

**“One of the most serious problems confronting us at present”:
Nurses and government hospitals in Southern Rhodesia, 1930s to 1950**

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Abstract

At the centre of enquiry of this article is the nexus between the problem of the shortage of nursing personnel and provision of healthcare services in Southern Rhodesia from the mid-1930s to 1950. The article interrogates the causes of the shortage and its effects on nurses, patients and hospitals. It also investigates various responses by the Rhodesian government. I suggest that both internal and external factors were responsible for the shortage. Whereas colonial policies that were influenced by racial and gender ideologies of the day were partly responsible, equally important was Rhodesia's reliance on foreign nurses, and the Second World War which accelerated the pace of urbanisation among Africans and in the process stretched health resources in urban areas. Such an examination is significant in analysing nurses' everyday work and the provision healthcare services, and is important in exploring how the problem forced the responsible authorities to readjust the nursing policy. Efforts at improving the situation opened the way for the Rhodesian government to train African nurses. This began in 1958 and was a move that gradually transformed the structure of Southern Rhodesian Nursing Services.

Key words: shortage of nurses; provision of health services; hospitals; Southern Rhodesia.

Opsomming

Hierdie artikel handel oor tekorte aan verpleegpersoneel, en die verband tussen die probleme wat dit veroorsaak het en die verskaffing van gesondheidsdienste in Suid-Rhodesië vanaf die middel-1930's tot 1950. Daar word ondersoek ingestel na die oorsake van die tekort, en die uitwerking daarvan op verpleegsters, pasiënte en hospitale. Die Rhodesiese regering se reaksie hierop kom ook onder die loep. Ek voer

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aan dat beide interne en eksterne faktore die tekort veroorsaak het. Koloniale beleid, wat deur die rasse- en gender-ideologieë van die tyd beïnvloed is, was deels hiervoor verantwoordelik, maar so ook Rhodesië se afhanklikheid van buitelandse verpleegsters. Die Tweede Wêreldoorlog het swart verstedeliking versnel, en sodoende gesondheidshulpbronne in stedelike gebiede onder druk geplaas. Dit is belangrik om hierdie elemente van nader te bekyk, ten einde verpleegsters se alledaagse werk en die verskaffing van gesondheidsdienste te ontleed. Dit is ook belangrik om vas te stel hoë die probleem die owerhede genoop het om verpleegbeleid aan te pas. Pogings om die situasie te aan te spreek het die weg gebaan vir die opleiding van swart verpleegsters. Dit het in 1958 'n aanvang geneem en het mettertyd die struktuur van die Suid-Rhodesiese Verpleegdienste omvorm.

Sleutelwoorde: tekort aan verpleegsters; verskaffing van gesondheidsdienste; hospitale; Suid-Rhodesië.

Introduction

On 24 May 1941, Henry de Boer, the Medical Director of Nyasaland wrote a letter to the his counterpart, the Medical Director, Southern Rhodesia, Andrew P. Martin requesting four nurses from Southern Rhodesia (Rhodesia) to work at Blantyre Hospital.¹ De Boer anticipated an increase in the number of patients, notably Italian prisoners of war from Ethiopia.² Martin's reply underscored Southern Rhodesia's precarious position regarding nurses at the time:

As far as nurses are concerned, we have barely been able to keep going on. Actually during the weekend we had discussed bringing in a conscription order which would enable us to compel unemployed married women without families to assist for some part of the day in the European hospital of the colony. I am therefore, unable to assist you in any way in regard to obtaining nurses.³

It was proposed that conscripted women would help qualified nurses in government hospitals,⁴ but the conscription order was never introduced. However,

¹ I have used colonial place names for this article. Current names have been placed in brackets: Southern Rhodesia/Rhodesia (Zimbabwe); Nyasaland (Malawi); Salisbury (Harare); Umtali (Mutare); Gwelo (Gweru); Gatooma (Kadoma); Fort Victoria (Masvingo); and Harare (Mbare). In addition, the terms "white" and "European" are used to refer to people of European origin. I use these two terms interchangeably. The term "Coloured" refers to people of mixed race while the term "Asian" is used to refer to people of Asian origin. The term "African" refers to black people of African origin. The term "African" is not used in any way to deny any group the right to belong to Africa or to claim to be identified as African.

² National Archives of Zimbabwe (hereafter NAZ): Nurses General, 1935–1941, S 2177/1/8, Henry de Boer, Medical Director, Malawi, to A.P. Martin, Medical Director, Southern Rhodesia, 24 May 1941.

³ NAZ: Nurses General, 1935–1941, S 2177/1/8, A.P. Martin to Henry de Boer, 4 June 1941.

⁴ It must be pointed out that the paper focuses on white qualified nurses trained by the government. The level of entrance was a secondary education. In most cases, the course took 48 months to complete. In Southern Rhodesia, the training schools were in Bulawayo and

the fact that the idea was privately debated is significant in exposing the parlous situation within hospitals during the period under discussion. Four years later the situation had not changed. In 1945, the government medical superintendent at Salisbury General Hospital warned the National Health Services Commission (NHSC) that the shortage of nurses was not only getting worse but was also “one of the most serious problems affecting us at present” and it seemed there was no solution in sight.⁵ The shortage affected the smooth functioning of hospitals. Medical officials, hospital administrators and nurses agreed that the problem had to be dealt with immediately.

This article puts the problem of the shortage of nurses and implications for government hospitals at the centre of discussion. Three interrelated questions frame this article. First, how do we account for the shortage of nurses in Rhodesia during the time under study? Second, in what ways did the shortage affect the running of government hospitals? Last but not least, what measures were taken by nurses and by the government to alleviate the situation? While the first question interrogates and disentangles the internal and external causes of the problem, the other questions seek to understand and flesh out the effects of the shortage on the day-to-day running of the hospitals and the various responses from nurses themselves and the state authorities. In this article, I suggest that the problem of the shortage of nurses must be located within Rhodesian colonial labour policies. Qualified nursing was a preserve for white women, and by the time under discussion their numbers had dropped far below what was required to run the hospitals efficiently. Furthermore, the Rhodesian policy requiring women to resign from the Southern Rhodesian Nursing Services once married also contributed to the shortage.⁶

It is also the contention of this article that the problem must be located in external factors. Rhodesia failed to train enough nurses for her hospital, relying on nurses from South Africa and the United Kingdom to fill the gap. When these two countries restricted the migration of nurses, Rhodesia was left in a dilemma. In addition, the situation became dire during the Second World War, especially with Rhodesia having to host imperial troops; this exerted pressure on hospitals and nursing personnel. Then too the growing tendency of Africans to leave rural areas for the urban areas in search of employment meant that urbanisation stretched the medical services in the colony even further. The story reveals the complex nature in which local and global factors interacted within clinical spaces, in the process having implications for nurses working in hospitals for the provision of services to patients of all races, and for the necessary transformation in nursing policies in Rhodesia.

Salisbury and up to the 1950s, government training of qualified nurses focused on people of European descent only. It was not until 1958 that the first cohort of Africans to train as qualified nurses started their training at Mpilo and Harare Hospitals respectively.

⁵ NAZ: National Health Services Commission (hereafter NHSC), ZBP 2/1/3, Government Medical Superintendent Officer, Salisbury General Hospital, Oral evidence to NHSC, 11 September 1945.

⁶ Southern Rhodesian Nursing Services was a branch of the civil service that employed the white nurses.

Nurses and the government responded in various ways. The responses from nurses included petitions, letter writing and slowing the work process. On the other hand, medical authorities tried enticing retired nurses back into the service, lowering entry qualifications into the training programme and even introducing pre-nursing courses in schools. One of the significant effects of the problem was to galvanise medical authorities towards thinking of the possibilities of training and employing African, Coloured and Asian qualified nurses.⁷ While the history of these nurses is not part of this article, debates surrounding the training of nurses from racial groups other than white, illuminate not only the gendered aspects of Rhodesian nursing, but equally importantly, its racial dimensions. Thinking about the position of people of colour within the nursing profession – as Darlene Clark Hine argues – enables scholars to incorporate race as a category of analysis.⁸ In Rhodesia, the training of African qualified nurses for example, was informed by gender and racial ideologies of the time. This change, as will be shown in the essay, reinforced racial separation within hospitals in Rhodesia.⁹

The history of nurses and hospitals in Rhodesia is an under-researched area. Except for Ruramai Charumbira's article¹⁰ and Michael Gelfand's work,¹¹ such studies on nurses and hospitals as there have been, focus on nursing in the postcolonial period, with an emphasis on nurses' survival strategies in the post-1990 neo-liberal era.¹² Even Charumbira's work, significant as it is in exploring the early developments of nursing in Rhodesia, only covers the first eleven years of colonial rule.¹³ For this reason, the present article emphasises the need to go beyond the first eleven years of colonial rule, examining the changes that took place within nursing services in Rhodesia and considering how these changes affected the provision of health services.

⁷ It must be noted that mission hospitals trained what were called nursing assistants and orderlies. The government considered such nursing aides to be of a lower standard of competency. So much so that in 1935 the government began its own training of male orderlies. In 1946, the government extended the training of orderlies to African women. It also officially started training African midwives in the same year. It was not until 1958 that Africans were fully recognised as being well qualified nurses. For brief and general examination on the training of mission nurses and orderlies see for example Michael Gelfand, *A Service to the Sick: A History of Health Services for Africans in Southern Rhodesia, 1890–1953* (Mambo Press, Gwelo, 1976).

⁸ Darlene Clark Hine, "The Intersection of Race, Class and Gender in the Nursing Profession", in Ellen D. Baer, Patricia d' Antonio, Sylvia Rinker and Joan E. Lynaugh (eds), *Enduring Issues in American Nursing* (Springer Publishing Company, New York, 2002), pp 25–36.

⁹ I should point out that racial separation was the foundation of Southern Rhodesian society. Whites occupied the top of the racial ladder, with Coloured people and Asians in the middle, while Africans occupied the base of the ladder. Racial separation was practised in all aspects of everyday life.

¹⁰ Ruramai Charumbira, "Administering Medicine without a Licence: Missionary Women in Rhodesian Nursing History, 1890–1901", *The Historian*, 68, 2, Summer 2006, pp 241–266.

¹¹ Gelfand, *A Service to the Sick*.

¹² See for example, Jo Ann McGregor, "Professionals Relocating: Zimbabwean Nurses and Teachers Negotiating Work and Family in Britain", Geographical Paper No. 178, February 2006; Rudo Gaidzanwa, *Voting With their Feet: Migrant Zimbabwean Nurses and Doctors in the Era of Structural Adjustment* (Nordiska Afrikainstitutet, Uppsala, 1999).

¹³ Charumbira, "Administering Medicine without a Licence", pp 241–266.

To explore this issue is particularly significant considering that the problems experienced during the period under study and the efforts at remedying the situation were destined to reshape the structure of Rhodesian Nursing Services and the provision of medical services from the 1950s onwards.

Written in the 1970s, Michael Gelfand's work is a general account of the provision of biomedical services to Africans in the colony. It briefly focuses on training of African nursing assistants at mission stations and government nursing orderlies.¹⁴ Written in triumphalist mode, Gelfand did not provide a critical examination of the intersections of gender, race and nursing. Furthermore, he did not examine the problems affecting government hospitals in the 1940s, or the experiences of white nurses. By contrast, not only does this present study put nurses' experiences at the centre of historical enquiry, it also examines the conditions in government hospitals and the provision of health services in Rhodesia by the Second World War. By problematising the connections between race and gender in nursing policy, I also trace the reasons behind the gradual changes made to nursing policy in the 1950s, especially the move towards training African women. This article is thus an addition to what has already been written on nurses and hospitals in Rhodesia.

What follows also draws from the historiography of nursing in South Africa in particular, and nursing history in general. The literature on nursing in the Western world is important in exposing the trajectories that the profession took over time.¹⁵ Even so, it is the historiography of nursing in South Africa that is significant for this article, considering the important historical links between these two southern African states. For South Africa, scholars such as Helen Sweet and Anne Digby, Catherine Burns and Shula Marks have not only examined the developments of nursing as a profession, but have also exposed the struggles over control of the work process between medical doctors and colonial authorities on one hand – and nurses on the other. These daily struggles were informed by gender, race and class conflicts of the day.¹⁶ Some of the South African experiences resonated with those of nurses in

¹⁴ Gelfand, *A Service to the Sick*, pp 121–125, 130–137 and 138–143.

¹⁵ See for example, R. Fitzgerald, "Making and Moulding the Nursing of the Indian Empire": Recasting Nurses in Colonial India", in A. A. Powell and S. Lambert-Hurley (eds), *Rhetoric and Reality: Gender and Colonial Experience in South Asia* (Oxford University Press, Oxford, 2006), pp 185–222; Clark Hine, "The Intersection of Race, Class and Gender", pp 25–36; Dea Birkett, "The 'White Woman's Burden' in the 'White Man's Grave': The Introduction of British Nurses in Colonial West Africa", in Nupur Chaudhuri and Margaret Strobel (eds), *Western Women and Imperialism: Complicity and Resistance* (Indiana University Press, Bloomington, 1992), pp 177–188; Susan Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850–1945* (Cambridge University Press, New York, 1987); Barbara Melosh, *The Physician's Hand: Work Culture and Conflict in American Nursing* (Temple University Press, Philadelphia, 1982).

¹⁶ Helen Sweet and Anne Digby, "Race, Identity and the Nursing Profession in South Africa, c. 1850–1958", in Barbara Mortimer and Susan McGann (eds), *New Direction in Nursing History: International Perspectives* (Routledge, New York, 2005), pp 109–124; Shula Marks, "We were Men Nursing Men: Male Nursing on the Mines in Twentieth-Century South Africa", in Wendy Woodward, Patricia Hayes and Gary Minkley (eds), *Deep Histories: Gender and Colonialism in Southern Africa* (Rodopi, Amsterdam, 2002), pp 177–204; Catherine Burns, "A Man is a Clumsy Thing who Does not Know how to Handle a Sick Person': Aspects of the History of

Rhodesia.¹⁷ For example, when it came to debates over whether Africans could be appointed as principal nurses in hospitals, the debates in Rhodesia, as in South Africa, were informed by the prevailing race and gender norms.

This study builds upon and expands this impressive literature. Importantly, the article proposes that shifting the angle of analysis using the Rhodesian case study enables us to examine the problems affecting smaller settler colonies. Rhodesia competed with the other dominions such as Canada and Australia for settlers. Likewise, it was in competition for nurses with these dominions to cover the gap left by its failure to train enough Rhodesian nurses for her hospitals. The reliance on foreign nurses was unsustainable. For when foreign governments scaled down the migration of nurses to Rhodesia, the country was left in a quandary. It was this predicament that was in part responsible for the changes in nursing policies in the 1950s.

“The lack of trained staff in the colony is most serious and appears to be getting worse”: The context

Southern Rhodesia became a British colony in 1890 after its annexation by Cecil John Rhodes and the British South Africa Company (BSAC).¹⁸ The BSAC established the first government hospitals in Bulawayo and Salisbury, the biggest towns in the colony.¹⁹ In 1895, “both Salisbury and Bulawayo had reasonable general hospitals”.²⁰ By 1898, the hospital system had expanded to other towns with “Umtali, Fort Victoria and Gwelo [all having] hospitals of a reasonable size”.²¹ Gelfand notes that by 1909, “advances were made in hospital construction” – including the building of a hospital at Gatooma and renovations at Gwelo. In 1911, the government began constructing a new hospital at Salisbury, which was duly occupied by 1914.²² In the post-First World War era, expansion of the hospital system continued. According to Gelfand, by the 1930s, “the hospital system set up in the towns of Southern Rhodesia” provided “a wide cover in all the urban areas for the sick with medical, surgical and other special care”.²³ It must be noted that these hospitals provided care to people of all races.

Masculinity and Race in the Shaping of Male Nursing in South Africa, 1900–1950”, *Journal of Southern African Studies*, 24, 4, December 1998, pp 695–717; Shula Marks, *Divided Sisterhood: Race, Class and Gender in South African Nursing Profession* (St Martin’s Press, New York, 1985).

¹⁷ For instance, Southern Rhodesia followed South Africa’s lead in appointing a commission of enquiry into health services. Recommendations from the commissions were destined to transform the provision of nursing services in the two southern African countries. For more information on South Africa see Marks, *Divided Sisterhood*, p 131.

¹⁸ For more on the colonisation of Zimbabwe see, for example, Sabelo J. Gatsheni-Ndlovu, “Mapping Cultural and Colonial Encounters, 1880s–930s”, in Brian Raftopoulos and Alois Mlambo (eds), *Becoming Zimbabwe: A History from the Pre-colonial Period to 2008* (Weaver Press, Harare, 2009) pp 39–74.

¹⁹ Gelfand, *A Service to the Sick*, p 17.

²⁰ Gelfand, *A Service to the Sick*, p 17.

²¹ Gelfand, *A Service to the Sick*, p 17.

²² Gelfand, *A Service to the Sick*, p 55.

²³ Gelfand, *A Service to the Sick*, p 58.

However, as will be shown in this paper, there were disparities in the provision of medical services between patients of different races.

The first nursing staff at these general hospitals comprised women who belonged to religious orders. For example, Catholic nuns were in charge of nursing services at Salisbury Hospital until 1901.²⁴ These nuns were not formally trained.²⁵ Important to note is that by the late 1800s, standards within the profession were fast changing. Nursing historian Joan E. Lynaugh notes that by the 1890s nursing was transforming into a “distinct occupation requiring specified skills and knowledge”.²⁶ The profession was carving out its own niche in the world of work outside of the domestic sphere and it was being redefined as “an occupation based on formal training, instead of every woman’s work”.²⁷ The transformations taking place within hospitals and within nursing at the international level were also experienced in Rhodesia. In 1901 the government took over the provision of nursing services from Catholic nuns. The issue of training was central, as Dr Andrew Fleming, the first Medical Director pointed out. According to Fleming, by 1901 the Dominican sisters were finding themselves “unable to guarantee the number of *trained* nuns required to carry out the increase in the nursing services which the country was demanding”.²⁸ Therefore, they relinquished nursing services and concentrated on the running of Convent schools. Their place was taken “by *trained* nurses and probationers brought out from England or engaged from the Cape Colony”.²⁹ In addition, in 1901 medical authorities began the process of formulating a nursing curriculum for the European section of the community.³⁰ The central idea was not only to make sure that nurses were trained in the colony, but that Rhodesian trained nurses would be acceptable in other parts of the British Empire.³¹ Thirty years later, in 1931, the government passed the Nurses, Midwives and other Persons Registration Act.³² This Act required, inter alia, that the Rhodesia Medical Council form regulations for the examination of student nurses in Southern Rhodesia: the first of which were held in 1932.³³ The examinations closely resembled those conducted in the United Kingdom. Furthermore, the Rhodesian government signed an agreement with the General Nursing Council of England and Wales, whereby the two medical bodies recognised

²⁴ Charumbira, “Administering Medicine without a Licence”, pp 241–266.

²⁵ Charumbira, “Administering Medicine without a Licence”, pp 241–266.

²⁶ Joan E. Lynaugh, “Nursing’s History: Looking Backward and Seeing Forward”, in Baer, D’Antonio, Rinker and Lynaugh (eds), *Enduring Issues in American Nursing*, pp 10–24.

²⁷ Lynaugh, “Nursing’s History: Looking Backward and Seeing Forward”, pp 10–24.

²⁸ NAZ: Historical Notes on Medical Services in Southern Rhodesia, S2406/1/1, Andrew Fleming, “Early Years of Medical Services in Southern Rhodesia”, Unpublished document (emphasis added).

²⁹ NAZ: Historical Notes on Medical Services in Southern Rhodesia, S2406/1/1, Fleming, “Early Years of Medical Services in Southern Rhodesia”. Fleming notes that the privileges were made as attractive as possible and at that time nursing services in Rhodesia were comparatively well paid.

³⁰ Michael Gelfand, *Tropical Victory: An Account of the Influence of Medicine on the History of Southern Rhodesia, 1890–1923* (Juta, Cape Town and Johannesburg, 1953), p 209.

³¹ Government of Southern Rhodesia, Public Health Report, 1932.

³² Government of Southern Rhodesia, Public Health Report, 1932.

³³ Government of Southern Rhodesia, Public Health Report, 1933.

one another's training curriculum and examinations.³⁴ The agreement equated the nursing certificate offered in the colony with the British qualification. In doing this, Rhodesian authorities wanted to align their education standards to those in the United Kingdom, so that "our nurses would practice on the same footing as those trained in England".³⁵ This was also meant to assure expatriate nurses of the uniformity in standards and encourage nurses to emigrate from the United Kingdom to Rhodesia.

Even with such efforts, Southern Rhodesian Nursing Services in particular and hospitals in general were facing numerous challenges from the 1930s onwards. One of the most significant problems was the shortage of qualified nurses. In 1935, the Secretary of Health warned the government of the looming shortage of nursing personnel. By 1937, the situation was described as potentially dire. In 1939, the Secretary for the Department of Internal Affairs noted that at least 35 nurses were required if the main hospitals were "to function normally".³⁶ In the same year two matrons, three sisters and 24 nurses left the service, meaning the hospitals were short of 65 nursing personnel.³⁷ The situation did not improve thereafter. In 1942, 25 nurses resigned.³⁸ Between 1943 and 1944 Rhodesia had only 352 nurses. At this time, state hospitals required a minimum of 428 nurses. Effectively, they were short of 76 qualified nurses. The shortfall increased to 105 nurses in 1945. This prompted Mary Mackenzie Munro, the Matron of Salisbury's Lady Chancellor Maternity Home to reiterate that, "the lack of trained staff in the Colony is most serious and appears to be getting worse."³⁹ Although the absolute shortfall was relatively small, it made a huge difference in the provision of services to patients in government hospitals during the 1940s.⁴⁰ The situation did not improve in the immediate postwar period. While in 1946 there was a shortage of 65 nurses, in 1947, the shortfall had increased by two to 69 nurses.⁴¹ By 1950, however, the Medical Director indicated that whilst they were still experiencing problems and there was still cause for "anxiety", the situation had improved somewhat.⁴² Unfortunately the Medical Director does not explain why there was a sudden improvement. However, one can speculate that this was in part due to increased immigration in the post-1948 period. In 1948 alone, some 17 000 people of European descent entered Rhodesia, in what Alois S. Mlambo notes as the

³⁴ Government of Southern Rhodesia, Public Health Report, 1933.

³⁵ NAZ: Salisbury Hospital, Correspondence, 1928-1940s, S2177/3/3, A.P. Martin, Memorandum on New Native Hospital, 20 April 1938.

³⁶ NAZ: Recruitment, Nursing Staff, 1937-1939, S 2014/2/3, Secretary of Internal Affairs, Memorandum, 31 March 1939.

³⁷ Government of Southern Rhodesia, Public Health Report, 1939.

³⁸ Government of Southern Rhodesia, Public Health Report, 1941-1945.

³⁹ NAZ: NHSC, ZBP 1/2/3, Mary Mackenzie Munro, Matron, Lady Chancellor Maternity Home, Oral evidence to NHSC, 19 September 1945.

⁴⁰ Government of Southern Rhodesia, Public Health Report, 1946.

⁴¹ Government of Southern Rhodesia, Public Health Report, 1946; and Public Health Report, 1947.

⁴² Government of Southern Rhodesia, Public Health Report, 1950.

largest inflow ever.⁴³ It is highly possible that qualified nurses were amongst these immigrants.

“Admission to the Nursing Services [being] limited to persons of European descent”: The industrial colour bar and the Southern Rhodesian Nursing Services

One of the reasons behind the shortage was the policy that reserved qualified nursing for white women. The policy emanated from a racist practice that saw nursing as part of white women’s contribution to the Rhodesian colonial project. This ideology was not peculiar to Rhodesia; it found expression in most settler colonial societies. Scholars of nursing and empire have noted that from the 1880s onwards, nursing and other professions became entangled in the politics of empire, appropriating imperial language and imagery.⁴⁴ While many nurses who left the United Kingdom for the colonies in the 1890s were looking for work abroad to escape from insecurity and poor pay,⁴⁵ they invariably became implicated in the imperial project. Nursing was considered “part of white woman’s burden” and seen as integral to and supportive of the imperial endeavour.⁴⁶ As Sheryl Nestel has noted, “European nurses in the colonial setting were deeply enmeshed in the nets of imperial power ...”.⁴⁷ Furthermore, to borrow from the analysis by Katrin Schultheiss, “imperial nurses served as agents of empire by helping establish and reinforce European control over the bodies and cultures of colonized societies”.⁴⁸ In the process, “they confirmed existing European racial and gender hierarchies and sought to instil those hierarchies in the colonial territories”.⁴⁹ While the concept was not explicitly publicised in Southern Rhodesia, it can be argued that the very notion of “admission to the Nursing Services [being] limited to persons of European descent ...”⁵⁰ was informed by this ideology.

The ideology was strengthened by labour policies which emphasised the industrial colour bar, especially in the 1930s. Indeed that racial segregation had shaped colonial practice from the earliest times cannot be denied. However, the need to protect European interests became more urgent during the Great Depression of the 1930s. As in other settler societies, the depression threatened to erode Europeans’ living standards. In Rhodesia, the Legislature passed labour laws that formalised non-

⁴³ For more on immigration see, for example, Alois S. Mlambo, “From the Second World War to UDI, 1940–1965”, in Raftopolous and Mlambo (eds), *Becoming Zimbabwe*, pp 75–114.

⁴⁴ Fitzgerald, “Making and Moulding the Nursing of the Indian Empire”, pp 185–222.

⁴⁵ Cecillie Swaisland, *Servants and Gentlewomen to the Golden Land: The Emigration of Single Women from Britain to Southern Africa, 1820–1939* (University of Natal Press, Pietermaritzburg, 1993), p 152.

⁴⁶ Birkett, “The ‘White Woman’s Burden’”, pp 177–188.

⁴⁷ Sheril Nestel, quoted in Katrin Schultheiss, “Imperial Nursing: Cross-Cultural Challenges for Women in the Health Professions: A Historical Perspective”, *Policy, Politics, & Nursing Practice*, 11, 2, 2010, p 152.

⁴⁸ Schultheiss, “Imperial Nursing”, pp 151–157.

⁴⁹ Schultheiss, “Imperial Nursing”, pp 151–157.

⁵⁰ NAZ: Recruitment, Nursing Staff, 1937–1939, S 2014/2/3, The Secretary of Internal Affairs, Memorandum, 31 March 1939.

competition between racial groups. While the colour bar was mainly concerned with industrial labour, it was also used to protect professionals such as lawyers, teachers, medical doctors and nurses, from African competition. The centrality of such professions to the development of Rhodesia cannot be underestimated. These professions were the core of white Rhodesian society. No one articulated this idea more clearly than the then premier, Godfrey Huggins who argued that:

The European in this country can be likened to an island in a sea of black, with the artisan and the tradesman forming the shores and the professional classes the highlands in the centre. Is the native to be allowed to erode away the shores and gradually attack the highlands?⁵¹

The answer was obvious. The Rhodesian Legislature ensured that Africans remained in a subordinate position. When put into practice, such ideas meant the formalisation of white protectionism against black competition. Within the public sector, the Public Service Act (1931) gave Europeans preferential employment. In industry, the Industrial Conciliation Act (1934) prohibited Africans from being classified as employees.⁵² These laws became the cornerstone of the Rhodesian labour policy, relegating skilled Africans to the bottom of the labour ladder. Although the Industrial Conciliation Act was concerned with industry and mining and did not formally extend to hospitals, it nonetheless provided a framework that could be used at any time to justify the non-employment of Africans as nurses in government hospitals. For that moment, though, Africans were restricted to “fetching and carrying for the European worker.”⁵³ Hence, during 1930s and 1940s, there were neither African nor Coloured qualified nurses in government hospitals or nursing schools. African and coloured women were only employed as nursing assistants and orderlies. Their main duty was to concentrate on the domestic and “dirty work” within clinical spaces, leaving white women as the principal healthcare workers.

It is important to appreciate that even with an industrial colour bar in place, authorities nonetheless failed to train enough white nurses to work in government hospitals. To plug the gap, the government relied on South African and British nurses. However, in the case of British nurses, Rhodesia was competing with other British territories such as Canada, New Zealand and Australia for the same nurses. By the mid-1930s Southern Rhodesia was in a dilemma.⁵⁴ Britain officially began restricting the migration of nurses in 1930 due to staffing problems. South Africa was also facing a staffing crisis in her hospitals during the 1930s. Helen Sweet and Anne Digby note that by the early 1930s, there were pushes to recruit and train African nurses to

⁵¹ Godfrey Huggins, quoted in Ian Phimister, *An Economic and Social History of Zimbabwe 1890-1948: Capital Accumulation and Class Struggle* (Longman, London, 1988) p 192.

⁵² For more on the Industrial Conciliation Act see for example, Edmore Mufema, “The Industrial Conciliation Act, 1934-1959: A Fortification of Settler Hegemony in Colonial Zimbabwe”, MA dissertation, University of Zimbabwe, 1997.

⁵³ Richard Gray, *The Two Nations: Aspects of the Development of Race Relations in the Rhodesias and Nyasaland* (Oxford University Press, London, 1960), p 194.

⁵⁴ Swaisland, *Servants and Gentlewomen to the Golden Land*, p 152.

alleviate the problem.⁵⁵ Besides co-opting Africans, South Africa began to control the migration of nurses to Rhodesia. This was to ensure that the country was self-sufficient in nursing personnel. In 1939, South Africa banned medical personnel, especially doctors and nurses, from leaving the country, in the process adversely affecting Rhodesia.⁵⁶

“A woman must retire from the Service on marriage”: Resignations from the Southern Rhodesian Nursing Service

Numerous resignations of nurses from government service were among the immediate causes of the shortage. As noted earlier, in 1939 more than 30 nurses resigned and in 1942, at least another 25 left. The government tried – with mixed results – to find replacements. The major reason behind the resignations centred on the government policy on the employment of married women. During the time under review Rhodesia Civil Service policy stipulated: “... married women may not be appointed to any post, except in a purely temporary capacity. A woman must retire from the Civil Service on marriage”.⁵⁷ This policy was based on the undervaluation of women’s work. As Ellen D. Baer reminds us: “... in the very societies that established nursing as a female occupation, women’s work is generally devalued”.⁵⁸ Such a policy was a great disadvantage for women in general and nurses in particular. As already pointed out, reserving nursing for white women was part of the colonial project. Yet, on the ground, colonialism was a more complex affair. In the colonies, as Anne L. Stoler argues, white women faced “rigid restrictions in their domestic, economic and political options...”.⁵⁹ Thus as much as white nurses were powerful, certain policies, such as the marriage policy in the Civil Service worked against them.

Of those who resigned in 1939, close to half of them cited marriage as a factor in their resignation. In 1946, 19 nurses resigned from the service with 10 resigning to be married. The following year, the Medical Director complained that “marriage is the cause of this wastage”. Thirty three nurses had resigned, of whom 22 did so on the grounds of marriage.⁶⁰ Because they could only be re-employed on a temporary basis, they immediately lost all pension benefits. Such a stipulation was a major disincentive for married nurses to return to the profession. The issue of marriage also affected student nurses. For example in 1949, the Medical Director was very clear on this issue. Of the 36 student nurses who completed their training in 1948, only three joined the permanent staff. While some left the colony for further studies, “the great majority of

⁵⁵ For more on this see for example, Sweet and Digby, “Race, Identity and the Nursing Profession in South Africa”, pp 109–124.

⁵⁶ Government of Southern Rhodesia, Public Health Report, 1940.

⁵⁷ NAZ: Shortage of Nursing Staff, 1940–1946, S 2014/2/3, Internal Memorandum, “The Government of Southern Rhodesia, Recruitment of Nursing Staff.”

⁵⁸ Ellen D. Baer, “Introduction: Contemporary Issues in Historical Context”, in Baer, D’Antonio, Rinker and Lynaugh (eds), *Enduring Issues in American Nursing*, pp 3–9.

⁵⁹ Anne L. Stoler, “Making an Empire Respectable: The Politics of Race and Sexual Morality in 20th Century Colonial Cultures”, *American Ethnologist*, 16, 4, 1989, pp 634–660.

⁶⁰ Government of Southern Rhodesia, Public Health Report, 1939, 1946 and 1947.

student nurses marry soon after [receiving their] qualifications”.⁶¹ Having married, they could not be employed on a permanent basis within the Southern Rhodesian Nursing Services.

The issue of low salaries was also important in compelling nurses to resign. Qualified nurses complained that their salaries were not commensurate with the work they were expected to do. In 1942, for instance, the matron of Umtali Hospital sent a letter to the matron at Salisbury Hospital suggesting that frequent resignations at the hospital were the result of the low salaries paid to the nurses. The resignation of one such nurse, Augusta James, was a case in point. Half her salary went to pay her rent. The matron’s letter emphasised that others were contemplating resigning and that the government should take urgent action to improve the situation.⁶² Two years later, it was claimed that at least three nurses had resigned because they could not afford to buy enough petrol to travel to and from their place of work.⁶³ Salaries had to be improved to enhance nurses’ morale and confidence, to “free the minds of these nurses from anxiety and fear for the future, and imbue them with a deeper sense of self-respect and pride in the practice of their profession”.⁶⁴ In 1944, nurses again wrote to the Medical Director complaining about their pay: “... salaries paid should recognize our full professional status and enhance our dignity in the community”.⁶⁵ Receiving such low salaries was tantamount to undermining their position. Furthermore, just as had happened in South Africa, the shortage of qualified nurses was worsened by high wartime inflation which placed new burdens on them.⁶⁶

“The burden of military and Air Force medical work became so heavy”: The Second World War, African urbanisation and the provision of medical services

While the Rhodesian Nursing Services was affected by resignations, the Second World War exacerbated the staffing crisis. The war made heavy demands on nurses in the colony, just as it did with other forms of labour.⁶⁷ In 1940, as part of Southern Rhodesian war effort, the government transferred 22 nurses from Nursing Services into the newly established Military Nursing Services. Of the 22, eight were senior nurses; their transfer further depleted the resources available for hospitals.⁶⁸ By the

⁶¹ Government of Southern Rhodesia, Public Health Report, 1949.

⁶² NAZ: Southern Rhodesia Nurses Association, F 242/SM/300/26, F. Stewart, Matron Umtali Hospital to Staff Matron Pettigrew, 1942.

⁶³ NAZ: Southern Rhodesia Nurses Association, F 242/SM/300/26, Memorandum, 12 May 1944.

⁶⁴ NAZ: Southern Rhodesia Nurses Association, F 242/SM/300/26, Memorandum, 12 May 1944.

⁶⁵ NAZ: Southern Rhodesia Nurses Association, F 242/SM/300/26, Memorandum, 12 May 1944.

⁶⁶ Marks, *Divided Sisterhood*, p 113.

⁶⁷ See, for example, David Johnson, *World War II and the Scramble for Labour in Colonial Zimbabwe, 1939–1948* (University of Zimbabwe Publications, Harare, 2000).

⁶⁸ NAZ: Shortage of Nursing Staff, 1940–1946, S 2014/2/2, Matron F. Pettigrew to the Medical Director, 7 April 1943. These were needed to train the personnel who were to be part of the Red Cross and St John Ambulance Services.

end of the war, 48 Rhodesian nursing sisters were serving at the Nairobi General Hospital as part of the Rhodesian war effort.⁶⁹

The hosting of the Imperial Air Training Scheme clearly exposed the alarming shortage of nurses in the colony.⁷⁰ The cohort of British military and airmen in Rhodesia reached 12 000 by 1945. While the presence of British airmen was a boon to the economy,⁷¹ it nevertheless stretched hospital services, increased nurses' workloads and made it very difficult for them to give full attention to their European and African patients. The Medical Director confessed that "The burden of military and Air force medical work became so heavy ... [because] all the seriously sick and [those who were involved in] accidents were treated in Government hospitals".⁷² The case of Gwelo Hospital, where a significant number of airmen were stationed, is a good example of the precarious circumstances of the healthcare system during the 1940s. Between October 1940 and October 1941, the number of patients undergoing operations almost trebled from 20 to 56; the number of outpatients doubled from 117 to 235; and the number of inpatients more than doubled from 49 to 117.⁷³ At the same time, nurses on night duty were so pressed that a single nurse had to attend to an average of 20 patients every night.⁷⁴ By 1945, the shortage of critical nursing staff forced the closure of wards in some hospitals for short periods and the authorities recommended that only seriously ill patients should be admitted to hospital.⁷⁵

Furthermore, the war also accelerated the process of urbanisation. The need for a stable, permanent labour force compelled both business and the state to reach an agreement on the need to improve the urban health system. Hence, in 1943, because of the pressure from the industrial sector, the government appointed the Howman Commission to investigate urban living and health conditions.⁷⁶ The commission exposed appalling health conditions among Africans in urban areas. Because sanitation was rudimentary in most African townships and compounds,

⁶⁹ Government of Southern Rhodesia, Public Health Report, 1941–1945.

⁷⁰ This was a scheme whereby as part of the war effort, Rhodesia provided the Royal Air Force with training facilities for Royal Air Force personnel. By June 1941 Rhodesia had four air training schools located in Salisbury, Bulawayo and Gwelo. See Johnson, *World War II and the Scramble for Labour*, pp 34–40.

⁷¹ For more information see for example, Phimister, *An Economic and Social History of Zimbabwe*.

⁷² Government of Southern Rhodesia, Public Health Report, 1941–1945.

⁷³ NAZ: Shortage of Nursing Staff, 1940–1946, S 2014/2/3, Matron F. Pettigrew to the Medical Director, 19 November 1941.

⁷⁴ NAZ: Shortage of Nursing Staff, 1940–1946, S 2014/2/3, Matron F. Pettigrew to the Medical Director, 19 November 1941.

⁷⁵ Government of Southern Rhodesia, Public Health Report, 1941–1945.

⁷⁶ One of its recommendations attacked the segregationist policies and their impact on the African labour force. The commissioners exposed the negative impact of segregation on industrial productivity. For the commissioners, higher industrial productivity could be achieved providing there was a stabilised and healthy urban population. For more on the Howman Commission, see Clement Masakure, "An Unfulfilled Step': An Examination of the Commission to Investigate the Socio-economic Health and Social Conditions of Africans Employed in Urban Areas, 1944", B.A Honours essay, University of Zimbabwe, 2001.

hookworm and other intestinal diseases were widespread.⁷⁷ The commission estimated that close to 70 percent of all black workers in urban areas suffered from bilharzia.⁷⁸ In addition, as Richard Gray has noted, malnutrition, tuberculosis and pneumonia all became common during the 1940s.⁷⁹

The successful creation of an effective urban workforce rested in part on the provision adequate health services. However, at a time when there was increased evidence of the deterioration of African health, hospitals were failing to meet the African population's medical demands. For example, between the years 1933 and 1943, the number of patients visiting the clinic in Salisbury's Harare Township increased exponentially from 2 608 to 36 668.⁸⁰ Between 1937 and 1943, attendance at the maternity section of Harare clinic rose from 466 to 6 850 and the clinic was failing to cope with the influx of patients.⁸¹

A number of factors were responsible for the increase. It must be noted that from the 1930s onwards, annual medical reports revealed an increase in the number of Africans resorting to biomedicine than in the previous decade.⁸² Despite the government's expansion of medical facilities in the 1930s,⁸³ one must also underscore African agency when examining this increase. Historically, diverse healing traditions with competing claims to efficacy, were common among Africans.⁸⁴ The introduction of biomedicine expanded their medical options. Indeed the hospital system – which expanded in the 1930s – became one of the many alternative therapeutic systems available to Africans. This was at the same time that Africans were actively embracing biomedicine, as Megan Vaughn notes.⁸⁵ In addition, Nancy Rose Hunt argues that during the same decade, Africans were also playing an important role in shaping colonial maternal health programmes.⁸⁶ By the 1940s therefore, the use of the hospitals was already entrenched amongst Africans. Simultaneously there was a

⁷⁷ Masakure, "An Unfulfilled Step', pp 16–17.

⁷⁸ Masakure, "An Unfulfilled Step', pp 16–17.

⁷⁹ Gray, *The Two Nations*, p 278.

⁸⁰ NAZ: Native Welfare in Townships, 24 October 1939 to 19 September 1958, LG 191/12/7/1, Native Welfare at the Location. In Salisbury there was one clinic for Africans which was located in Harare (Mbare) Township. This clinic had a maternity section. The clinic was funded by the central government but run by Salisbury City Council.

⁸¹ NAZ: NHSC, ZBP 2/1/2, Salisbury Hospital Advisory Committee, Draft evidence to the NHSC.

⁸² See for example, Government of Southern Rhodesia, Public Health Report, 1935.

⁸³ Gelfand, *A Service to the Sick*, pp 126–129. In the 1930s the government began in earnest to implement the expansion of medical facilities to rural Africans in rural areas. The clinics erected complemented the services already provided by missionaries. There were close to 30 government clinics that were either functioning or in the process of completion in the colony.

⁸⁴ Steven Feierman, "Struggles for Control: The Social Roots of Health and Healing in Modern Africa", *African Studies Review*, 28, 2/3, June to September, 1985, pp 73–147.

⁸⁵ Megan Vaughan, *Curing their Ills: Colonial Power and African Illness* (Stanford University Press, Stanford, 1991) pp 68–69.

⁸⁶ Nancy Rose Hunt, "Le bébé en brousse': European Women, African Birth Spacing, and Colonial Intervention in Breast Feeding in the Belgian Congo", in Anne Stoler and Fredrick Cooper (eds), *Tensions of Empire: Colonial Cultures in a Bourgeois World* (University of California Press, Berkeley, 1997), pp 287–321.

massive migration of Africans into urban areas in search of better job opportunities and this had a serious effect on the provision of services in state hospitals.

African urbanisation stretched medical resources even further and working conditions in the hospitals became a major frustration for the nursing staff. An examination of the disparities between European and African sections of Salisbury Hospital illuminates this point very well. In 1934 the European section of Salisbury Hospital had modern facilities comparable to any in the Western world. It was viewed, as the Medical Director of the time, R. Askins boasted, as an example of “the possibilities Rhodesia could offer its white inhabitants”.⁸⁷ The African section of the hospital was remarkably opposite. Ten years after Askins had boasted about the excellent European section of the hospital, the African section was overcrowded and poorly equipped, a situation that made the work of the nurses not only extremely unpleasant but also exhausting. The Hospital Advisory Committee exposed the shambolic nature of the hospital:

With a population of some 30 000 Natives in Salisbury, it is obvious at a glance that the accommodation provided by the government for the Native is utterly inadequate and in addition, the patients who are not confined to bed have no proper dining accommodation as they are required to have their meals in the open, which must be definitely be dangerous to patients in times of inclement weather.⁸⁸

A letter by B. Gilbert to the National Health Services Commission hit the nail on the head when it mentioned the effect of poor working conditions on the morale of the nurses. The writer suggested that additional accommodation was needed immediately. However, the remedy was not simply a matter of the provision of more beds because “one should note that work in a place such as the African section of the hospital in Salisbury, is not congenial from the point of view of nurses who are expected to work [there].” If the government was to build a new African hospital in Salisbury,

... all new buildings must be lit and airy, neither of which Salisbury [the African section of the Hospital] can claim to possess. They should be carefully protected from the heat which is so noticeable in wards under a galvanized iron roof.⁸⁹

The same letter complained that the inhospitable nature of the building made it difficult to recruit nurses who were willing to work in the African section of the hospital because many nurses went to great lengths to avoid such conditions.⁹⁰

⁸⁷ NAZ: Salisbury Hospital, Correspondence 1928–1940s, S 2177/3/3, Address by R.A. Askins at the opening of a new Salisbury Hospital Block, 1934.

⁸⁸ NAZ: NHSC, ZBP2/1/2, Salisbury Hospital Advisory Committee to the NHSC, 14 September 1945.

⁸⁹ NAZ: NHSC, ZBP 2/1/2, B. Gilbert to the NHSC, 1 March 1945.

⁹⁰ NAZ: Southern Rhodesia Nurses' Association, F 242/SM/300/26, Memorandum, 12 May 1944.

“There is not enough time to treat the European and to give the native better attention”: The impact of the shortage on African patients

Given nurses’ poor working environment, it is not surprising that patient care was severely affected. During the time period under study, nurses and other medical personnel always reminded responsible authorities of how the staffing crisis impacted on their daily work. For example, Dr Honey, with ten years’ working experience at Salisbury Hospital noted that:

In the Salisbury Hospital there has always been an insufficient number of trained staff. This of course has been accentuated in the last six years. This gives rise to the position that some Sisters [and nurses] find it difficult to conduct all their duties satisfactorily.⁹¹

Within this environment, African patients became the immediate casualties of the staffing crisis. Most doctors and nurses concentrated on white patients. African newspapers in the 1940s commented on the poor treatment African patients generally experienced in hospitals. For example, *The Bantu Mirror* of 14 August 1942 stated that at Salisbury Hospital:

There is not sufficient accommodation. There is great deal of congestion, and there are not sufficient nurses and ... sisters ... we feel that something should be done about that ... sometimes the staff there is obliged to discharge patients before they are completely cured.⁹²

The Bantu Mirror of 20 May 1943 also noted that at times, “African patients are turned away from the Outpatients Department and many of them have come a long distance of 15 or 20 miles”.⁹³ In 1945, this situation still persisted. B. Mnyanda, the African representative on the National Health Services Commission (NHSC) complained that significant numbers of Africans were being turned away without proper treatment.⁹⁴ He placed the blame squarely on the lack of staff.

African patients were the victims of the staffing crisis, with African female patients receiving even less attention than men. The fact that this was the case underscores the contradictions of colonial urban policy in Rhodesia before the 1950s, which stipulated that urban areas were first and foremost spaces for people of European origin. The presence of Africans in the towns was sanctioned in as far as they were providing labour. They were expected to live in rural areas if not providing labour services. Because the majority of these labourers were men does not mean the exclusion of women went uncontested. Scholars such as Teresa Barnes and Elizabeth Schmidt demonstrate that women traversed these boundaries and registered their

⁹¹ NAZ: NHSC, ZBP 1/2/4, Dr R Mackenzie Honey’s oral evidence to the NHSC, 31 October 1945.

⁹² *The Bantu Mirror*, 14 August 1942.

⁹³ *The Bantu Mirror*, 20 May 1943.

⁹⁴ NAZ: NHSC, ZBP 2/1/3, B. Mnyanda, Oral evidence to the NHSC, 18 September 1945.

presence in urban areas.⁹⁵ However, because colonial laws did not sanction the presence of African women, facilities for African women were severely limited. At Salisbury Hospital, female wards were few in number and African women were given less attention. Maternity cases were the worst affected. Mnyanda cited a case in Salisbury “where a woman was unable to gain admission to the maternity clinic in the location and so she came to the Salisbury hospital, but was refused admission.”⁹⁶

Although Mnyanda recounted only one such incident, records consulted show that such experiences were common with African women being given insufficient attention as nurses struggled to cope with their increased workload. In 1944 it was reported: “Patients are turned away as was the case of a woman in labour. Both she and the child died.”⁹⁷ In 1945 Michael Gelfand, one of the most influential medical doctors in the history of biomedicine in Rhodesia, exposed the African patients’ situation when he noted that: “The truth in my opinion, is that in the majority of the stations there is not enough time to treat the European and to give the Native better attention than is being done at the moment.”⁹⁸ This clearly shows that black patients were being neglected, in part because medical personnel were overworked and the government was failing to address the shortage.

**“Government is not making sufficient efforts to improve the staff shortage”:
Failure of early measures to remedy the situation**

For some authorities, the problem could be solved by half measures. For instance, the government amended leave procedures in 1943, allowing nurses three months’ leave of absence instead of two. It was hoped that those who had families in South Africa, for example, would be able to travel back home and spend quality time with their families.⁹⁹ In addition, in 1944 the Medical Director appealed to nurses who had left the profession to re-join the service. They could do this either on a part time or full time basis. By doing this, the government was targeting the 152 known nurses who had left the profession but were still resident in Rhodesia. However, only 18 nurses indicated that they were willing to take up nursing again and of these, 13 intimated that that they would be prepared to return to work on a part time basis.¹⁰⁰ For those who opted to work on a full time basis, they were dismayed to discover that they were still officially classified as temporary workers.¹⁰¹

⁹⁵ For more on African women in urban areas in Rhodesia see Teresa. A. Barnes, “*We women worked so hard*”: *Gender, Urbanization and Social Reproduction in Colonial Harare, Zimbabwe, 1930–1956* (Baobab Books, Harare, 1999); and Elizabeth Schmidt, *Peasants, Traders, and Wives: Shona Women in the History of Zimbabwe, 1870–1939* (Baobab Books, Harare, 1992).

⁹⁶ NAZ: NHSC, ZBP 2/1/3, B. Mnyanda, Oral evidence to the NHSC, 18 September 1945.

⁹⁷ Captain Whittington, Legislative Assembly Debates, Volume 24, 1944, p 871.

⁹⁸ NAZ: NHSC, ZBP 2/1/3, Michael Gelfand to the NHSC, 13 August 1945.

⁹⁹ NAZ: Southern Rhodesia Nurses Association, F 242/SM/300/26, Memorandum, 12 May 1944.

¹⁰⁰ NAZ: Southern Rhodesia Nurses Association, F 242/SM/300/26, Staff Matron Pettigrew to the Medical Director, 3 August 1944.

¹⁰¹ NAZ: Southern Rhodesia Nurses Association, F 242/SM/300/26, Staff Matron Pettigrew to the Medical Director, 3 August 1944.

It is clear that by 1945 these half measures had failed to achieve desired results. In 1945, the Matron of Umtali revealed that:

There appears to be great dissatisfaction amongst the staff. They maintain that the government is not making sufficient effort to improve the staff shortage, which has now reached a climax. The majority of the temporary staff who have already completed years of fulltime service are feeling utterly exhausted and consider it impossible to carry on under existing conditions.¹⁰²

Married nurses working on a temporary basis claimed that they were still being overworked. They argued that while the government had made changes to the distribution of shifts, the nature of the arrangements were still disadvantageous to them. Full time nurses worked an average of eight to ten hours a day, their shifts were divided into either the morning shift, with time off in the afternoon, then an evening shift; or an afternoon and a late evening shift. Married nurses, who were employed on a temporary basis, worked an average of four to six hours. Likewise, their daily shift was divided into two. This arrangement proved very inconvenient for many, so much so that married nurses requested changes in the regulations. They suggested that they be allowed to take the whole morning shift or afternoon shift or the entire evening shift.¹⁰³ This arrangement was easier to manage because breaking the day into two, or at times three shifts, interfered with their family lives.¹⁰⁴ However, the government ignored these requests.

Others suggested that greater effort should be made to entice young white women into the nursing profession. In 1940, the authorities reduced the minimum age for entering nursing school from 18 to 17½ years and increased the maximum age of entry to 30 years.¹⁰⁵ The government made further changes to the rules governing the entry of women into nursing. The minimum requirement had been a four-year secondary school education. Authorities began accepting those with only three years of secondary school education.¹⁰⁶ The government also cast its net wider. In 1942, the Rhodesian authorities introduced pre-nursing training in secondary schools. The main aim was to impart an interest in nursing in the schools.¹⁰⁷ Although the new programme was only taught in Salisbury and Bulawayo, the Southern Rhodesia Medical Council hoped to extend it to other major centres.

¹⁰² NAZ: Southern Rhodesia Nurses Association, F 242/SM/300/26, F. Stewart, Matron Umtali Hospital to Staff Matron Pettigrew, 15 September 1945.

¹⁰³ NAZ: Southern Rhodesia Nurses Association, F 242/SM/300/26, F. Stewart, Matron Umtali Hospital to Staff Matron Pettigrew, 15 September 1945.

¹⁰⁴ NAZ: Southern Rhodesia Nurses Association, F 242/SM/300/26, F. Stewart, Matron Umtali Hospital to Staff Matron Pettigrew, 15 September 1945.

¹⁰⁵ NAZ: Southern Rhodesia Nurses, F 242/SM/300/26, Nurses Association to the Medical Director, 11 September 1944.

¹⁰⁶ NAZ: Teaching of Nursing: Pre-Nursing in Schools, 1942–1947, S 8224/462, Medical Director's Memorandum, 1942.

¹⁰⁷ NAZ: Teaching of Nursing, Pre-Nursing in Schools, 1942–1947, S 8224/462, Medical Director's Memorandum, 1942.

Penelope Gordon, the headmistress of the Evelyn Girls' School in Bulawayo, a major supporter of the new pre-nursing programme underscored the importance of these efforts. In her letter to the Medical Director, she argued that it was one of the best ways of ensuring that young girls remained disciplined and made a valuable contribution to their country. For Gordon, having the programme meant that more young women would enter the nursing profession. She believed that most of the girls at Evelyn Girls' School intended to become nurses as soon they finished school at the age of 17. However, in her view, because girls could not enter nursing school until they were eighteen years of age, many would be "tempted into office work" in the meantime and although these girls probably assured themselves that they would go into nursing school later, they "hardly ever" went back.¹⁰⁸

Although the new programme probably created some interest among secondary level schoolgirls to enter the nursing profession, it did not meet with a great deal of success. Exposure to a pre-nursing course did not guarantee automatic entrance into the nursing school. A student who had studied pre-nursing course at secondary school had to repeat the same process at nursing school.¹⁰⁹ Some officials who were afraid that "nursing standards" would be compromised also attacked the programme. The Senior Medical Officer of Bulawayo, for instance, was not only critical of the project's curriculum, but also argued that the teachers were not qualified enough to teach pre-nursing courses because they lacked the necessary requirements for practical demonstrations.¹¹⁰ The experiment was eventually scrapped in 1947. Its failure was not surprising because it was based on the mistaken assumption that most young white women were interested in nursing. On the contrary, with the expansion of the economy in the postwar era, more lucrative opportunities with better working conditions became available to white women in other sectors of the economy.

"Unless there is a great change of heart ...": Searching for a long term solution

The staffing situation in the immediate postwar period saw very little improvement. The 1948 Public Health Report indicated that of the entire group of student nurses who passed their examinations in 1947, "not one had joined the permanent staff".¹¹¹ The majority had proceeded to the Union of South Africa while others had gone overseas to undertake further studies. The following year, the Medical Director complained again about the situation with student nurses:

The student nurse position remains unsatisfactory and it is quite evident that unless there is a great change of heart, the colony will have to depend on

¹⁰⁸ NAZ: Teaching of Nursing, Pre-Nursing in Schools, 1942-1947, S 8224/462, P. Gordon to the Medical Director, 13 June 1942.

¹⁰⁹ NAZ: The Training and Examination of Student Nurses, 1939-1945, S 2014/2/15, Medical Director's Memorandum.

¹¹⁰ NAZ: The Training and Examination of Student Nurses, 1939-1945, S 2014/2/15, Medical Director's Memorandum

¹¹¹ Government of Southern Rhodesia, Public Health Report, 1948.

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recruiting trained nurses from overseas and the Union of South Africa in order to maintain services.¹¹²

A complete change of heart appeared to be the only solution and the Medical Director began thinking of radical changes that implied an adjustment to the policy that was partly responsible for the problem in the first place. The most important and lasting shift in nursing policy was the opening up of careers in the qualified nursing profession to Africans, Coloured people and Asians in the 1950s.

It must be noted that calls for the government to train Africans, especially women, began way before 1949. From the late 1930s onwards, the Medical Director's Office was inundated with pleas from all sections of Rhodesian society to train African nurses in order to free white nurses to take care of white patients. As far back as 1938, there were remonstrations from European patients who objected to being nursed by student nurses. They called upon the authorities either to speed up the training of more European nurses or to begin training African nurses to take care of African patients.¹¹³ Two years later, the matron of the African section of Salisbury Hospital complained bitterly about the extreme workload and implored the government to start training African nurses – as was already the case in South Africa.¹¹⁴ In 1942 the senior government medical officer of Bulawayo Hospital urged, "The training of Bantu female nurses to work in the Native wards [is imperative] so as to set free the European personnel for European wards and thus lighten their burden".¹¹⁵ At the same time, the coloured community was also complaining about the absence of coloured women in hospital spaces. These calls coincided with Africans' demands for the training of qualified African nurses who could then work in African wards.

As much as practical reasons were behind the shift in this regard – in Rhodesia as in South Africa – the drive towards training African nurses in government hospitals had its origin in racist attitudes towards patient care.¹¹⁶ During the debate on hospitals in the Legislative Assembly, Captain Whittington spoke on behalf of many white Rhodesians when he said, "I do not think that the present position is right, that Europeans should look after natives".¹¹⁷ What he had in mind was not just the nursing care for any African. To be specific, he referred to white nurses giving nursing care to African men. There were always anxieties about close contact between African male patients and white female nurses. These racial fears were inextricably intertwined with the construction of the idea of black men as "threatening", of black men being profoundly "unclean", and of black men being "uncivilised".¹¹⁸ Of course, these views

¹¹² Government of Southern Rhodesia, Public Health Report, 1949.

¹¹³ NAZ: Salisbury Hospital, Correspondence 1928–1940s, S 2177/3/3, A.P. Martin, Memorandum on New Native Hospital, 20 April 1938.

¹¹⁴ For South Africa see for example, Marks, *Divided Sisterhood*.

¹¹⁵ NAZ: Nurses, General Correspondence, 1937, S 2177/1/2, Senior Government Medical Officer, Memorial Hospital to the Medical Director, 29 October 1942.

¹¹⁶ Sweet and Digby, "Race, Identity and the Nursing Profession in South Africa", p 111.

¹¹⁷ Captain Whittington, Southern Rhodesia Legislative Assembly Debates, volume 24, 1944, p 871.

¹¹⁸ Burns, "A Man is a Clumsy Thing", pp 695–717.

were contested. No one brings this inconsistency into sharper focus than B.J. Mnyanda. In his critique of the policy of segregation he writes:

It is incredible to believe that these very Europeans who are so eager to find fault with the Africans in the mass, sit down daily at breakfast, lunch and in the evening to sumptuous and delicious meals – all prepared entirely by African hands. Piccaninnies [African boys] and African nannies nurse and look after the welfare of young European children. In some cases, these servants look after the children while the mothers are away at work for the whole day.¹¹⁹

During the entire colonial period, white households were sustained by African domestic servants, male and female alike. Within hospitals, white nursing staff and medical doctors in government and mission hospitals continued to take care of convalescent Africans. Even so, the racist views of people such as Whittington were to play a major role in influencing state policies.

Important to highlight is that the envisaged training of African qualified nurses placed the emphasis on female nurses. Yet men have always been employed as nurses on mines and in psychiatric hospitals.¹²⁰ A veritable constellation of factors was significant in sidelining the possibilities of training male nurses for general hospitals in the 1950s.¹²¹ Besides official policy reserving the training of nurses to white women, there was also the ongoing construction of gender roles linked to the timeworn Victorian ideology. Elizabeth Schmidt demonstrates the various ways such an ethos, as well as the sex and gendered stereotypes imparted by missionaries and settlers, was inextricably intertwined with gender discriminatory systems within African societies.¹²² In nursing this was done by emphasising the intimacy of nursing and the feminine qualities of the nursing profession. At the same time, African men were construed as being both incompetent and violent.

By the 1940s, possibilities for African males to train and work as qualified nurses in general hospitals were very slim.¹²³ For example, the secretary of the Salisbury Hospital, C.S. Mitchell, was against the idea of training male nurses because he already had experience of working with male orderlies, most of whom, in his opinion, “neglect[ed] real nursing which can much more easily be developed from the natural temperament of the female ... women by their nature are more suitable than men for the job”,¹²⁴ while Plof W. Nirdjesjo, a nurse at Mnene Mission argued in 1945

¹¹⁹ B.J. Mnyanda, *In Search of Truth: A Commentary on Certain Aspects of Southern Rhodesian Native Policy* (Hind Kitabs, Bombay, 1954), p 41.

¹²⁰ See for example, Marks, “We were Men Nursing Men”, pp 177–204; Burns, “A Man is a Clumsy Thing”, pp 695–717; and Lynette A. Jackson, *Surfacing up: Psychiatry and Social Order in Colonial Zimbabwe, 1908–1968* (Cornell University Press, Ithaca, 2005).

¹²¹ While this is beyond the scope of this paper, it must be noted that the training of male qualified nurses was only instituted in 1966, both in European and African training schools. See Government of Southern Rhodesia, *Public Health Report, 1966*.

¹²² For more on this see Schmidt, *Peasants, Traders, and Wives*.

¹²³ For South Africa see for example, Burns, “A Man is a Clumsy Thing”, pp 695–717.

¹²⁴ NAZ: NHSC, ZBP 2/1/3, Memorandum by C.S. Mitchell, Salisbury Hospital Secretary to the NHSC, 25 October 1945.

that “male orderlies are rougher than female orderlies”.¹²⁵ Such suggestions were central in influencing the policies that sidelined African men from being accepted for training at nursing schools. Indeed, the first cohort of qualified African nursing students at Harare Hospital explicitly excluded men.

On 1 September 1958, 15 African student nurses began the journey of training as qualified nurses.¹²⁶ Trained at Harare Hospital, they were the first cohort of African women to undertake a nursing course that at one time was the preserve of white women. These nurses, just as student teachers before them, represented the “progress of African women” as veteran nationalist, Edison Sithole remarked.¹²⁷ The training for African nurses, which was also extended to Mplio Hospital in Bulawayo, began the gradual transformation of Southern Rhodesian Nursing Services from being predominantly white to include Africans, Coloureds and Asians.

Conclusion

The staffing crisis, especially the shortage of qualified nurses for general hospitals in Rhodesian general hospitals from the 1930s to 1950 is located at the intersection of the histories of nursing, hospitals and colonialism. This study illuminates the entanglements of internal and external factors in shaping nurses’ work, patient care and how hospitals functioned in settler colonies. In Rhodesia the staffing crisis was in part a result of racial policies of the day – especially the reservation of qualified nursing for white women as part of their imperial contribution. In addition, the civil service marriage policy that required women to resign from service also contributed to the shortage. This was at a time when authorities were failing to train enough nurses for hospitals.

To plug the gap, the authorities recruited nurses from South Africa and the United Kingdom. Here lies another problem as the article has shown. Rhodesia was competing with other dominions for nurses at a time when both the UK and South Africa began to limit the migration of qualified nurses to countries in central Africa so Rhodesia was left in a dilemma. Hence, by the late 1930s as has been shown, there was general agreement between nurses and medical authorities that Southern Rhodesian Nursing Services was in crisis. The situation grew even worse in the 1940s.

The study of the staffing crisis also demonstrates how a global event – the Second World War – had an impact in forcing internal changes in Rhodesia. These changes were to complicate the staffing crisis and the provision of medical services. As part of their contribution to the war effort, close to 50 nurses were transferred to military nursing. This gesture further reduced the number of nurses available for work in general hospitals. Rhodesia also hosted imperial forces, which had the effect of stretching medical services during the war. Perhaps it was the unintended

¹²⁵ NAZ: NHSC, ZBP 2/1/3, Plof. W. Nirdjesjo, Mnene Mission to the NHSC, 7 December 1945.

¹²⁶ *The African Parade*, January 1959.

¹²⁷ *The African Parade*, August 1958.

consequence of the war that African urbanisation exposed the contradictions in colonial policies. While Africans had already embraced the use of biomedicine by the 1930s, this use expanded in the 1940s, in the process stretching medical services in urban areas. The increase in use of medical facilities by Africans came at a time when the very same facilities were poorly equipped and reeling from an acute nursing staff shortage. This no doubt affected the morale of the nursing staff.

In the midst of all this, nurses and medical authorities responded in various ways. Among these were drawing up petitions; giving evidence to commissions of inquiry; and resignations in response to poor working conditions and low salaries. All these responses reveal the agency of the dissatisfied nurses. At the same time, the introduction of what I call “half measures” by the authorities indicates how they altered policies when faced by a crisis. These measures included modifying leave procedures; enticing retired nurses to return to the service; and introducing a pre-nursing curriculum in a number of schools. However, these adjustments failed to bring the desired results. The solution, lay in introducing “drastic” measures – introducing the training of African, Coloured and Asian qualified nurses. Calls for such training began in the 1930s, gained traction in the 1940s and were eventually introduced in the 1950s.

In this article I also suggest that as much as practical reasons were central in compelling authorities to think about training nurses of colour, racial practices of the day were also significant. Indeed, Rhodesian authorities still placed the emphasis on training females. It was in all likelihood hoped that once qualified, African nurses would concentrate on providing nursing services for their own people, leaving European nurses to care for European patients. The training of African qualified nurses that began in September 1958 at Harare Hospital with a cohort of 15 female student nurses was a result of this gradual change in policy. Although white nurses continued to nurse African patients during the entire colonial era, the entrance of Africans into the sector was set to transform the Southern Rhodesian Nursing Service.

In short, it is the contention of this article that an examination of the problems affecting Southern Rhodesian Nursing Services and hospitals from the 1930s to 1950, enables us to interrogate the contribution of white women to nursing and the provision of medical services in settler colonies. Such an enquiry, using Southern Rhodesia as a case study, leads us into disentangling the contradictions of colonial practices. The inconsistencies, informed by both internal and external factors, compelled the relevant authorities to adjust timeworn colonial policies.