INSTITUTE OF CURRENT WORLD AFFAIRS

PBM - 8
Native Hospital

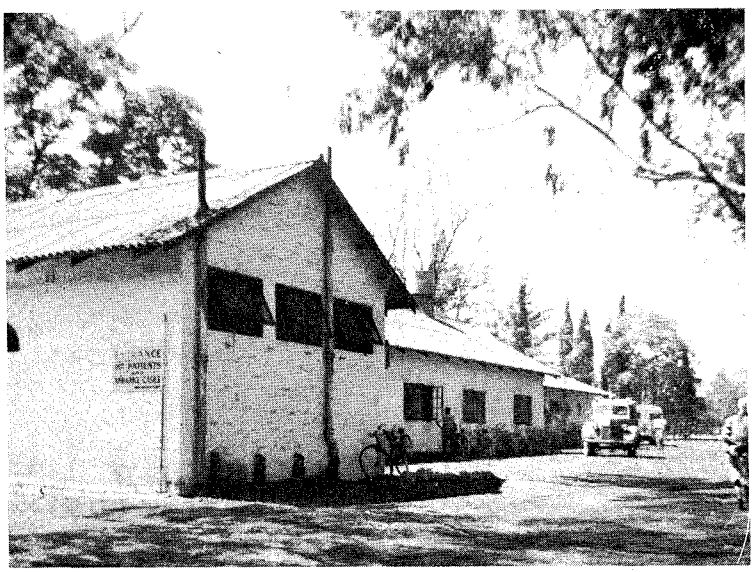
42 Fereday Drive
Eastlea,
Salisbury,
Southern Rhodesia
October 5, 1953

Mr. Walter S. Rogers
c/o Institute of Current World Affairs
522 Fifth Avenue
New York 36,
New York

Dear Mr. Rogers:

The present Native general hospital at Salisbury spreads like a litter of mangy puppies at the feet of the general hospital for Europeans at the intersection of North Avenue and Moffatt Street. It is a collection of low, one-storied buildings roofed with corrugated iron and painted white. There is no grass left in the courtyard around which the buildings are grouped, and Natives sit cross-legged or crouch on their haunches in the shade of two or three dusty old trees as they wait to be examined.

The hospital was built during the first World War, but despite its age it can by no means be called drab. Color is everywhere from the dark green polish on the concrete floors and the brilliant red of the hospital blankets to the cotton prints wrapped around women visitors.



The outer walls of the hospital

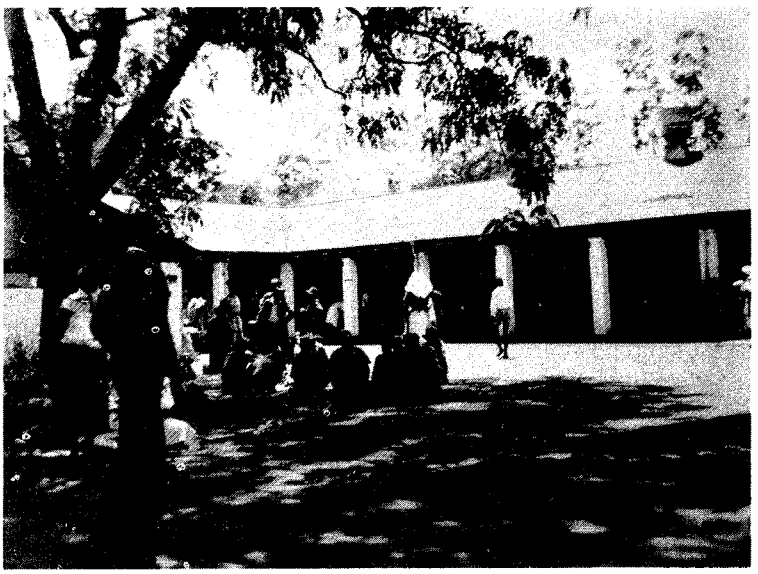
The Medical Superintendent of both the Native and European hospitals, Mr. W. Robertson (ordinary doctors are referred to as "Dr. Jones"--surgeons, who rank higher, are called "Mr. Jones."), showed me through, after first cautioning me that the place is a mess and asking that I keep an open mind until I had seen the progress which has been made on the new Native hospital at Harare, a Native location inside the municipal limits but outside the business area. I agreed, and he looked much happier.

His appearance might be described as "quaint"--a product of the old school with a line of conversation like something out of Wodehouse. His dark hair is parted in the middle and he wears rimless, blue-tinted eyeglasses. A very dapper man of middle age, he gives the impression of being completely in balance--from the center part of his hair to his very neatly polished shoes. If he has two half-crowns, I'm sure he carries one in the left trouser pocket and the other

in the right to make sure that, if his smoothly pressed trousers are going to sag, at least they will sag evenly.

He donned a long, white, duster-type coat for our trip through the wards, and with his forward-the-light-brigade expression and his tinted goggles, I had the curious feeling I was sitting in the back seat of an old, open Moon automobile as I followed him along a concrete pavement that is the link between the two hospitals.

After the warning I had been given I expected to find filth littering the floors and an unmedicinal smell in the air. But in the dusty courtyard efficiency was everywhere. Male patients were cared for by Native boys in clean, blue denim aprons and white surgical gowns. The rains have not started and on wide, covered porches at two sides of the courtyard high, complicated-looking beds with pulley-covered frames overhead were filled with traction splint cases.



The inner courtyard, showing Natives waiting to be admitted. In the background are the porches for traction splint cases.

The Natives who worked among these beds had red bars sewed onto their aprons, apparently denoting rank. I asked Mr. Robertson what the bars meant.

"Each bar means a year of training here," he said. "After the first year the boys are given a test in elementary first aid and hospital practice. If they pass, they get their second bar. They continue studying throughout the second year and then, at the end of the third year, they are given tests in diagnosis and simple medicine. The successful ones are made full orderlies."

I looked around. "It seems to me," I said, "that if that practice has been going on for very long, the place should be crawling with orderlies. Where are they all?"

"Oh, once they are trained here we send them out to clinics and other hospitals. There are 88 Native clinics throughout Southern Rhodesia and 13 Native hospitals in all the larger cities. Native boys being what they are, they require a lot of replacements. One funny thing about these orderlies, though. They work here for five or ten years, see the white man's medicine at work, and should come to respect it. But when they get sick, where do they go first? Back to the old witch doctors on the Reserves. Of course, more and more are staying here for treatment, but there's still a goodly number who don't trust

us."[1]

We turned and headed for a green-painted double door. "I'll show you one of the wards," Mr. Robertson said. As we walked across the courtyard he gave me more statistics. The number of beds available is listed at 284, but when everyone seems to get sick at once that number can be expanded to about 360 by putting mattresses on the floor and setting up cots in the aisles between the beds. There are six wards--four for men, one for women, and one for children. In 1952 the hospital handled 18,073 in-patients and 154,468 out-patients. Of the in-patients, 740 died. Deaths among the out-patients are almost impossible to compute, but it is guessed that the ratio is about the same. The average Native stayed in the hospital at Salisbury for 11.1 days, one-half day longer than the average white person.

"We have a little trouble getting them into the hospitals sometimes," the doctor commented, "but they seem to like it once they are here."

We walked into the long ward. Coming in from the bright sunlight, it was hard to see much at first. When my eyes focussed, the first thing I noticed was the cleanliness. The floors were waxed and polished to a deep emerald color and the beds, cheap little iron cots that they were, were neatly made and lined up in very orderly fashion.

The gentle, bantering attitude maintained by Mr. Robertson outside in the courtyard disappeared in the ward. He suddenly became all business. He greeted the nurse (a white woman) in charge and asked her to send him the three-year orderly assigned to the ward.

The Native boy who came looked to be about 19 years old, but Native age-guessing is at best a very tricky business. He looked frightened--as any student might who was about to be given a quiz by the headmaster himself.

For that was what was in store for me--a quiz to see how the orderly was progressing at diagnosis. We stopped at the foot of a bed. The patient was wrapped to the chin in his red blanket, his eyes wondering what we were going to do to him.

"What is this?" Mr. Robertson asked sternly.

"Tuberculosis, boss," the orderly answered. Apparently it was a correct answer, for we moved on to the next bed.

"What is this?"

"Sore throat, boss." Another right answer.

"What is this?"

"Skin disease, boss."

"What kind of skin disease?"

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1. Figures on Southern Rhodesia's clinics and hospitals can be found in a P.S.

"Don't know, boss. Skin disease." A look of slight dissatisfaction appeared on the doctor's face. He moved to the head of the bed and pulled down the blanket. The sick Native did not look up or move. Putting his hand under the Native's chin, he lifted, exposing the man's throat and chest. A rash, in the form of a "V", was apparent. I gathered that the rash must have had something to do with the sun, for the affected area was where the sun would strike a man wearing a shirt open at the throat.

"That's pellagra, boy. Remember that."

"Yes, boss, pellagra." We moved on.

"What is this?"

"Query pneumonia, boss."

Mr. Robertson's patience was apparently exhausted. "What do you mean, query pneumonia. Look at him, man. Is it pneumonia or not?"

The orderly looked more frightened than ever. "Don't know, boss, X-ray is not back." This sounded like a reasonable answer to me, but the doctor was not satisfied.

"You don't need an X-ray to see pneumonia! Look at him! What is wrong with him?"

"Pneumonia, boss."

"All right. Now what is that?" He quickly pointed to the next bed.

"Pneumonia, boss." Too bad, I thought. He is so rattled he just said the first thing that came into his head.

"That's right," the doctor answered. Evidently the orderly knew more than he appeared to.

We kept walking down one side of the ward, the doctor asking for diagnosis, and the orderly doing it as well as he could. I thought the doctor was being extraordinarily stern, but after a series of right answers, the boy seemed to gain confidence and he almost smiled when we reached the last bed in line and he correctly reported the last man's ailment as "stomach ache, observation."

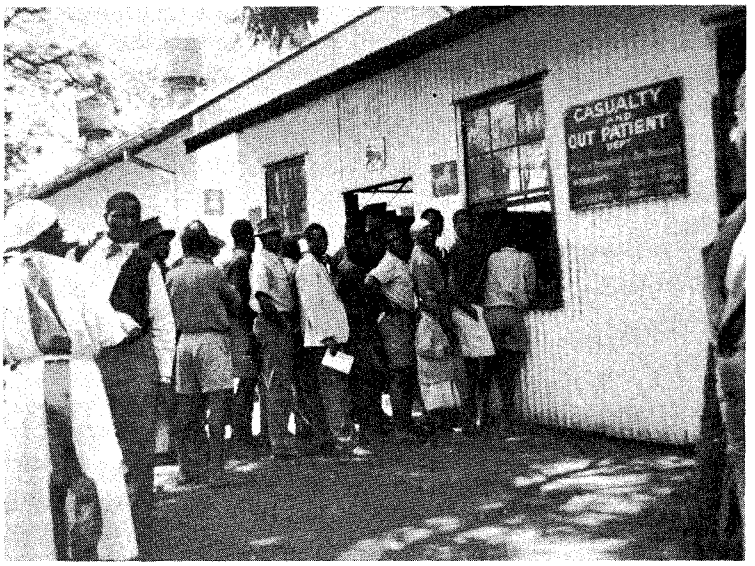
Mr. Robertson turned to the orderly. "You're getting much better," he said in a very kindly tone. After the tongue-lashing the change in his voice tone was welcome. "We'll make a doctor of you yet." The Native beamed a wide smile at the two of us. I guessed he scored about 90% in his quiz.

We walked through another ward, almost identical to the first, but without the running commentary on the medical scenery we were passing. The same neatness prevailed and as we walked down the center aisle Robertson told me of some of the ailments to which Natives are most susceptible.

"Of course," he said, "there's a tremendous amount of venereal disease. There's so much of it in and out of the hospital that it's hard to quote specific figures. Every laboring Native must have a physical examination, and a lot of the VD is caught there. Here, in the hospital, our biggest, non-social disease is pneumonia. Malaria is bad, too.[1]

"We get a lot of dysentery and typhoid fever. And there is a lot of pulmonary tuberculosis, but most of that is taken care of at special government hospitals. By the way, if you look through last year's government health report, you'll find that the most prevalent disease, after tuberculosis, is chickenpox."

We were crossing the courtyard again, headed towards the children's ward. Lined up in front of windows and doors were Native out-patients, waiting for their temperature-takings and their daily prescriptions. Over each window and door, instead of signs in English, were pictures. There was an owl, an elephant, a lion, and a rakish animal that appeared to be a jackal.



Native patients line up to receive daily prescriptions under animal signs.

Mr. Robertson saw me looking at the pictures, smiled, and stopped to explain them. "After a Native has been treated," he said, "and has recovered enough to be an out-patient, he must come back for checkups. If we tell him to come back to the eye clinic and put a sign over that door (he indicated the owl) saying 'eye clinic,' we would probably never see him again.

"He would come back, all right, but chances are he wouldn't be able to read and he wouldn't be able to find the right sign. Then he would go home--or, if he was very sick and wanted help, he would wander in and out of buildings trying to remember where he was supposed to go. So we put up pictures. And, when a Native must come back for treatment, we tell him to come back to the owl or the lion or the elephant--wherever he belongs. It works very well."

I laughed, and we started walking, only to stop again. "By the way," the doctor said, "I think I ought to explain how we give out the medicine. With Europeans you just put 12 days' doses of quinine in a packet and tell him to take one dose every four hours.

"You can't do that with Natives. If we give them more than one day's

1. 1952 figures at Salisbury Native Hospital--pneumonia, 1167; malaria, 108; dysentery, 80, and typhoid fever, 35.

dosage at one time there is a very good chance they'll never take the medicine--or, if they do, they may take it all at once. So we make them come back every day. It's inconvenient for the Natives who live 5 and 6 miles away, but there's nothing else we can do. We make them take one dose of their medicine here at the hospital, then give them enough pills or liquid to last them the rest of the day. The next day they must come back for more."

We started walking again. The noise in the children's ward was deafening. Crying children of all ages looked pitifully small in the man-sized beds. "Here's an interesting case," the doctor said. He pointed at a naked child lying on a red blanket. "You don't see much of this anymore. It used to be very prevalent among Native children."

Taking another stab at age-guessing, I'd say the baby was about 2 years old. His brown skin was dry and lifeless, as though it had been spray-painted brown. And, to continue the simile, it looked as if the paint job had been done a long time ago. The color was cracking, showing bright pink underneath, as the paint on a front porch will when it has been exposed too long to sun and rain.

"The Natives call these children 'red babies.' The skin condition is caused by a dietary deficiency in the mother. We're not quite sure what it is that is lacking in the mother's diet--most likely protein. At any rate, we're giving the child a protein-heavy diet hoping he'll come along. With luck, that skin condition will soon go and that puffiness"--he poked the child's legs which looked as though they had a layer of fluid under the skin--"should go down."

From the children's ward we moved to another men's ward. "In the winter when the Natives keep fires burning in their huts because of the cold, this ward is half-full of burn cases," the doctor said. "There are a great number of epileptics among the Native men and when one of them undergoes a seizure, he is very likely to roll into the fire. The rest of the ward is kept for limb cases.

"For instance," he said, walking to the foot of a bed, "I just operated on this fellow yesterday. His right leg was so crippled that it bent in front of the other and he had to walk like this." Mr. Robertson put one foot in front of the other as though it were frozen there, bent his back, and shuffled a few paces. "I removed some of the substance that was twisting his joints and straightened his foot."

The Native in the bed was wrapped in a plaster cast from his armpits to the end of his right leg. From the shape of the cast, I judged that the operation had been a success, at least as far as the straightening process was concerned. Robertson looked down at his handiwork with a critical eye. "I may have to do something about the other leg. His foot is beginning to freeze like that." He pointed to a solid-looking thickening at the front of the ankle. He stood looking at the Native for a minute, then said something to him in Bantu. The Native grinned and nodded his head. The doctor turned to the orderly who was standing behind us. "Bring a pillow and put it under the middle of his back. It will take some of the strain from his shoulders." I hadn't noticed, but the sag of the bed was giving no support to the cast and the weight was resting on his shoulders and his legs.

"Well, that pretty much covers the men's wards. Let's drop in on the ladies, shall we?" And we walked out into the sunlight again. We turned a corner and walked down a shady path between two of the buildings. At the end of the path was the door to another ward. To our right were a long line of doors, some open, some shut. "These are the bathrooms and the lavatories," my guide told me. "We are always having trouble with them because of the rawness of most of our patients. We'll tell a Native to use the bathroom--and he will, but that enamel bowl filled with water means nothing to him. He just uses the floor.

"And, in the washrooms, we can't get them to turn off the taps. They can't understand it. It's just like a stream or a river to them--and whoever heard of turning off a river when you're finished using it?"

The women's ward was about twice as large as any of the others and it was filled to capacity. I was told that there are fewer facilities for women than men at the hospital for the simple reason that there are fewer women in Salisbury. Married men must get permission to bring their wives to Salisbury and permission depends on whether there are married quarters available. And there are very few married quarters.

"The women have very much the same ailments as the men," Dr. Robertson said, and the facilities are the same except that they are cared for by women orderlies." In one corner of the room I saw a bottle of whole blood hanging over a bed. We walked in that direction.

"What is this, Sister," Robertson asked a nurse.[1] "This is a goiter, Mr. Robertson," she answered.

"Oh, yes." He turned to me. "This woman had the biggest goiter I've ever seen. She looks quite normal now, doesn't she?" I nodded. "Well, she is, except that she is deaf and dumb." The woman's eyes were closed and she did not move when the needle from the blood bottle was thrust into her arm.

We turned and walked out. "By the way," I asked, "where does that whole blood come from? Is there a blood bank in Salisbury?"

"Yes, the Red Cross just started one about a month and a half ago. Of course, they have to be very careful about keeping Native and European blood separate or there would be an awful howl." We were walking back to the European hospital along the concrete path. "There's a very acute shortage of donors, especially to the Native blood bank."

We were standing in front of the European hospital and shaking hands. "Don't forget," he said, "we have a date next Tuesday at noon to go see the hospital at Harare. It's really quite impressive."

"I won't forget," I said. "Thanks a lot." I decided, as the doctor walked into the cool depths of the hospital, that he was the essence of a white doctor in a colonial world. He was interested in Natives as case histories--but even more interested, as a doctor, in them as patients. The fact that he took the trouble, as few white men do, to gain a conversational knowledge of their language

1. Nurses with sufficient training to take charge of wards are called "Sisters."

is a mark of a strong and understanding personality.

Continued stories in magazines always infuriate me, but I am afraid this letter will have to be continued next week--when I have had a chance to do a bit more research into what is going on at Harare and take my walk around with Mr. Robertson.

Sincerely,

Peter Bird Martin

Peter Bird Martin

P. S. Southern Rhodesia clinics: (1952 figures)

Clinics	In-patients		Out-patients		Deaths		Number of beds
	VD	Other	VD	Other	VD	Other	
88	198,392	1,705,369	16,571	358,495	46	1851	3910

Southern Rhodesia Native hospitals: (1952 figures)

Hospitals	Admissions	Out-patients	Deaths	Number of beds
13	58,459	484,614	2,765	1,452 (expandable)

Clinic in-patients are usually those with minor illnesses and their stays at the clinics are usually short, accounting for the fantastic number of inpatients accomodated in so few beds.

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