

# Sanitation and health conditions in Windhoek, South West Africa, under South African rule between 1915 and 1939

*C.E. Kotze*

*Windhoek*

SOUTH AFRICAN TROOPS under General Louis Botha occupied Windhoek, the capital of what was to become known as the mandated territory of South West Africa, on 12 May 1915. The health facilities and sanitation system they found there were typical of many rural South African towns.

## THE SANITATION SYSTEM

The town's drainage system left much to be desired: effluent from the brewery in the centre of the town flowed along the streets into the Tal (valley) where it collected in a cesspit along with the rest of the town's sewage and waste water. This messy situation was compounded by the fact that overflow from the Pahl Spring just above Kaiser Street (the main street) was also allowed to flow freely down the slope, across the main street and down into the Tal. During the rainy season conditions became almost unbearable.<sup>1</sup>

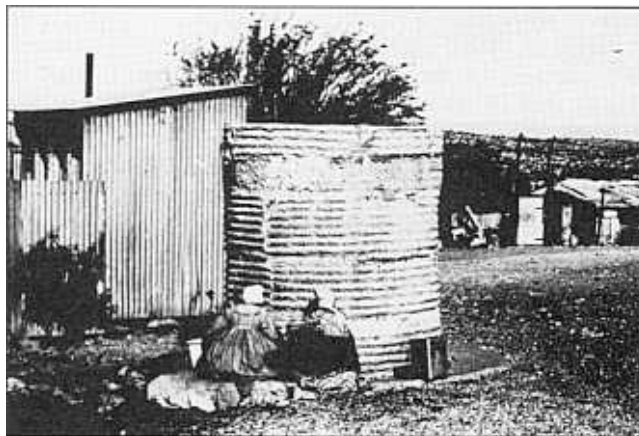
A bucket system was in use in Windhoek itself. The night soil was removed by gangs of black labourers, who emptied the used buckets into containers and returned the (still-soiled) buckets to the outhouses. A clean bucket was only supplied once every two or three weeks, due to an acute shortage of buckets. The containers with night soil were transported through the town on a mule-drawn trolley, running on railway lines laid down some of the streets. This system caused much spillage, and was often criticized in the newspapers.

However, nothing was done until 1920 to improve conditions, despite complaints from the public and the medical officer of health. The town council had their hopes pinned on a water-borne sewage system, which, they felt, would make any expensive changes to the bucket system unnecessary. Until funds for a water-borne system became available, they were willing to endure the existing system.<sup>2</sup>

While the sanitation system in the main town left much to be desired, that in use in the Main Location and the Klein Windhoek Location was appalling. The latrines consisted of nineteen trenches with cross beams on which to squat.<sup>3</sup> These trenches, which served about 5 000 people, were not enclosed, thus there was no privacy or segregation of men and women.<sup>4</sup>

The location inhabitants flung all slops onto the ground around their huts. As no provision was made for water run-off, this aggravated the situation. Despite numerous requests for receptacles for slop water by O.G. Bowker, the conscientious location superintendent, the town council decided against it since such receptacles would tempt the inhabitants to use them as urinals, creating unsanitary conditions around the huts.

All water was obtained from hydrants and water tanks at various points in the locations. Ablution or public washing facilities were not supplied, again despite constant pleas from Bowker.<sup>5</sup> This often led to the blacks working in the main town to wash themselves and their clothes at any convenient place, causing public



*Two Herero women filling their buckets at the water tank next to the communal toilets.\**

complaints. One such place was the tap connected to the Pahl Spring on the footpath between Leutwein Street and Garten Street, a favourite as the tap supplied hot water, something which was unavailable from any tap in either location.<sup>6</sup>

Under pressure from Windhoek's medical health officers and the public to improve the town's noisome night soil removal system, the town council finally appointed a commission in 1926 to investigate and report on sanitary removals in the town. The commission condemned the existing system out of hand and recommended the introduction of a dual bucket system.

The municipality, after studying the findings, agreed to introduce the new system on 1 April 1927. However, it also decided that it would no longer operate the removal system itself. The whole operation would be given out on tender to a private contractor for periods of five years.<sup>7</sup> Night soil also had to be removed from 23:00 to cause as little disturbance as possible.

In the locations the trench system remained in use, despite the pleas of the inhabitants for a bucket system

**NB:** All archival references are to materials in the Windhoek State Archives.

<sup>1</sup> Interview with Mr W. Geier in Windhoek, June 1988.

<sup>2</sup> LOC SWA 2/12/17: Sec. SWA — Administrator, 30.12.1926.

<sup>3</sup> SWAA A.312/9: Health report for Windhoek, 31.12.1924.

<sup>4</sup> MWI 1/2/5: Location Superintendent — Medical Officer of Health, 30.11.1923.

<sup>5</sup> MWI 1/2/34: Health report on Windhoek, 31.12.1933.

<sup>6</sup> LOC SWA 2/10/17: Director of Works — Town Clerk, 30.7.1919.

<sup>7</sup> MWI 1/2/34: Health report, 31.12.1933.

\*All photographs are from the Windhoek State Archives.

similar to that in the town. During an interview with the location residents' representatives in 1923 the mayor assured them that he had nothing against them having such a system, provided they could pay for it. The initial cost would be about £1 500, and a further £500 per annum would be needed for upkeep.<sup>8</sup>

At the beginning of 1930 construction was finally started on a main sewer for the town. The new water-borne sewage system became operational in 1932, but by then the depression was making itself felt. Despite the opinion of the government medical officer, Dr H. Hinsbeeck, that property owners should be forced to connect their drains to the new system, the council did not feel it could force residents to take such a step during the difficult economic situation.<sup>9</sup> As a result the town found itself operating the water-borne system side by side with the much reviled bucket system for households that could not afford the connection to the new system.

In the Main Location Bowker finally got his way in 1932, when the council agreed to do away with the trench system so hated by the blacks. In 1933 a water flush trough latrine system was introduced, albeit still in the form of communal toilets. The troughs, placed inside cubicles, were flushed three times a day, thus taking care of the most offensive odours, though not getting rid of them completely.<sup>10</sup> Ten such communal latrines were spaced evenly over the location. The total spent on this sanitation installation was £3 000.<sup>11</sup>

Regardless of these improvements public-spirited Windhoekers spent much time writing to the local newspapers to point out the failings of the town council as far as the cleanliness of the town was concerned. The commonest complaints concerned the open drains, the cesspool in the Tal riverbed, and the ghastly smells pervading the vicinity of the Zoo café, the drain near the mortuary and the north side of the hospital for blacks, as well as the effluent from the brewery in the centre of town.

## THE HEALTH SITUATION

### Prevalent diseases

Diseases prevalent in Windhoek after 1915 seemed to show a preference for certain sections of the population — stomach ailments and scarlatina were 'white' diseases, while chest ailments such as pulmonary tuberculosis and pneumonia were 'black' diseases.

When the South African Medical Corps took over the hospitals in Windhoek in 1915, it soon became obvious that there were numerous black people suffering from various forms of malnutrition. Most of these were 'Union' blacks,<sup>12</sup> who did not have the advantage of tribal connections in the territory. Most of the local blacks were usually able to supplement their diet in the unfamiliar urban surroundings with meat and milk in its many forms, which was one of their staple foods,<sup>13</sup> as they were allowed to keep a few head of large or small stock on the town commonage for a small fee.

During the first six months after the take-over of the Windhoek Native Hospital, 49 patients with scurvy were admitted, of whom two died. A large number of serious scurvy cases were treated as out-patients during this same period.<sup>14</sup> Most of these occurred among blacks brought in from the Union of South Africa as government labourers, which leads to the conclusion that their rations were unsuitable. Scurvy continued to

be a problem until the meat ration was increased in February 1916, following 38 cases of the disease among prisoners in the Windhoek jail.<sup>15</sup>

As mentioned earlier, the whites seemed peculiarly susceptible to stomach ailments, variously diagnosed as typhoid and enteric fever. However, there is good reason to believe that these illnesses were actually gastro-enteritis or bacillary dysentery, both far less virulent than either typhoid or enteric fever. Typhoid is caused by *S typhi*, and may be spread by inadequate hand washing or inadequate use of toilet paper. In endemic areas, where sanitary arrangements are generally inadequate (as in Windhoek at this time), *S typhi* is more frequently transmitted by water than food.<sup>16</sup> Thus, if *S typhi* was actually present in either the water or food (including milk) in Windhoek, the disease would not have been confined almost exclusively to the whites. Yet this seems to have been the case. Furthermore, before the introduction of antibiotics in 1948 typhoid had a mortality rate of about 12% world-wide, yet almost no deaths occurred among the so-called 'typhoid' cases in Windhoek.

Like the German government before 1915 the South West African Administration (SWAA) urgently attended to venereal disease among the blacks. The administrator issued a proclamation in 1919, making it an offence not to receive treatment for a venereal disease. This had economic repercussions especially for women, since they could not be employed as washerwomen, nursesmaids or housemaids if found to be suffering from such a disease.<sup>17</sup>

During the depression what was perceived by the SWAA as the high incidence of syphilis and gonorrhoea among black men and women caused serious concern. At a meeting of the administrator's advisory council in 1930 it was decided that all black prisoners passing through the Windhoek jail were to be examined in order to ascertain the percentage of convicts with venereal disease.<sup>18</sup> In 1932 this idea was taken further when it was suggested to the Windhoek Location Advisory Board that all black men and women should be examined for venereal disease on a regular basis, and that this should be made compulsory. This suggestion met with a negative response, but large numbers of both men and women came forward voluntarily for treatment during the following years, and the medical officer of health was of the opinion that no increase in venereal disease had occurred.<sup>19</sup>

In 1937 a campaign was set afoot to force all black women to undergo regular tests for venereal infections.

<sup>8</sup> MWI 1/2/5: Minutes Town Council Windhoek No. 36, 23.8.1923.

<sup>9</sup> MWI 1/2/31: Health report on Windhoek, 31.12.1932.

<sup>10</sup> MWI 1/2/34: Health report, 31.12.1933.

<sup>11</sup> MWI 1/2/33: Minutes Town Council Windhoek, 14.12.1933.

<sup>12</sup> SWAA A.324/5: Public Health Scurvy, Nov. 1915.

<sup>13</sup> E.L.P. Stals, 'Duits-Suidwes-Afrika na die Groot Opstande', *Argiefjaarboek vir Suid-Afrikaanse geskiedenis* 46 (2), 1983, p. 90.

<sup>14</sup> SWAA A.324/5: Report by N.F. Mann, Acting Officer in charge, Native Hospital Windhoek, 17.11.1915.

<sup>15</sup> SWAA A.324/5: N.F. Mann — Native Commissioner, 25.2.1916.

<sup>16</sup> R.J. Dubos, *Bacterial and mycotic infections of man* (New York, 1952), p. 292.

<sup>17</sup> SWAA A.320/1: Venereal disease; Stals, 'Duits-Suidwes-Afrika', pp. 92-93.

<sup>18</sup> SWAA A.320/1: Minutes Advisory Council, 16.5.1930.

<sup>19</sup> MWI 1.2.43: Health report Windhoek Municipality, 31.12.1936.

Until 1937 venereal disease was never diagnosed by means of bloods or smears, as there was no pathology laboratory in South West Africa.<sup>20</sup> However, when plans to have all black women tested were formulated it was arranged that all bloods and smears would be tested in Cape Town. Despite the sometimes violent protest of especially the Herero women against the new regulation, six-monthly examinations for venereal infection became law in October 1938. According to one author, the Herero women experienced these examinations as extremely traumatic. They went so far as to organize a demonstration in front of the government buildings, where they threw stones and attempted to interview the native commissioner. He, however, refused to speak to them, insisting that the examinations for venereal disease was a matter to be discussed with the Herero men. The women then held meetings with Bowker's wife, who listened to their arguments against what they felt to be an invasion of their privacy. But she, too, insisted that it would be for their own good, and that they should submit. This they were forced to do, but the whole episode left a deep distrust of 'white medicine' and medical methods especially among the Herero women.<sup>21</sup>

An interesting aspect of the prevalence of venereal diseases among the black population is discussed by a South African doctor and member of parliament, W.P. Steenkamp, in a pamphlet published in about 1937 or 1938 in Cape Town. He tries to ascertain the reasons for the low birth-rate among Herero women, and, after interviewing and examining large numbers of Herero men and women, concludes that almost all Hereros, including children, were infected with gonorrhoea. He gives this as one of the major reasons for the sterility of both men and women.<sup>22</sup>

As mentioned earlier, Windhoek's black population suffered mainly from chest ailments, with pulmonary tuberculosis and pneumonia having a high mortality rate. The high incidence of these two diseases may be attributed to poor living conditions and diet in the locations. Bowker complained with morbid regularity about the congested conditions in the two locations, as well as about the unsuitable building materials for huts. The material ranged from sticks and dried grass to old rags and flattened tins, and even included cardboard and paper. The floors and the insides of the walls were often 'plastered' with a mixture of clay and cow dung to make them waterproof and keep out the worst cold.<sup>23</sup>

Rubbish lying about between the tin shanties in the Main Location (left). A water-flush toilet next to a water tank in the same location (right).



## The Spanish Influenza of 1918

The only real epidemic to occur between 1915 and 1937 was the Spanish Influenza, which took a heavy toll throughout the Union of South Africa and South West Africa.

The first cases of this dreaded disease occurred on 7 October 1918 among the passengers and crew members of the incoming mail train from the Union.<sup>24</sup> In less than a week the military hospital staff was affected, and from there the infection spread rapidly to the troops stationed in the town, and to the civilians, both white and black. The black population was especially heavily hit by this epidemic as a result of their poor diet and living conditions (notably overcrowding and poor ventilation in their flimsy huts). The troops living in barracks in the town also experienced a greater mortality rate than elsewhere. The inmates of the military hospital, which was overcrowded, died in greater numbers than the patients treated in the emergency hospital (41 deaths out of 126 cases as opposed to 29 deaths out of 232 cases).<sup>25</sup>

The townspeople, assisted by the army, made every effort to contain the disease. Schools, churches and most businesses closed, some for as long as three months. The government offices closed for about two weeks until the worst was past, which was by about 25 October 1918.<sup>26</sup> Those who were fit enough volunteered for nursing and other duties in connection with the epidemic. Soup kitchens, medicine bureaus and temporary hospitals were established, mainly to care for the blacks. In the locations Dr L.H. Bowkett and Bowker explained the nature of the disease to the people before the first cases occurred, and instructed them on ways to combat the disease. At the same time they equipped a dispensary in each location. The one in the Main Location was under the district surgeon's control and the one in Klein Windhoek Location was controlled by a medical orderly. These two men saw to it that patients were regularly fed, that they received their medicine at the

<sup>20</sup> SWAA A.320/1: Medical Officer — Sir Edward Thornton, 22.10.1937.

<sup>21</sup> K. Poewe, *The Namibian Herero* (Lewiston/Queenston, 1985), pp. 202-203.

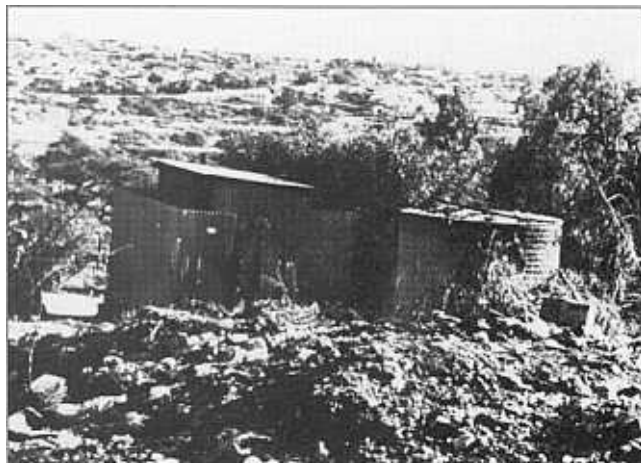
<sup>22</sup> W.P. Steenkamp, *Is the South-West African Herero committing race suicide* (Cape Town, 1937?), pp. 18-21.

<sup>23</sup> Interview with Mrs M. Mosiane in Windhoek, 1985.

<sup>24</sup> SWAA A.323/6: Public Health, Spanish 'Flu.

<sup>25</sup> SWAA A.323/1: Spanish 'Flu.

<sup>26</sup> SWAA A.323/6.



correct intervals and that the huts were visited regularly so that serious cases could be removed to the native hospital. Food from the soup kitchens was taken to patients lying ill in their huts. Thirty milk cows from the stock reserves provided fresh milk, while a wagon and sixteen donkeys transported the fuel and supplies. A special ambulance (a cart) conveyed the sick and dead to and from the hospital and the locations. The sick and dead also had to be collected from where they collapsed in the streets or the veld.<sup>27</sup>

By 20 October matters were well organized all over town, with especially the officials and troops coping with the epidemic. Vaccine was obtained from South Africa and an inoculation campaign began. However, blacks and coloureds only received vaccine after all whites had been inoculated, the excuse being that vaccine was scarce and expensive! After 15 November the whites in particular gradually began to recover. The United Services Club served as a convalescent home between 20 October and 14 November 1918.<sup>28</sup>

Despite the laudable efforts by the medical authorities and the Department of Native Affairs, 568 inhabitants of the two locations died, representing about 11% of the population of about 5 000.<sup>29</sup> There were 55 deaths among the military personnel, 23 among the white British civilians, and 79 among other nationalities, bringing the total of deaths among the whites to 157.<sup>30</sup> This was about 4,75% of the estimated white population of 3 000.

However, the accuracy of these official figures is doubtful. As in South Africa the government lacked the means to record every death, even in normal times. In theory the Births and Deaths Registration Act applied to all inhabitants, but in practice it was seldom strictly

adhered to by the public, especially the blacks.<sup>31</sup> In South Africa the total number of deaths during the epidemic was variously estimated at between 139 471 or 2% of the population (the figure supplied by the Influenza Epidemic Commission) and as much as 511 726 or 7,5% of the population.<sup>32</sup> In Windhoek a fairly accurate record was kept of deaths among the whites, but, as was the case in South Africa, the records of deaths among blacks in the locations were often not kept at all. Thus, the number of deaths in Windhoek during the epidemic should at best be seen as a minimum figure.

### Health services and hospital facilities

When the Union of South Africa occupied Windhoek in May 1915, all medical services were taken over by the South African Medical Corps. Army doctors acted as district surgeons, while others were employed in the military hospital in Windhoek.<sup>33</sup> In addition the German doctors already active in the town were allowed to continue ministering to their patients. Obtaining nursing staff was a major problem, especially towards the end of the military administration period. Nurses did not like coming to Windhoek, preferring to work in the Union, usually at a higher salary.<sup>34</sup>

<sup>27</sup> SWAA A.323/1.

<sup>28</sup> SWAA A.323/26.

<sup>29</sup> *Ibid.*

<sup>30</sup> *Ibid.*

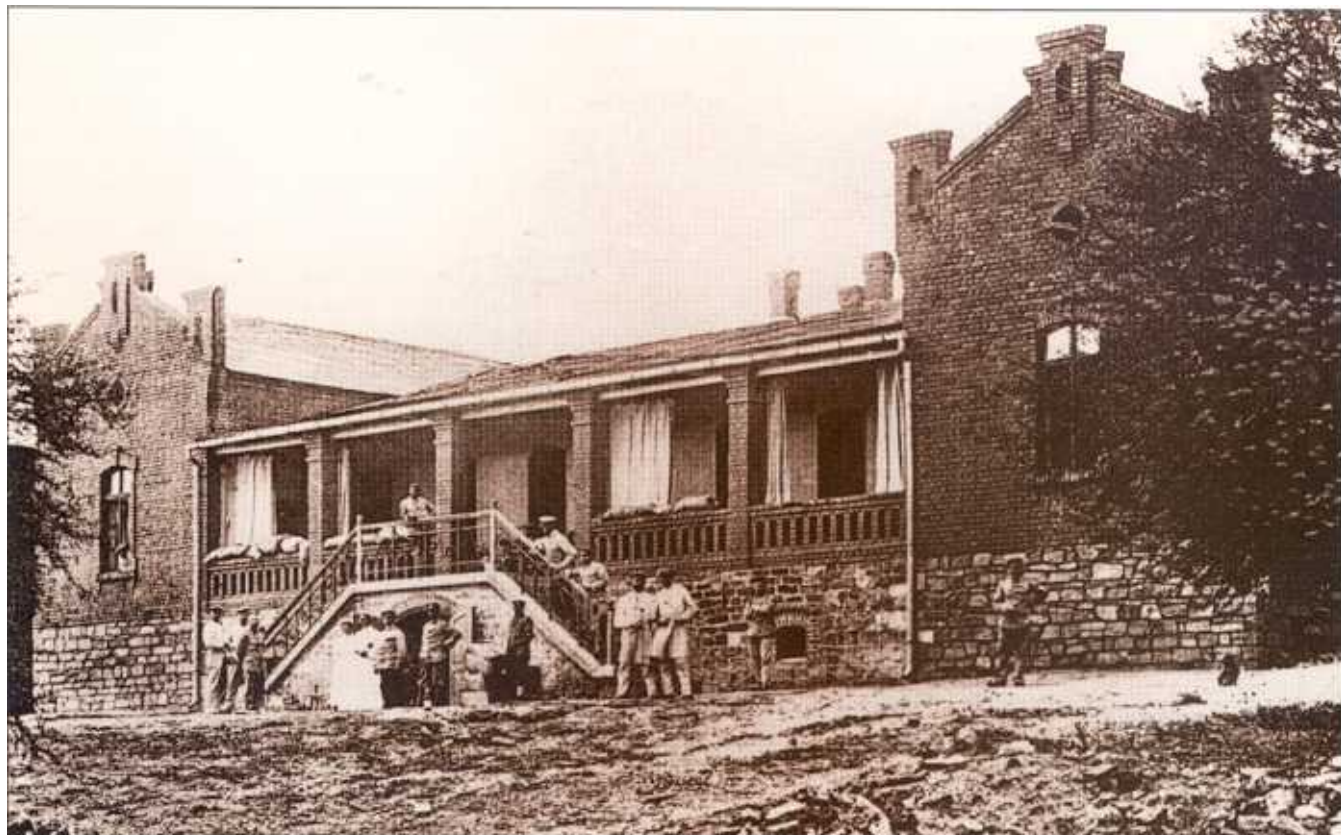
<sup>31</sup> H. Phillips, 'South Africa's worst demographic disaster: The Spanish Influenza Epidemic of 1918', *South African Historical Journal* 20, 1988, p. 59.

<sup>32</sup> *Ibid.*, p. 63.

<sup>33</sup> S.J. Schoeman, 'Suidwes-Afrika onder militêre bestuur 1915-1920' (M.A., Unisa, 1975), p. 37.

<sup>34</sup> SWAA A.307/4: Windhoek Hospital, Financial, 19.5.1932.

*The German military hospital which for many years served as Windhoek's 'state' hospital.*



Apart from the military hospital, which also treated white civilians, the town was served by the Roman Catholic mission hospital, Maria Stern, run by nuns, and the Elisabeth Maternity Home. These three hospitals were in a fairly central position, although the maternity home was to the west of the railway line. White patients involved in accidents at work or in town were carried through the streets on a stretcher, or, if they were lucky, transported to hospital by a passing vehicle.

The military hospital, which was run by the SWAA until 1920, was built by the German government in 1902. Being such an old building, constant problems were experienced concerning its maintenance. The main building had six private wards (six beds), one general ward for women (five beds) and two men's wards (ten beds) — a total of 21 beds. No provision was made for maternity cases.<sup>35</sup> The building was totally unsuited for the purposes of a modern hospital. It was on a busy thoroughfare (Leutwein Street), while the layout made the proper observation of patients very difficult. There was no accommodation for out-patients, no waiting-room, no out-patients' surgery or even a dispensary. The operating theatre was in the backyard and connected to the wards by an open gangway.<sup>36</sup>

In February 1920 the administrator appointed a committee to formulate a scheme for establishing a public hospital in Windhoek. This committee reported that a civil hospital would need to accommodate at least twenty patients — twelve males and eight females and children. The staff would need to consist of a sister in charge and three nurses, of whom one should be qualified in handling maternity cases. No doctors would be employed by the hospital, as the local private practitioners could attend to the patients, perform the operations and dispense their own medicine. This latter arrangement also made the opening of a dispensary unnecessary. Once again, keeping down costs was an overriding concern for the members of the committee, as the running of the hospital would have to be funded by public donations, fees and a proportionate government subsidy. The suggested fee was 8s. per day.<sup>37</sup> The public hospital was only established when the military government ceased to function at the beginning of 1921.

Under the Hospitals and Charitable Institutions Proclamation of 1922 Windhoek was constituted a hospital district, and its existing government hospital buildings and equipment were handed over to the newly appointed Hospital Board at a nominal rental of £1 per annum. In order to help the board to maintain the hospital services, the following subsidy was paid by the SWAA: 30s. for every pound received as collections, contributions or donations; one pound for every pound of the value of all bequests; and one pound for every pound received as fees from patients.<sup>38</sup>

The hospital served the general white public, although these people also had access to the Roman Catholic Mission Hospital in Stubel Street, as well as the Elisabeth Maternity Home in Storch Street. In 1927 a maternity block was built on to the government hospital, with accommodation for five patients. A sixth room was used as a labour ward.<sup>39</sup>

In 1923 this hospital was run by a matron and three qualified nurses. The number increased gradually as nurses became available. By 1925 there were five qualified nurses in a year when the hospital treated 360 in-patients. Finances were a constant source of worry for the board as, during the early years of civil administration, many patients were unable to pay their fees, thus

reducing the subsidy. The administrator's wife traditionally took the lead in collecting money for the hospital, by giving tea and garden parties and an annual hospital ball. From time to time affluent members of the public also made contributions of fruit and vegetables to the hospital.

The Elisabeth Maternity Home, which had been built in 1908, provided excellent maternity care for women, not only from Windhoek, but from all over the territory. As a result the public, regardless of nationality, supported the home financially when it found itself unable to pay for enlargements which had been commissioned shortly before the outbreak of the First World War.<sup>40</sup>

In 1929 the SWAA introduced a system of medical examinations for all white school children. The district surgeon undertook these examinations, helped by a nurse. Teachers selected children thought to have learning disabilities, and these were given a special examination, while the other children simply underwent a routine examination of eyes, ears and teeth. Special cases included poor eyesight, teeth problems, fainting, deafness, fatigue, nose obstructions, excessive liability to catch cold, poor physique, constant coughing, skin diseases, suspected internal diseases and mental disabilities. However, this scheme proved too costly during the depression, and had to be stopped in 1932.<sup>41</sup>

At the time of the military take-over in 1915 the black and coloured population was served by a native hospital in what was then called 24th Avenue (today Okahandja Road), and, like the military hospital in Leutwein Street, taken over as a going concern from the German administration. The native hospital was about seven kilometres from the Main Location and about five kilometres from the Klein Windhoek Location. No ambulance was provided, and patients had to be transported to the hospital in a small hand cart.<sup>42</sup>

Many blacks and coloureds preferred to pay a private doctor for treatment at their surgeries, rather than accept the free treatment provided at the native hospital. There were only two private practitioners in Windhoek until 1920, when Dr Schaumberg, who had gone to Germany during the war, returned and resumed his practice in the town. The other doctors in the town were employed by the SWAA.

In the Main Location treatment was also provided by indigenous practitioners of traditional medicine. Especially the Hereros believed in hedging their bets, by consulting both a white doctor and a traditional healer. Traditional healers were often skilled in the use of herbs and plants, but, more importantly in the minds of the blacks, they knew how important spiritual matters were

<sup>35</sup> SWAA A.307/4: Medical Officer of Health — Sec. SWA, 6.2.1931.

<sup>36</sup> MWI 1/2/45: Memo re Improvements in hospital, 31.8.1936.

<sup>37</sup> *Windhoek Advertiser*, 28.2.1920.

<sup>38</sup> SWAA A.312/5: Annual Report, Public Health, by Dr L. Fourie, 1922.

<sup>39</sup> SWAA A.307/4: Medical Officer ..., 6.2.1931.

<sup>40</sup> *Südwest-Zuid West*, 28.10.1921.

<sup>41</sup> G.W. Fourie: 'Onderwys in SWA 1894-1971', *Educa* 50(4), 1971, p. 55.

<sup>42</sup> SWAA A.340/4: R.S. Cope — Native Commissioner, 27.10.1924.

as part of healing body ailments.<sup>43</sup> The Herero women, especially, insisted on being treated for venereal diseases by their own traditional healers, as they felt that the treatment given by the white doctors was not as effective.<sup>44</sup>

During the period of military government the officer in charge of native affairs, R. Cope, was responsible, through the location superintendent, for the health of the location inhabitants. The Main Location was divided into seven sections, each housing a different ethnic group. Each section had its own headman, who was supposed to report cases of serious illness to the superintendent. If this was not done, the sick were left to their own devices. The superintendent's rather callous attitude, in view of the fact that there was no ambulance available, was that 'if the Natives wished, they could go to hospital'<sup>45</sup> when they were ill. However, most blacks soon came to regard it as a fate worse than death to become an in-patient at the native hospital. On making inquiries about the reasons for the reluctance of patients to stay in hospital, Cope came to the conclusion that this was because of the verminous state of the building and the poor food. (The reluctance was nothing new — the same attitude had prevailed for the same reasons during the German period.)

The hospital was indeed infested with lice and bed-bugs, despite the best efforts of the staff, and this, as well as tribal custom may have caused patients to prefer to sleep on the floor. The wooden walls and bedsteads taken over from the German government were an excellent breeding ground for vermin. Shortly after the South African take-over, all the partitions were removed, the German type bedsteads destroyed and the walls and ceilings cleaned and sprayed with alum and disinfectant. Iron bedsteads and Malta beds were introduced as they were easier to disinfect. However, the wooden linings of the walls made it impossible to eradicate the problem, despite regular spraying and cleaning. Also, despite all steps taken by the hospital staff, new infestations of vermin were constantly introduced by new patients, as well as their many visitors.

Dr L. Fourie, the medical officer of health, refuted the complaints about the food, saying that no one ever complained about not receiving enough food; in fact, most patients managed to put on weight, despite their sending part of their daily rations home to their families! Every patient on 'full diet' received the following: 250 g mealie-meal, 500 g meat, 500 g bread, 125 g beans/rice or 500 g vegetables (twice weekly), 30 g tea or coffee, 60 g sugar, 600 ml milk, 15 g salt, 30 g dripping and 60 g jam (once a week). The greatest dissatisfaction was caused when the supply of fresh milk was inadequate and condensed milk had to be substituted.

The government hospital for blacks had 100 beds and a staff of five whites and 25 blacks to serve 732 admissions and 1 882 out-patients during 1921.<sup>46</sup> Since no mattresses were provided, the patients had to sleep on the bare bedsteads. Many patients in fact preferred to sleep on the floor.<sup>47</sup> No sheets were supplied, and the blankets in use were old and threadbare. The enamel plates and mugs in use were badly chipped, but kept as clean as possible. According to Dr Fourie, however, the patients were often neglected while the black orderlies sat outside, smoking and chatting.

Due to the congestion in the hospital, it was almost impossible to keep the place clean; so in 1922 the number of beds was reduced to 75. By 1926 however it was decided to make extensions: Four new blocks contain-

ing wards with 52 beds, a kitchen block and an isolation block with two beds were erected at a cost of £6 000.<sup>48</sup>

In May 1929 the municipality appointed Miss Rose Mokwene (later Mrs Pieterse) as the first district nurse for the Main Location. She worked from her home, as there was no clinic building for her use. Her 'clinic' consisted of two rooms, one of which she used as a dispensary and the other as her living quarters. When she married, her husband added another two rooms at his own expense.<sup>49</sup> Nurse Pieterse's salary was £10 per month.

Between 1934 and 1939 various attempts, some more successful than others, were made to improve the hospital for blacks in Windhoek. Electricity was connected to the hospital in 1935, and water-borne sewage in 1938, while two new wards for venereal disease patients were built in 1938/1939 as part of the SWAA's campaign against this disease.<sup>50</sup> However, attempts by the board of the hospital for whites to persuade the SWAA to lend them between £30 000 and £40 000 to build a new hospital were firmly rejected in 1938.<sup>51</sup>

## CONCLUSION

Despite its generally unsatisfactory system of sanitation and health facilities, Windhoek was a surprisingly healthy town, with few deaths and no epidemics occurring as a result of these conditions. This could be ascribed to Windhoek's moderate climate, the low humidity which discouraged the growth of bacteria, and the relatively small population who did not live under congested conditions. Thus, even if a number of people contracted an infectious or contagious disease, it did not easily take on epidemic proportions.<sup>52</sup> Also, despite the chronic shortage of funds between 1915 and 1939, the Windhoek municipality and the SWAA managed to maintain an acceptable standard of hygiene, at least in the 'white' part of the town. Although by modern standards conditions in the Main Location appear to have been a health hazard, one can only conclude that the situation must have been adequately controlled by the town's health authorities. □

<sup>43</sup> N. Etherington, 'Missionary doctors and African healers in Mid-Victorian South Africa', *South African Historical Journal* 19, 1987, p. 85.

<sup>44</sup> Poewe, *The Namibian Herero*, pp. 186-188.

<sup>45</sup> SWAA A.340/4: R.S. Cope — Native Commissioner, 27.10.1924.

<sup>46</sup> SWAA A.312/5: Public Health Report for 1921.

<sup>47</sup> SWAA A.340/4: Memo re Windhoek Native Hospital, 26.11.1924.

<sup>48</sup> PWD 587: Director of Works — Medical Adviser to the Administration, 11.4.1925.

<sup>49</sup> SWAA A.344/6/1: District Nurses, Windhoek Location.

<sup>50</sup> SWAA A.340/8: Native Hospital Windhoek, buildings.

<sup>51</sup> MWI 1/2/45: F.P. Courtney-Clarke — Secretary Hospital Board, 23.11.1937.

<sup>52</sup> Interview with Dr B. Schickerling, 1988.