INSTITUTE OF CURRENT WORLD AFFAIRS

RFG - 1
Nairobi Hospitals

October 20, 1954
c/o Barclays Bank
Queensway
Nairobi, Kenya

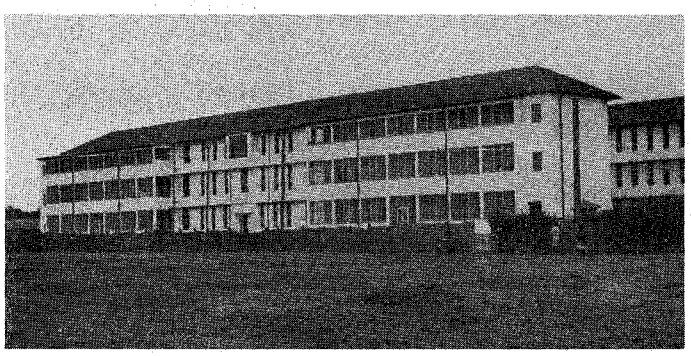
Mr. Walter S. Rogers
Institute of Current World Affairs
522 Fifth Avenue
New York 36, N.Y.

Dear Mr. Rogers:

The Kenya Medical Department is, understandably, proud of the King George VI Hospital in Nairobi. Built and operated by the Kenya Government, this institution is in theory open to the sick of all races; but in fact it is not used by the European community. King George VI is a post-war project which is still not quite finished. At present it has a capacity of some 672 beds and takes care of about 13,000 patients a year. It was planned for the dual purpose of serving as a general hospital for Nairobi and vicinity and providing a specialist center to which difficult cases could be referred from other parts of the country. Dr. Rigby, the Senior Medical Officer, estimates that about 5% of patients are now being sent from other hospitals; the rest come from the Nairobi area. The number of referred cases would normally be greater, but the emergency regulations limiting the movements of natives into Nairobi now tend to keep out patients with less serious ailments.

The clinical staff, which includes about 40 graduates of medical schools, is headed by 12 full-time specialists. In addition, a number of specialists in private practice hold positions as "honorary" surgeons or physicians and do part time work at King George VI. There are five African graduates from Makerere Medical School in Kampala; two of these are of senior rank and three are what we would call interns. The other three interns are Europeans from the United Kingdom, one of them being a woman. The nursing and orderly services of the hospital are directed by a staff of 30 European nurses. Most of the routine ward work is done by African men who are being trained for different grades of medical auxiliaries and by girls who are training as student nurses. Altogether nearly 500 Africans are employed in the Hospital. These people are provided with modern living quarters and have a special school for their children.

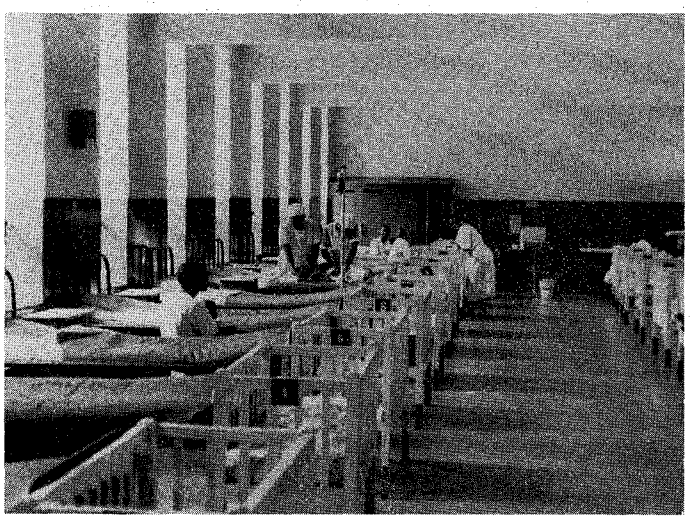
The main building of the hospital consists of a row of four separated wings connected by a central corridor which gives access to a block of receiving rooms and administration offices. The wings are three stories high, each floor having two wards and some private rooms. Thus there are 24 wards in all which are equally divided between medical and surgical services. This building arrangement provides the wards with a maximum of sunshine and ventilation, while retaining a reasonable degree of compactness for the whole hospital. In regard to standards



A Wing of
King George VI

of cleanliness and neatness, compared, say, with large municipal hospitals such as Bellevue in New York or Cook County Hospital in Chicago, my impressions were favorable. The bedsteads are of iron, but most of the accessory ward furniture--bedside tables, stools, cribs, and so on--are locally made of wood rather than enameled iron or stainless steel. Supplies of ward linen and medical instruments seem to be adequate, as are facilities for sterilization and laundry. The X-ray department, centrally located in the main building, possesses modern diagnostic equipment including portable machines for ward and emergency use. The surgical block comprises six well-furnished operating theatres in which about 4,500 major operations are performed in a year.

The laboratory work of the hospital, except for simple tests such as routine urinalyses, is done at the Medical Research Laboratory, a separate institution with a number of other functions, which is located a short distance from the hospital. The laboratory work done here is of high standard, but it appears to be not entirely satisfactory to have specimens sent to a different institution for analysis, and there is talk of developing a clinical laboratory as an integral part of King George VI. A pointed criticism of the present arrangement was made in a lecture to the East African Medical Society on October 12 by Sir Philip Manson-Bahr,



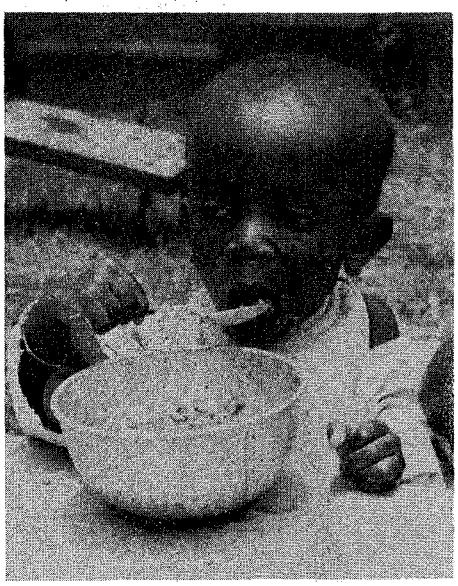
A Ward for
Mothers and Babies

when he referred to the "impossible circumstances in which hospitals are required to send specimens half a mile down the road for laboratory analysis." The overlapping and interlocking of different institutions is characteristic of the medical services in Kenya and makes it difficult to present a concise outline of the Nairobi hospital system.

As an indirect result of Mau Mau terrorism, King George VI Hospital now has an efficient blood bank. After the Lari Massacre* last year some 60 patients were treated for panga wounds and burns, three operating theatres being used continuously in handling the casualties. The difficulty in obtaining the blood needed for 17 simultaneous transfusions indicated the need for a permanent blood bank, which has now been organized.

Although a large variety of tropical diseases appears in the wards during the course of a year, providing rich clinical material for training and research, the bulk of the patients are admitted with sicknesses which are common in the temperate zone as well—Pneumonias, anemias, neurological conditions, diseases of the heart, liver, stomach, kidneys, and so on. The proportion of exotic tropical diseases is unusually low just now due to the emergency restrictions of the movements of Africans into Nairobi from the native reserves. In the pediatric wards bronchopneumonia accounts for the largest number of admissions, with gastroenteritis a close second, followed by various conditions of malnutrition which are often complicated by severe anemia. Three wards are allotted to the pediatrics sevice, the children being assigned to wards according to their age groups. One ward is equipped with beds and cribs so that sick infants who are nursing may be attended by their mothers. Another

*On the night of March 27, 1953, Mau Mau terrorists attacked the wives and children of Kikuyu Guard men from Lari Location 28 miles from Nairobi. About 150 were hacked or burned to death while the men were out on patrol.

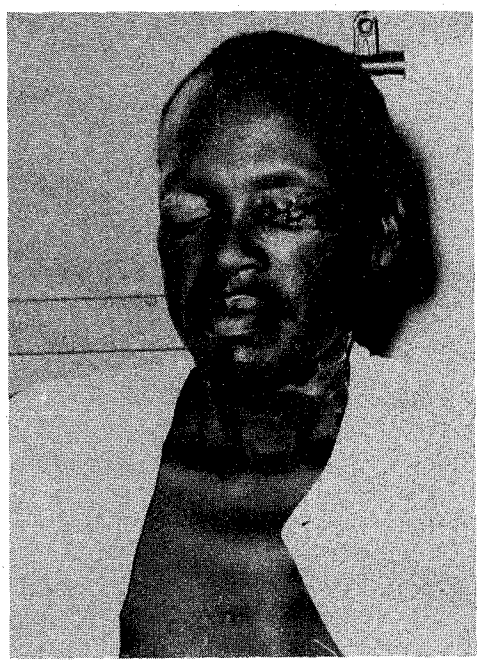


Treatment of Malnourished Child

Teaching Toilet Habits

mother-and-baby ward takes care of sick mothers who have nowhere to to leave their nursing infants while staying in hospital. Dr. McDougall, the woman physician in charge of pediatrics, finds that African children are more manageable patients than White children. These wards are unusually quiet and orderly, the children rarely cry, they stay where they are put, and try to do as they are told. In an attempt to inculcate toilet habits according to Western standards, the younger infants are placed on little chamber pots at regular time intervals. The infants respond quickly to "potty parade" and soon acquire regular toilet habits. In some cases the docility of these African children may be simply the apathy of malnutrition or other disease, but in the main it is no doubt a psychological manifestation of early experience and training.

The surgical service is subdivided into various specialties such as general surgery, thoraco-abdominal, E.N.T., and others. Two adjacent surgical wards are designated as "security wards" and are carefully guarded by armed police askaris. Wounded Mau Mau gangsters are treated in one of these wards, while the other contains Mau Mau victims who are kept in protective custody during their hospital treatment. Nearly all of the Mau Mau patients are being treated for serious gunshot wounds. Most of them face charges of terrorist activities which carry a death penalty, but the staff works patiently at restoring them to health. All but the most critical patients of this group are manacled to their bedsteads, but nevertheless there are several escapes each month. The victims of Mau Mau violence suffer mostly from panga (the East African machete) wounds and burns. Other common wounds result from attempted strangling, gouging of the eyes, and beatings. A number of patients are seen with fingers chopped off and skulls badly hacked up, apparently as a result of trying to protect their heads with their hands from panga attacks. It sometimes happens that a patient in the victims' ward is the principle witness in the case of a Mau Mau casualty in the adjacent ward.



Survivor of Mau Mau Violence—
Attempted Strangling and
Gouging of Eyes

Operating on Mau Mau Gangster with Gunshot Wound of Hip

Several attempts have been made to poison these witnesses, and strict precautions are exercised to keep the two groups apart.

The orthopedics service, headed by Mr.* Kirkaldy-Willis, is often listed as a separate institution of the Kenya Medical Department—the Orthopedic Centre. It is located in a block of temporary buildings about half a mile from the main hospital, but is administered as an integral part of King George VI and makes use of the x-ray facilities and operating theatres of the hospital. Of the 135 orthopedics beds, 60 are in the Centre and 75 in the hospital. If, as seems to be anticipated, the Orthopedic Centre develops independently, it might well be limited to the treatment of chronic conditions, leaving fractures and acute orthopedic conditions to be treated in the surgical wards of the main hospital. At present fractures constitute an unduly large proportion of the work due to Mau Mau violence. The most common of the chronic diseases are tuberculosis of the bones and joints, poliomyelitis, and the usual mixed bag of congenital and post-traumatic deformities. Attached to the Orthopedic Centre is an establishment for making artificial limbs. A staff of African and Asian workmen under the direction of two European experts, one of them trained in Kenya, turn out 100 artificial limbs a year in addition to a wide variety of orthopedic appliances.

While the Kenya Government undertakes to provide Africans with complete medical care, this service does not extend to obstetrics, which is regarded as a responsibility of Municipal Councils or, in the Reserves, of District Native Councils. The gynecology department of King George VI is thus unconnected with the obstetrical services in which most of the gynecological pathology arises. The Government gynecologist Dr. Candler notes that the most common condition among his patients is vaginal fistula resulting from lacerations of childbirth. This disease is almost entirely

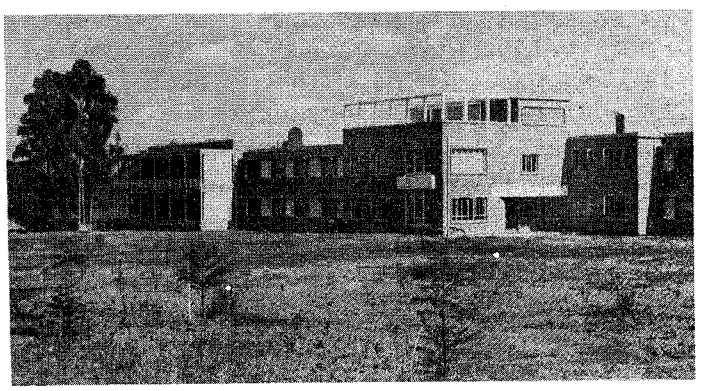
---

*By British usage, surgeons are usually addressed and referred to as "Mr.," while medical specialists and general practitioners are called "Dr."

confined to women of the Kikuyu and Kamba tribes, who tend to have narrow pelvises of a male type. He suggests three possible explanations for this anomaly: first, and most unlikely, narrow pelvis may be a racial trait of these two related tribes; secondly, the condition may arise from widespread subclinical rickets; finally, the custom by which these women carry heavy loads supported by a tumpline over the forehead may result in pelvic deformity early in life. The correct answer will only be found after careful research in cooperation with obstetrical workers. On the controvertial question of female circumcision among Kikuyu women, Dr. Candler has seen little pathology result from the operation, except for occasional childbirth lacerations which sometimes might have been prevented by the unusual operation of "anterior episiotomy."

Another pathological condition, common among African women living in Nairobi, is the result of generalized pelvic inflamation. Here again it is impossible to state the predominant cause. Attempted abortion, a common cause of pelvic inflamation in other countries, seems unlikely here because of the strong desire of African women to bear children. In fact the most common complaint of African women is sterility or insufficient fertility, but no attempt is made at present to deal with these conditions. In regard to the other presumptive cause--gonococcal infection--the statistics of the Nairobi Health Department are at variance with hospital statistics and it is difficult to estimate the true incidence of gonorrhea among Nairobi women. Strenuous efforts are being made to improve the accuracy of diagnoses in routine laboratory tests of this kind. Differences in language and culture make it difficult to take adequate medical histories from African women--and this applies to children as well--but fuller knowledge about the personal and social background of African women patients is essential for further advance in gynecology. Better coordination among the welfare, obstetrical, and gynecological services should make it possible to acquire this knowledge.

On the whole King George VI Hospital with its auxiliary institutions is well prepared to provide adequate hospital treatment of high quality for the Africans of Nairobi, but there are some admitted shortcomings in the present set up. The hospital is located in the wrong place, for one thing. It is on the opposite side of town from the native locations where nearly all Africans live. It is also several miles from the Central Dispensary where the majority of patients are seen before being admitted to hospital. The two medical functions that it now fulfils—a special treatment center for the whole country and a District Hospital for the



The European General Hospital

Nairobi Area—are so different in many respects that they might perhaps better be served by separate institutions. On the other hand, the hospital as it now exists is well adapted for teaching, as it offers interns and other grades of medical students a wide variety of acute and chronic diseases including a concentration of most of the rare and difficult cases which occur in Kenya.

In dealing with the subject of hospitalization for Europeans it is not necessary to describe the facilities in detail, but it may be said at once that they are very good and compare favorably with hospital services in most American communities of similar size. The center of the European hospital system is the new General Hospital which was only opened a few months ago. The system also includes the Princess Elizabeth Hospital for Women and several nursing homes. European children are treated at the Gertrude's Garden Children's Hospital. All I shall attempt to do here is explain the ownership, financing, and management of these hospitals and something of the interracial complications which have arisen.

The European hospitals, with the exception of the Children's Hospital, are owned and managed by the Kenya European Hospital Association in which most of the taxpayers of the country are members. The Association is organized as a limited liability corporation with membership subscriptions set at 45 shillings per year. The members appoint a Board of Management which controls the management of the hospitals. As the name suggests, membership in the Association is limited to Whites. Item 6 in the Articles of Association reads: "No person who is not of pure European descent. . . shall be admitted to membership of the Association." By way of dividends, members are entitled to a reduction of 5 shillings per day in hospital expenses.

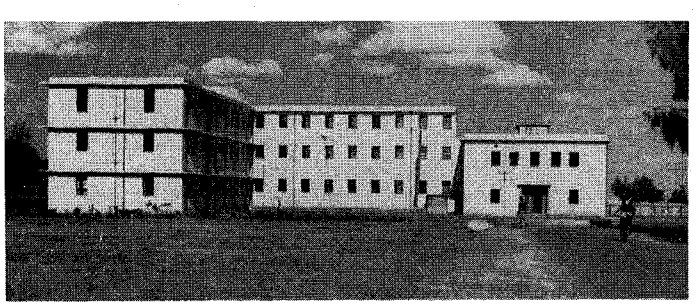
The cost of the new General Hospital was £303,000. Half of this sum was paid by the Association, the remainder being provided by Government under a policy of encouraging community initiative in building hospitals and certain schools by matching community funds £ for £ with government appropriations. Up to now, in the field of hospitalization, only the European community has taken advantage of the £ for £ offer, and the policy is sometimes represented as government subsidy of European private hospitals to the prejudice of other racial groups. However, the Ismailia community of Nairobi is now planning a hospital for Asians along the same lines as the European General Hospital which will be financed on the £ for £ scheme.

Even with the capital expense of the European hospitals taken care of by the Association and Government, there still remains the formidable cost of operating and maintaining the hospitals. This is met mainly through a special statutory hospital tax levied on all Europeans. The Hospital Tax is assessed according to income and paid into a special fund called Kenya European Hospital Fund Authority. The present rate is from ½ to 1%: for example, incomes from 5,000 to 10,000 shillings are taxed 50 shs; from 10,000 to 15,000 shs, 100 shs; from 100,000 to 150,000 shs, 1,350 shs. The Hospital Fund functions as an insurance society by

reimbursing patients for a portion of their hospital expenses, rather than paying the hospitals directly. Thus the hospitals operate as private institutions by collecting bills from the patients who are then compansated for all or part of their expenses by the Hospital Fund. Europeans from other East African Territories or of other nationalities are received in Nairobi hospitals and charged at the same rates as Kenya Europeans, but of course they receive no benefits from the Hospital Fund. As a further aid to hospital finances, Government pays into the Hospital Fund from general revenue the equivalent of 1/4 of the annual receipts from Hospital Tax. Each taxpayer is entitled to recover 30 shs a day on hospital expenses for himself and his dependants, but if the expenses are less than 30 shs he must pay the first 5 shs himself.

The Hospital Fund applies to all European hospitals in Kenya, but the details of ownership and management of hospitals in some parts of the colony differ from Nairobi. So far I have only visited Nairobi hospitals. The European hospital system is undoubtedly complex and appears not to be well understood by the taxpayers themselves. Mr. Branich, Superintendent of the General Hospital, is used to explaining to puzzled taxpayers just what their rights and obligations are in regard to hospitalization. The situation is further complicated by special provisions for hospitalization of the Government Servants who constitute a large proportion of the European population. Government has undertaken to provide free hospitalization for its officials and employees, which it does by simply paying the hospital bills. But it is also obligated to provide free medical care, and in discharging that duty the staff of the Kenya Medical Department invades the European hospitals. Whereas private citizens are treated in and out of hospital by private practitioners, Government Servants are attended in hospital by government doctors and go to special dispensaries for outpatient treatment. For this purpose, the General Hospital maintains two government doctors in residence and is visited by a staff of consulting specialists, many of whom also serve on the staff of King George VI.

The Asian community of Nairobi is at present less well served for hospitalization than either the Africans or Europeans. An Asian hospital planned to have 120 beds was opened in 1952. This was built jointly by Government and a private endowment fund called the Rahimtulla Suleman Virjee Trust, and is managed by Government. Located only a block or two from the Government African Hospital, it is usually referred to as the Asian Wing of King George VI, and it depends on the larger institution for facilities such as sterilization and x-ray. The permanent



The Asian Hospital

kitchens have not yet been installed and only 57 beds are now in use, the rest of the patient space being used as temporary living quarters for the Asian staff pending the construction of a nurses home. Patients at the Asian Hospital may choose to be treated free by the staff of King George VI Hospital or by their own private physicians. Hospital bills are charged in full to the individual patients, as there is no Asian organization comparable to the Kenya European Hospital Association, nor have the Asians as yet agreed to submit to a Hospital Tax like the Kenya Europeans. According to Mr. Cruikshank, the Superintendent of King George VI, who also handles the accounts for the Asian Hospital, collections of hospital bills are very poor, the majority of patients being unable or unwilling to pay the full charges.

In addition to the Asian Hospital, several small hospitals for Asians are owned and operated privately in Nairobi, and there is one multi-racial hospital imaginatively called Rainbow Nursing Home. The standards of these institutions are low, and it is generally recognized that privately owned hospitals are economically unfeasible in Nairobi. A large number of Asian patients are treated in the home at present, but a growing awareness of the benefits of hospital treatment will soon create a demand for more and better facilities. The Ismailia community (the Aga Khan's sect) will soon start the construction of a modern 100-bed hospital which will match the European General Hospital. Government will aid this project with £ for £ funds.

Even assuming that all races were equally well provided with hospitals, a serious problem in race relations would still remain. The same problem that plagued the American policy of equal but separate educational facilities for Negroes exists in Nairobi and will no doubt increase with time. The European hospitals carry prestige over and above any superiority in equipment and service which they may possess, and upper-class Asians feel that their social position entitles them to use these hospitals. In recognition of the potentially serious international incidents which might arise on this score, the racial bar at the European hospitals is not absolute but can be, and occasionally has been, lifted at the discretion of the Board of Management. For example, an exception to the rule was made when the Sultan of Zanzibar came down with pneumonia while staying as an official guest at Government House. It was impossible to treat him at Government House because his room was needed for other official visitors, but it was thought that it would appear derogatory to send him to the Asian Hospital. The European Board of Management was approached and the Sultan was accepted at the Maia Carberry Nursing Home, one of the European hospitals. Other delicate situations arise in the case of the increasingly frequent mixed marriages, usually between a European woman and an Indian man. Such a woman might be accepted in a European hospital as an ordinary patient but not as a maternity case, since the new-born infant could hardly meet the qualification of "pure European descent." As far as possible, such cases are settled on other than racial principles. For instance, married women do not usually appear on the tax register, and when the husband is an Asian no one in the family pays Hospital Tax: thus the woman is not legally entitled to subsidized hospitalization at European hospitals.

The number of Africans in Kenya who have reached the educational and cultural level of Europeans is as yet small, but those few find themselves in the embarrassing situation of being barred from European and Asian hospitals and can only be admitted to the African Hospital which is primarily planned to serve the uneducated masses of Africans. The injustice to educated Africans is sometimes perhaps more apparent than in the case of Asians, because they tend to become more closely assimilated to European culture in such matters as religious beliefs, dietary habits, and standards of hygiene. Somalis and Comorans refuse to go to the African Hospital and are generally treated at the Asian Hospital. The Seychellese, who represent every color shade, often insist that they are of "pure European (French) descent" and demand entrance to European hospitals.

The more prosperous Africans are also dissatisfied with the existing arrangements for outpatient or office treatment. They are reluctant to patronize the free Government Dispensary, but can hardly afford to pay the high fees of private practitioners. It has been suggested that these people represent potential private patients for African graduates from Makerere Medical School. This problem, however, is outside of the subject of hospitalization.

Before ending this letter I shall just mention that the East African Railways and Harbors Administration provide excellent medical and hospital care for their employees of all races. This example, if followed by other large firms, might lead the Colony in a new direction in the development of hospitalization.

Sincerely,

Robert F. Gray

Robert F. Gray

Received New York 10/25/54.