subsequently requested from Germany but the Herero-led guerrilla tactics prevented the Germans from gaining the advantage. The Battle of Waterberg, under the leadership of Lieutenant General Lothar von Trotha (1848-1920), would turn the tide in favour of the Germans and took place on 11 August

7. H.E. Lessen, *Chronik von Deutsch-Südwestafrika 1883-1915*, (Windhoek: Namibia

Wissenschaftliche Gesellschaft, 2008) 37; Mossolow, *Windhoek Damals*, 59-97.

8. N. Mossolow, 'Die ersten ärzte und das lazaretto in Windhoek', *Afrikanischer Heimatkalender*, 1974, 35-38; Van Dyk, *op. sic.* (note 4), 15-16; Lessen, *op. sic.* (note 7), 37.

9. Mossolow, *op. sic.* (note 1), 59-97.

1904.¹⁰ Many Herero combatants fell and the surviving woman and children were pushed further into the desert in a campaign of racial extermination. This first phase of the ensuing genocide resulted in the death of many retreating Herero due to starvation, dehydration and disease.¹¹ The second phase of the genocide saw thousands of Herero and Nama relocated to concentration camps in railway cattle cars in spite of the German assurance of their fair treatment. The majority subsequently died of abuse, disease and exhaustion in these labour and concentration camps.¹² One of the most striking descriptions of consequences of these events comes from a missionary report from Karibib:¹³

‘... What did the wretched people look like?! Some of them had been starved to skeletons with hollow eyes, powerless and hopeless, afflicted by serious diseases, particularly dysentery. In the settlements they were placed in big kraals, and there they lay, without blankets and some without clothing ... Here death reaped a harvest! ... they died in droves ...’

The largest of the concentration camps were found in Karibib, Luderitz, Okahandja and Windhoek. One of the Windhoek camps held close to 5,000 prisoners-of-war in 1906 and their daily rations consisted of a handful of uncooked rice, some salt and water. The outbreak of diseases were common due to a lack of medical attention, unsanitary living conditions and

10. I.V. Hull, ‘The measure of atrocity: the German war against the Hereros’, *GHI Bulletin*, 2005, 37, 39-44.

11. J. Bridgman, L.J. Worley, ‘Genocide of the Hereros’, In S. Totten, W.S. Parsons, I.W. Charny, eds, *Century of Genocide: Critical Essays and Eyewitness Accounts*, (New York: Routledge, 2004), 15-52; Hull, *op. sic.* (note 10), 39-44.

12. Bridgman and Worley, *op. sic.* (note 11), 15-52.

13. Missionary Elger, *Berichte Rheinische Missions Gesellschaft*, (Wuppertal: Germany, 1906), 10-12.

insufficient clothing. Typhoid and tuberculosis spread rapidly within the confines of the camps and claimed the lives of many.¹⁴

The short period of conflict in Namibia, from 1904-1908, is known as the darkest chapter in the country's history and personified the genocidal potential of colonial battles.¹⁵ Bley (1971) estimates that around 50,000 (75%-80%) of the Herero population perished, whilst around 7,000 (35%) of the Nama population died. The Damara, another Namibian ethnic group of presumably hunter-gatherer origin, were often caught in the middle of the conflict. Estimates suggest that 17,000 Damaras perished during the conflict.¹⁶ The Rhenish missionaries played a vital role in caring for the infirmed and the physically abused within the camps and many lives were saved despite the aforementioned poor conditions.¹⁷

The town's population in 1891 stood at 326 and included 47 Europeans and 279 indigenes. A temporary tent hospital was established on a site near the Windhoek Public Library in Lüderitz Street, shortly after Richter's arrival in 1893.¹⁸ The tent hospital was followed by another provisional structure near the administrative gardens on modern day Robert Mugabe Avenue. Both these facilities were the first known structures to represent modern western medicine.¹⁹

14. General Staff, *Die Kämpfe der deutschen Truppen in Südwestafrika*, (Berlin: Ernst Siegfried Mittler, 1906), 68-118.

15. Bridgman and Worley, *op. sic.* (note 11), 15-52; 2004; Hull, *op. sic.* (note 10), 39-44.

16. Bley, *op. sic.* (note 6), 150-151.

17. Van Dyk, *op. sic.* (note 4), 18

18. *Ibid.*, 15-16.

19. *Ibid.*

Nursing care was provided by two Red Cross trained nurses from Germany; Augustine Domscheidt and Marianne Böhler who arrived in 1893.²⁰ In 1894, Windhoek had 85 white civilians (including five women), about 500 members of the *Schutztruppe*, and 300-400 indigenes, which were mostly Damara.²¹ A house was built for Dr. Richter in 1895 and this was followed by a more permanent fixture, a *Garrison Lazarett* or military hospital, during the first half of 1895. Both Richter's house and the *Garrison Lazarett* were established near the modern day Lazarett Street (formerly known as Leutwein Street).²² The hospital was located on the site of the current Delta Primary School.²³ The Herero-Nama conflict drove further medical developments and the *Garrison Lazarett* in 1895 evolved to gain a surgical theatre, mortuary, sterilisation facilities and a series of wards. An isolation hospital for typhus cases, the so called *Fever Lazarett*, was also established on the same grounds.²⁴

Dr. Gadow's arrival coincided with Richter's, and Gadow established a private practice during this period in an area known as Klein Windhoek in 1893. A dispute between the two men saw Gadow leave Klein Windhoek.²⁵ Gadow travelled north where he gained the trust of the Herero after successfully treating Manasse Tjasseseta, chieftain of the Herero at Otjibinge, and was rewarded with a special pass permitting him to travel the country freely.²⁶

20. Mossolow, *op. sic.* (note 1), 59-97; Van Dyk, *op. sic.* (note 4), 15.

21. Mossolow, *op. sic.* (note 1), 59-97.

22. *Ibid.*; A.C. Stern, S.A. Harper, 'Some streets and street names of Windhoek: 1885-1915', *South-West Africa Annual*, 1977, 107-109.

23. Van Dyk, *op. sic.* (note 4), 15-16.

24. *Ibid.*

25. Mossolow, *op. sic.* (note 8), 35-38.

26. *Ibid.*

‘This man is a doctor who came from Germany to help sick people [...]. The German emperor gave him the right to travel wherever he wants to go and he’s got nothing to do with the soldiers in Windhoek.’

Infectious Diseases, Epidemics and Hygiene

War was not the only adversary at the time and Rinderpest swept through the southern regions of the country in 1897 and deleteriously affected Namibia’s indigenous pastoralists. The Herero alone lost 60% of their cattle.²⁷ Sadly, both tribes refused to inoculate their cattle upon recommendation of the German authorities and their severe losses deprived them of their usual milk and food supply. Desperate, they turned to the missionaries for support. Matters were made worse when a series of epidemics (presumably typhus, enteric fever and malaria) which ensued in 1898.²⁸ Rinderpest reached Namibia via traders and the ox-wagon trail from Transvaal, despite the precautionary measures of the colonial administrator of German South-West Africa, Theodor Gotthilf Leutwein (1849-1921).²⁹ The outbreak of rinderpest and contagious bovine pleuropneumonia in 1856 forced the German administration to establish a Bacteriological Institute at Gammams near Windhoek in 1897.³⁰

27. W. Külz, *German South-West Africa in the 25th year as a German protectorate*. (Berlin: W. Süsserott, 1909), 114, 278-279.

28. Bley, *op. sic.* (note 6), 123.

29. H.P. Schneider HP, ‘The history of veterinary medicine in Namibia’, *Journal of the South African Veterinary Association*, 2012, 83(1), 1-11.

30. *Ibid.*

Extensions to the *Garrison Lazarett* were completed by 1902 and also served the needs of the white civilians.³¹ Windhoek gradually expanded its boundaries as a result of economic growth despite of the 1904-08 Nama and Herero uprisings. Two other physicians, Philalethes Kuhn (1870-1937) and Max Bail (?) joined the growing community of health professionals. Bail set up a private practice in Windhoek in 1901 and would later be an active proponent to the expansion and establishment of health care facilities within Windhoek, especially the Maria Stern Hospital (the current Roman Catholic Hospital) as described in the subsequent section.³² Kuhn was attached to the German headquarters in South-West Africa and specialised in tropical medicine and hygiene and he purportedly managed to bring malaria under control.³³ Kuhn, however, was a major proponent of racial hygiene and his 1907 book, *Gesundheitlicher Ratgeber für Südwestafrika* (Health guide for South-West Africa), bears testament to the influence of Alfred Ploetz (1860-1940).³⁴ The work of Kuhn, at the time, provided extensive and meticulous the prevention of infectious diseases (such as typhus), and the preservation of the Arian race:³⁵

31. Van Dyk, *op. sic.* (note 4), 19.

32. Anonymous, (Windhuk: *Windhoeker Anzeiger*, 14 March 1900); S. Davis, 'The place of the sheep stealers or Queen Adelaide's Baths', *South-West Africa Annual*, 1977, 96-99; A.P.J. Beris, 'From mission to local Church: One hundred years of mission by the catholic church in Namibia - With special reference to the development of the Archdiocese of Windhoek and the apostolic vicariate of Rundu' (unpublished PhD thesis, Pretoria, UNISA, 1996), 21.

33. Anonymous, 'Further observations on the results of anti-typhoid inoculations amongst the German troops in South-West Africa', *Journal of the Royal Army Medical Corps*, 1907, 8, 647-657.

34. P. Kuhn, *Gesundheitlicher Ratgeber für Südwestafrika*, (Berlin: Mittler, 1907), 229-230.

35. *Ibid.*

‘There is one more big danger, which often unnoticed, creeps up to threaten our folk, it is the danger of Africanisation’.

The period of the Herero-Nama revolt saw a rise in both military and civilian inpatient cases. The count ranged between 80 and 90 for the period extending between November 1904 and June 1906. As many as 109 inpatients were counted in May 1905 and the major health challenges at the time appear to be typhus and typhoid. A total of 146 typhus cases were reported in January 1905.³⁶ The magnitude of the typhus epidemic and resulting fatalities are unknown but typhus reportedly claimed the life of Sister Arnulpha Winkelman towards the end of the epidemic, five months after her arrival in November 1907.³⁷ Further information of the extent of the epidemic comes from Von Leutwein’s autobiography. Typhus beset the German forces and Leutwein lamented that typhus ‘demand[ed] more victims than the Hereros’.³⁸ The disease claimed the lives of 321 soldiers and officers between April 1904 and June 1905.³⁹ It appears that the Herero-Nama genocide, in part, was justified under a public health banner, underpinned by Social Darwinism, as Von Trotha wrote:⁴⁰

‘I think it is better that the Herero nation perish rather than infect our troops...’

36. Van Dyk, *op. sic.* (note 4), 19.

37. *Ibid.*; Beris, *op. sic.* (note 32), 21.

38. T.G. von Leutwein, *Elf Jahre Gouverneur in Deutsch-Südwest Afrika*, (Berlin: E. S. Mittler und Sohn, 1907), 507.

39. Generalstab, *Die Kämpfe der deutschen Truppen in Südwestafrika, I*, (Berlin: Ernst Siegfried Mittler und Sohn, 1906), 237-247.

40. A. Gray, ‘The German colonies of Africa’, *Journal of Comparative Legislation and International Law*, 1919, 1(1), 25-35.

This health rhetoric would continue to drive the evolving medical market in Windhoek as we shall see in the following sections. Poor personal hygiene was to blame for the spread of the disease and Kuhn writes that first Swakopmund-Windhoek railway line was the primary vector for the disease at the time. It is also important to note states that the disease he understands as being typhus is referred to as typhoid fever by the English.⁴¹ This is perhaps another reason why there are so many discrepancies in the prevalence of both diseases at the time.

Yet, more data exists on the typhoid cases.⁴² An average of 1,867 cases with 188 fatalities were recorded for the period between May and December of 1904 with an average mortality-rate of 42.3. The following year saw a slight decrease in fatalities for the same period and totalled 101 with an annual total of 186 fatalities and an average mortality-rate of 17.8.⁴³ The total reported cases for 1905 totalled 2,707 but decreased in 1906 to total 1,389 with 92 fatalities. Fifteen fatalities were documented in 1906 and the epidemic extended well into 1907 with 50 and 43 cases in January and February respectively.⁴⁴ Typhoid was a major public health concern during the nineteenth and early twentieth centuries in Europe and England and was further complicated by the similar and consequently misleading symptoms of paratyphoid.⁴⁵ Conflicting reports exist around the prevalence of typhus and typhoid. Kotze (1991) alludes to a probable reason and suggests that so-called typhoid and typhus cases in Windhoek might

41. Kuhn, *op. sic.* (note 34), 160.

42. A. Hardy, 'Typhoid', in A. Hardy, *The Epidemic Streets: Infectious Disease and the Rise of Preventive Medicine, 1856-1900* (Oxford: Clarendon Press, 1993).

43. Anonymous, *op. sic.* (note 33), 647-657.

44. *Ibid.*

45. J.G. McNaught, 'Paratyphoid Fevers in South Africa', *Journal of the Royal Army Medical Corps*, 1911, 16, 505-14; Hardy, *Typhoid*.

have been less virulent gastroenteritis and bacillary dysentery as almost no typhoid deaths were recorded.⁴⁶

The true extent of the typhus and typhoid cases might have been hidden amongst an array of so-called stomach ailments of the period. Additional insights comes from the work of Van der Merwe (1981) who noted that Namibia's white population was mainly afflicted by gastrocolic (or *maagkoliek* in Dutch), a generic and non-specific term used for an array of conditions that science has now distinguished as nephrolithiasis, appendicitis and cholecystitis.⁴⁷

In addition, a strange disease resembling malaria was reported from Karibib from the east of Namibia. The memoirs of Pastor August Elger, a missionary of the *Rheinische Missionsgesellschaft* (Rhenish Missionary Society), documented a strange case of a malaria-like disease.⁴⁸ Kuhn suggested that it was sexually transmitted typhoid or venereal typhoid. Nonetheless, the typhus cases purportedly decreased once the Herero-Nama war ended and stringent regulations prevent contact between the prisoners-of-war and German soldiers.⁴⁹ Kuhn further advised that it is best to 'treat workers lest you become infected' and if a 'native gets typhus, they are to be brought to a native field hospital'. His strict guidelines further stated that if a field hospital was not accessible, which applied to most cases, the patient should be left in their hut with a carer whilst the other family members move into a new hut. The same section also advises that the water supply should be 'separated into regions for whites, cattle

46. Kotze, *op. sic.* (note 4), 23-30.

47. P. Van der Merwe, *Otjiwarongo – 1906-1981*, (Kapaastad: Kaap en Transvaal Drukkers (Edms) Bpk, 1981), 143-149.

48. National Archives of Namibia, Accession 569, 'Memoirs of Pastor Elger', 569.

49. Anonymous, *Geschichte der Katholische Mission in Südwestafrika: 1896-1946*, (Windhoek, 1946), 51.

and natives' and the 'natives should be downstream from the white's camp' in order to prevent the spread of the disease.⁵⁰

Additions to Windhoek's care facilities for the white populous included the Windhoek Hospital, established in 1912, which consisted of a series of buildings constructed with corrugated iron. It had a total of 120 beds and one of the most significant improvements, compared to the existing military hospitals, was a state of the art kitchen.⁵¹ Elizabeth House was established by the joint efforts between the German Women's Association of the Red Cross for Germans Abroad, the Women's League of the German Colonial Society (GCS) and the Bund Deutscher Frauenvereine (*Deutsche Kolonialgesellschaft*).⁵² Elisabeth House was a maternity hospital and was named in honour of Duchess Elisabeth Alexandrine of Mecklenburg-Schwerin (1869-1955), wife of the President of the *Deutsche Kolonialgesellschaft*. Both Windhoek and Berlin agreed in 1897 that the GCS should allow the wives of the settlers to travel to the colony free of charge. A total of 350 women arrived over time until 1906.⁵³ This was motivated by concerns of the low number of German woman in the

50. Kuhn, *op. sic.* (note 34), 54, 161-168.

51. E. Lentin, H-E. Stacy, 'The Lantern of Health: Health and Hospital services in SWA', *South-West Africa Annual*, 1977, 117-121.

52. Beris, *op. sic.* (note 32), 21; M. Goldbeck, 'n Ooievaarsnes in Windhoek', in M. Goldbeck, ed, *Gondwana Geskiedenis - Grepe uit Namibië se verlede*, (Windhoek: John Meinert (Pty) Ltd, 2014), 126-129.

53. I.J.D. Wiesbaden, 'Das Elisabeth-Haus in Windhoek', *Afrikanischer Heimatkalender*. 1997, 75-82.

colony and that the Schutztruppe would pursue sexual relations with the indigenes and prisoners-of-war. Kuhn had this to say about the matter:⁵⁴

‘There has sadly been an extraordinary increase in our German population mixing with natives and it would be high time that every German vigorously works against the “blood-deterioration”. Above all, societies should not accept any Germans, who have natives or ‘bastards’ as wives’.

There was undoubtedly continuous contact between the German soldiers and the prisoners-of-war in the camps, which inevitably lead to the spreading of diseases.⁵⁵ The facility was completed in April 1908 and the maternity ward consisted of four rooms located within the cooler south of the building. Elisabeth House boasted a large reception area which doubled as a dining hall, a surgical theatre, a separate staff room and paediatric ward for both infirm and healthy children.

The two establishments mentioned above once again emphasises the stark racial segregation that existed within the medical landscape of colonial Windhoek. Both institutions exclusively catered for the German communities of Windhoek and Namibia. The ethnic lines, as Wallace (1997) notes, extended further to that of nursing care.⁵⁶ Nursing care was racially divided and the German institutions were served by Benedictine sisters and the German Red Cross. The *Garrison Lazarett* became a state-aided hospital upon the Germany’s surrender and was staffed

54. Kuhn, *op. sic.* (note 34), 229.

55. Kommando Der Schutztruppen Im Reichskolonialamt, *Sanitaets-Bericht Ueber die Kaiserliche Schutztruppe fuer suedwestafrika waehrend des Herero und Hottentotenaufstandes fuer die Zeit vom 1. Januar 1904 bis 31. Maerz 1907*, (Berlin, Ernst Siegfried Mittler und Sohn, 1909), 139-141.

56. Wallace, *op. sic.* (note 2), 260-261

mainly by South African nurses. Nevertheless, the quality of health care was far better compared to that of the indigenes as outlined below.⁵⁷

Windhoek's Native Hospital

The previous sections highlights the medical landscape and the rise of modern medicine in Windhoek which served the growing European population. This was accompanied with the segregation of races as a result of the political influence of the German military physicians. The herbalist and the traditional remedies of the indigenes featured within this milieu amidst the establishment of a so called "Native Hospital". Insights to the medical services that were available to Windhoek's indigenes relate to primary sources after South Africa's occupation of the colony. The Germans surrendered to the South African forces on July 9, 1915 and the town at the time had around 7,500 inhabitants, including 4,500 indigenes and 3,000 Europeans.⁵⁸ Five major care facilities along with a Fever Hospital existed by the end of the First World War, namely, the *Garrison Lazarett*, Windhoek Hospital, Roman Catholic Hospital, Elizabeth House, and the old Native Hospital.⁵⁹ The military hospitals, described in the preceding sections, became public hospitals upon Germany's surrender in 1915 but was converted once again to military hospitals during the outbreak of the First World War. Namibia's districts

57. *Ibid.*, 262.

58. D. Simon, 'Windhoek: Desegregation and change in the capital of South Africa's erstwhile colony', in A. Lemon, *Homes Apart – South Africa's segregated cities*, (Cape Town: David Philip Publishers, Cape Town, 1991), 174-190.

59. H.F.B. Walker, *A Doctor's Diary in Damaraland*, (London: Edward Arnold, 1917), 130-160; B. Bravenboer, *Windhoek – Capital of Namibia*, (Windhoek: Gamsberg-Macmillan, 2004), 85-89, 283-285.

relied on Medical Officers, where their duties included the care of troops and civilians. The health care workforce in March 1916 three military doctors, eight nurses and 26 auxiliary staff members.⁶⁰

There were four Native Hospitals within the territory by 1921. The largest was in Windhoek with a total of 100 beds.⁶¹ Wallace (1997) noted that these Native Hospitals did not have permanent doctors and relied heavily on District Surgeons of European descent as well as local auxiliary personnel.⁶² Windhoek's Native Hospital was of such poor quality that native patients subsequently avoided using its services.⁶³ As a result, early attempts to treat the indigenes were met with resistance. Furthermore, local folklore dictated that the spirits of the dead could injure the living and hospitals were seen as a place of death.⁶⁴ The limited amount of information on the origins of Windhoek's Native Hospital points towards the establishment of an improvised care facility from two existing structures in 1905. The buildings of Bachstein-Koppel, a railway contractor, was established for the care of railway workers in 1902. The second building was a military operated clinic established to treat the African population and prisoners after the 1904-1907 conflict.⁶⁵ Both these hospitals were located to the north of the town and taken over by the government in December 1910.⁶⁶ Both these hospitals would collectively form the Native Hospital and were reportedly located near one of the Windhoek concentration camps. The

60. Wallace, *op. sic.* (note 2), 118.

61. Union of South Africa, *Report of the Administrator for the Year 1921*, (Pretoria: Government Printer, 1922), 22-23.

62. *Ibid.*

63. *Ibid.*

64. E. Rhodie, *South West: The Last Frontier in Africa*, (Pretoria: Voortrekkerpers, 1967). 178-179.

65. Kommando, *op. sic.* (note 55), 139-141; Wallace, *op. sic.* (note 2), 224-229.

66. Wallace, *op. sic.* (note 2), 224-229.

modern day Windhoek Central Hospital Complex, one of the current public hospitals in the city, is close to the original site of the Native Hospital. It remains unclear whether this is coincidental or intentional.⁶⁷ Nursing care at the Native Hospital came from unqualified individuals, unlike the nursing provision that was available to white population. However, there were a few individuals that dared to cross the colour line. Elisabeth Deubler was the first German midwife in the colony and, like the nurses attached to the missionary services, treated the indigenes at the time.⁶⁸ Matters were made worse due to the fact that the Native Hospital did not provide standard maternity services except in emergencies.⁶⁹

Van der Merwe (1981) writes that health care in Namibia, during 1906, was mediocre at best. Venereal diseases were widespread among the indigenes. Oral history noted that the Herero used devil's claw (*Harpagophytum procumbens*) burnt over a tailored made clay pot that allowed the fumes to reach the affected area.⁷⁰ The Herero chiefly relied on their indigenous traditional medicine and distrusted the colonial doctors.⁷¹ The health conditions of Namibia were marked by the prevalence of malaria and intestinal diseases (due to the poor quality of drinking water and the ingestion of undercooked meat). Wallace (1997) aptly noted that the established health care systems were centralised and segregated by the end of the German rule and favoured the white population.⁷² The South African administration continued to cultivate

67. Kommando Der Schutztruppen Im Reichskolonialamt, *op. sic.* (note 55), 140-141.

68. L. Stahlhut, 'Von den Krankheiten den Hottentotten', *Jahrbuch der Ärztlichen Mission* 1914, 113-118.

69. *Ibid.*

70. Van der Merwe, *op. sic.* (note 47), 143.

71. Kotze, *op. sic.* (note 4), 23-30.

72. Wallace, *op. sic.* (note 2), 65-69.

this system despite its distinct features of health inequality.⁷³ The indigenes population fell victim to racial segregation and struggled against the national state for residential space and their own identity.⁷⁴ Endemic diseases posed a major challenge for the health professionals after the Herero-Nama conflict came to an end. Many women were forced or turned to prostitution as a last resort for survival and venereal disease became highly prevalent among the German troops and prisoners-of-war.⁷⁵

Conclusions

The first formal health care services in German South-West Africa were established as field hospitals in Swakopmund and Windhoek during the 1890s and only served the European whites. This period coincided with the establishment of several clinics by the Finnish Missionary Society which in turn served the indigenes. The initial strategy under German colonial rule was to increase the formal treatment facilities and associated health professionals in support of the colonialists and troops. The German military physicians and their scientific framework appear to have the political leverage to ensure segregation between Europeans and the local indigenous population in order to ensure the purity of the colonialist. This framework would later evolve during the German colonial period and manifested as a well-oiled machine during Hitler's reign of terror.

The early growth of the medical market was more localised to the central parts of the country and was chiefly associated with the needs of the white Europeans. Strict hygiene rules applied

73. Nord, *op. sic.* (note 4), 422-446.

74. Wallace, *op. sic.* (note 2), 65-69.

75. *Ibid*, 156-173.

in order to limit the spread of diseases and sexual relations with indigenes were considered be taboo. Hieratical stratification existed amongst the whites but they were still afforded health care that was far superior to that offered to the indigenes.

Native hospitals were established within the colony and served the indigenous population but was poorly staffed and under equipped. Windhoek's Native Hospital served as an example and was of poor quality without the necessary qualified staff and chiefly relied on a few qualified European volunteers. In summary, the rise of health care and hospitals in Windhoek progressed as a result of colonial settlement but was dominated the pseudoscience of Social Darwinism, followed by the Herero-Nama genocide, and the transition phases associated with the establishment of the South African Administration in South-West Africa.