REGIMENTAL DOCTORING IN A BATTALION OF THE KING'S AFRICAN RIFLES

BY

Captain C. A. VEYS, M.B., Ch.B.
Royal Army Medical Corps
R.M.O., 6 K.A.R. Dar es Salaam, Tanganyika

The following account is based on eighteen months' experience as R.M.O. of the 6th Battalion K.A.R. stationed at Dar es Salaam, Tanganyika, East Africa.

Dar es Salaam, the coastal capital of Tanganyika, is situated almost directly opposite Zanzibar Island. Its Arabic name means the "Haven of Peace" and despite the hustle and bustle of the modern world that centres round the new deep water berths of the harbour and the modern almost sky-scraper buildings in town, this title is still appropriate, particularly as one looks out from the yacht club across the calm waters of the bay at the many and varied boats that sway at their moorings.

This Haven has a colourful mixed population of several races. There are about 4,500 Europeans; 25,000 Indians and Pakistanis; 2,500 Goans; 1,500 Arabs and an African population of approximately 93,000. Needless to say this very cosmopolitan and multi-racial group live in smooth harmony together.

From June to September the climate though tropical is delightful with sunny cloudless days and a gentle breeze followed by cool nights. It can be very hot and humid from November to March when the heavy rains bring welcome relief. The average mean maximum and minimum temperatures are 86° F. and 71° F. respectively.

The prevalent endemic disease is malaria, exclusively malignant tertian in type. All military personnel and their families on station take a prophylactic anti-malaria drug (paludrine) as well as observing such other preventative measures as the use of nets, repellant, long sleeved clothing and so on.

Here where P.U.O. is a diagnosis because of the many different types of virus fever not yet recorded in the literature, a unit R.M.O. might record a pyrexia of 106° F. one evening and find the same patient normal next day.

Clinical material provides a wealth of interest such as malaria, leprosy, filariasis, relapsing fever, the dysenteries, tuberculosis, poliomyelitis, bilharziasis, sickle cell anæmia, all types of venereal disease and many others, all met in the course of normal everyday experience. For those with a desire to sharpen further their clinical acumen, diseases such as typhoid fever and smallpox can be seen in the civilian isolation hospital not uncommonly.

6 K.A.R.

The K.A.R. cantonment is situated some eight miles out of Dar es Salaam close by a very warm and buoyant Indian Ocean, refreshingly cool in the cold season, rather like taking a warm bath in the hot season. The camp is five years old, the quarters are modern tropical bungalows in design, and the officers' mess
with a superb view and setting on top of Observation Hill is probably the best in the command.

The European and African population of the station totals about 1,500. This figure includes wives and children both of Europeans and askaris. The picturesque colourful clothing of the bibis, their wide-eyed tatos, the rhythmic drum beat and dancing on a ngoma (celebration) night typify this dark continent.

Thus the unit R.M.O. (in this station) is responsible for the medical health of about 1,500 persons and his work entails both the specialist aspect of military health and the medical and welfare aspects of a general practice. This, consisting of patients with two completely opposite extremes in health, living standards and background, fully occupies the R.M.O.'s time with malaria, midwifery and measles, dealing in drains, "devilry" and diseases. However the work is more than interesting and the experience gained is invaluable.

Recruiting

The medical standards for a potential recruit are very high and only those completely physically fit are acceptable. Normal vision and hearing, good muscular co-ordination and development, and a minimum standard of height and weight are all necessary if the raw recruit is to complete his strenuous basic training satisfactorily.

It is remarkable how quickly recruits evolve into trained askaris. Recruiting is not done locally but out on recruiting safaris throughout Tanganyika. These safaris take place two or three times annually.

Necessarily the medical examination for entry is a very thorough one and includes a routine X-ray of chest, examination of urine and so on. The chief causes for rejection on medical grounds, apart from obvious physical defects are markedly enlarged spleen, umbilical hernia, albuminuria (mainly due to bilharziasis), chronic otitis media, and respiratory diseases (often tuberculosis). Other causes are corneal scarring and especially extensive pre-tibial scarring which results in papery-thin healed skin that breaks down easily. Poor muscular co-ordination is common especially the inability to close one eye.

The medical aspects of recruit training are those that result from an adaptation by the recruit himself to a completely regular and strenuous way of life, quite foreign to his nature and experience to date.

The regular food, the diet less bulky but more nutritive than before, soon fills out any hollows but it gives him dyspepsia and diarrhoea; his boots cause blisters, moist feet and tinea; his clothes raise a prickly heat rash, but all these discomforts occur only at first.

The condition of a recruit at the end of training is superb in comparison with that on entry. An average weight gain is ten pounds and he goes back to his village on leave, proud and ostentatious over his new statistics and status.

The askari

The trained soldier or askari is often a slightly built but muscular man some 66 inches high and weighing 140 pounds. He has an unusual sense of humour,
shown at its best when his fellow is in a predicament. His character is a likeable one and he is a fine soldier to train and work with. His face and body may still be rather extensively marked with tribal decoration, particularly his ears whose lobes mechanically stretched might reach almost down to his shoulders, were it not that they are discreetly wound round the rest of his ear for anchorage.

Tribal removal of teeth is common, generally the upper or lower incisors. One tribe, the Jaluo, do this, it appears, in order that a potent herbal medicine can be poured down the permanent gap thus formed in all circumstances. For the patient the disease of practical importance is the affliction with the “fit” when the mouth is clenched tight. This practice of removing teeth may have been the primitive forerunner of our artificial air-way, but nobody can remember the name of the witch doctor who first thought of it.

The African is very proud of his or her personal appearance as the following story indicates. The African R.S.M.’s bibi was involved in a difference of opinion with another bibi. As a result of their exchange the former suffered the indignity of having her pendulous left ear lobule badly torn, so that the two ends hung down rather like tassels. Three days afterwards with her wounds partially healed she sought medical advice. The wounds were allowed to heal completely then re-incised and the two ends stitched together again. As there was not much tissue left to join, the ear healed giving an almost normal appearance. She is eminently satisfied and pleased with her newly acquired beauty and is now insisting that the other side be trimmed down to even things up!

The askari has firm faith in his medicine (dawa) and believes that an injection will cure all; even his inoculations are readily accepted in the belief that great strength is thereby imparted by this “white magic.”

There are those, however, who still believe very much in “black magic,” and the following three cases are interesting in this respect. An African clerk patiently underwent many treatments for alopecia and then politely but adamantly stated that his hair would not grow until the curse had been removed by his village medicine man, and the necessary herbal ointments applied. He went on leave and returned cured!

Two other cases are concerned with “devilry.” An askari rifleman requested permission to take his wife back home to her village because she was possessed by a devil, it being well known that she came from a family possessed of devils which were handed down from one generation to the next. She was sent home and subsequent exorcism of the migratory devil was successful.

Finally there was the case of an askari who was possessed by a violent devil. One morning this devil after chasing the soldier all round his quarter, bit him on the arm. He reported special sick very out of breath, nursing an imaginary wound and complaining of pain all over the body due to the poison of the bite. Both for the medical officer’s and the patient’s peace of mind the treatment prescribed was two A.P.C. tablets and a gentian violet dressing to the non-existent wound.

With cases of this kind, provided that malingerers are sifted out, it is important
that genuine requests for witch doctor therapy are given a fair trial. These cases are few but experience shows that they do not otherwise do well on "white magic."

**Medical aspects of normal routine**

Despite the unfavourable climate the fitness and health of the troops remain generally good. Military training and hygiene are the two most important factors contributing to this.

The African families however, clinging stoically to their more primitive ways and culture, derived from their dwelling together with their livestock in simple huts of mud and sticks, provide most of the medical problems. Vitamin deficiencies and diseases resulting from bad hygiene are most commonly encountered. An African mother invariably breast-feeds her infant, who remains permanently slung to her back and is fed on demand. Totos up to nine months do well, but because breast feeding is very prolonged and their diet is a poor one anyway, it is a question of the survival of the fittest subsequently. Great advances in this respect have been made through the institution of the Battalion Welfare Clinic where advice is freely given and supervision maintained.

The askari trains hard and is well adapted to the hazards of sun and climate. During battalion route marches which the unit R.M.O. accompanies, liberal but controlled fluid intake and extra salt in tablet form is taken. Company or platoon groups on training are usually accompanied by a nursing orderly with medical haversack containing first-aid dressings, etc. A snake-bite set is also taken. Although there are some deadly poisonous snakes at large, such as cobras, puff adders and mambas, snake-bite is uncommon because snakes have acute hearing and usually take evasive action.

The African, very much of a walking race, can march long distances. He never wears a shirt on marches, seems immune from sunburn and the chafing of the rough webbing of his equipment. His marching song has a wonderful lilt and tune, characterising his inborn gift of rhythm. The commonest injuries received on training are fractures of the leg and collar bone, and internal derangements of the knee.

**Sick Parade**

This averages about fifteen daily, and is roughly the accepted two per cent of numbers. There has never been no attendance, and like any unit the attendance is high on Monday mornings and on the day of the R.S.M.'s parade.

True defaulting is rare, but an exaggeration of alimentary dysfunctions, diarrhoea or constipation is common. Symptoms relating to his bowels are of a serious nature to the askari. His simple but biased belief sometimes blinds his common sense as is illustrated in the following tragic story.

A ten-day-old baby was brought to the M.R.S. quite rigid and grimaced with neonatal tetany, which it appears had been present for several days. The complaint of the parents was only that the child had been constipated for two days and it was still this that worried them, even though the true nature of the disease was continuously explained until the infant died.
The total average malaria rate is 8 per month (for A.O.Rs. and families), but this varies seasonally. During the last 18 months there has been no case of malaria recorded amongst Europeans on this station. It may seem surprising that there should be any malaria at all in a potentially protected population. Remembering that mepacrine, which is the drug at present taken by all the Africans in camp, is a suppressive; that malaria commonly breaks through when there is a concurrent infection; that troops and families fail to take their mepacrine regularly on leave; and that it is not easy to survey adequately the taking of a suppressive drug by the families who do not parade like the troops, this incidence is understandable.

Venereal disease of all types is seen on sick parade, but gonorrhoea is most common. The V.D. rate is only about 4 per month. Colds, influenza, bronchitis, tonsillitis, otitis and conjunctivitis comprise the majority of those reporting sick, just as they do in the United Kingdom. Pain in the chest (lower sub-ternal in position) is a very common complaint for which no etiology has been found. Bacillary dysentery and bilharziasis are not uncommonly seen, amoebic dysentery is unusual. The remainder are either worms (all types), wounds or wind. This latter refers not only to flatulence but also to the elaborate way in which the African likes to describe his symptomatology.

Admission to civil hospitals and civilian liaison

There is no military hospital or ancillary diagnostic service for this unit. All these services are provided by the Government Medical Service, the Tanganyika Ministry of Health.

A very good and close liaison exists between the unit R.M.O. and the civilian doctors in Dar es Salaam. This is only maintained by continuous and frequent personal contact necessitating many visits, almost daily, into Dar es Salaam.

These visits are to the Ocean Road Hospital (European), Sewa Haji (African), Muhumbili Hospital (maternity), the Pathology Laboratory and the Medical Officer of Health. As much as possible, except surgical and infectious disease, is treated in the M.R.S. The askaris prefer to remain on station where they receive grade 1 hospital treatment. Early discharge, partly because of a bed shortage in the civilian hospitals is common, and the askari or his family complete their treatment or observation in the M.R.S.

All medical stores and equipment are obtained locally from the Government Medical Stores, and invaliding procedure is by a two-man board, the R.M.O. and a civilian doctor. A close liaison also exists with the civilian Red Cross, who provide the battalion with many excellent first-aid pamphlets in Ki-Swahili.

The blood transfusion service relies a great deal on the donor register composed of A.O.Rs., many of whom have given blood several times.

The M.R.S.

This is without doubt the battalion show piece and rightly so, because if the medical welfare of the askari is being well catered for, then all other aspects fall in line at a similar level.
The hospital half of the M.R.S. is composed of three wards. There are two six-bedded wards for A.O.Rs. and a six-bedded ward also containing three infant cots, for the African families. Other facilities include a well-equipped labour room with an obstetric bed, a minor operating theatre, sluice and laboratory. The latrines, showers and bathroom are all in separate but adjoining buildings. The M.R.S. is decorated throughout according to the latest colour scheme which is complimentary to the African's sense of colour.

As there is no other R.A.M.C. or European staff, a heavy load of administrative duty falls on to the shoulders of the unit R.M.O. and steals time that can be ill spared from his patients and other medical duty.

The African personnel consists of five nursing orderlies and a resident civilian midwife who also runs the families ward and assists at the Welfare Clinic. The battalion kindly lends a clerk. With such a small staff the problem is finding enough pairs of hands to run a dispensary, deal with the flock of bibis and totos that descend daily at 0930 hours for their consultations, and administer to the three wards.

Visiting groups of African students, civil servants and sub-chiefs are all tremendously impressed by the high standard of the hospital and its service, and are amazed that it is a free service. Dispensary treatment is given to the civilian employees, such as grass cutters working in the camp and to personal servants of the British households.

Patients admitted to the A.O.R. wards with diagnoses as previously indicated are usually short-term, but there is ample opportunity and provision for treating the long-term case such as rheumatic fever and petrol burns of the forearm, in co-operation, of course, with the hospital consultant. Such cases can and have been successfully treated in the M.R.S. and the askaris much prefer it this way.

The admissions to the families ward form a rather mixed bag. Apart from the midwifery patient, cases of malaria, P.U.O., respiratory infections, scabies, measles and chickenpox and not uncommonly miscarriages all receive in-patient treatment. The bibi is the beast of burden in the African household. She tills the shamba (fields), carries the heavy bundle of sticks on her shoulders and thus away from her toil is an unwilling and difficult patient to keep confined to bed.

Immunological procedures constitute a major part of normal routine work. The institution and maintenance of a full vaccination programme against smallpox, yellow fever, tetanus, enteric fevers and an increasing poliomyelitis programme for 1,500 persons require many long injection sessions. The bibi's reaction to the initial needle stab is interesting in that they cover their heads with their shawl in order to hide any facial expression. The older children fight madly, while the infants still clinging and asleep on their mothers' backs only wake up after it is all over.

Often in appreciation of "medical services rendered" the M.O. has found a live chicken in the back of his car or a hand-made reed basket containing a dozen eggs.
Midwifery and welfare

During the last seventeen months 157 patients were booked for delivery, of these 132 were seen in labour and the remainder were either transferred to another station with their husbands, or returned home to their villages for their confinement. This is a relatively common practice in Africa. Twenty cases were hospitalised and sent to the Muhumbili Hospital, because of some anticipated difficulty or complication developing during labour. Many of the conditions listed between hyperemesis gravidarum and post-partum haemorrhage in the text-books are seen, so that a sound knowledge of obstetrics is required. Ergometrine is used routinely and analgesics are not commonly necessary. The African *bibi* accepts the pain of labour, has a relatively easy one and her baby tends to be a small one. Only on coercion does she stay in the ward for three days post-partum. An interesting and more common minor pelvic abnormality is “straight sacrum,” probably contributed to by her posture and stance resulting from the ever present child or load slung from her shoulders.

Welfare work, its meaning and voluntary aspect is not readily understood by the African. It is new to his culture, but is now rapidly becoming part of it. An excellent welfare clinic is held weekly for African families. It embraces the post-natal care of the mothers and their infants and is the advice bureau where problems of feeding and weaning are solved. The medical officer’s wife, a trained State Registered Nurse, assisted by some of the other wives does a great job of work in running the Colito Welfare clinic. It is from this clinic that the families really do derive most benefit. Quite often medical conditions are discovered, and thus therapy is instituted more promptly and surely than would otherwise have been the case. At the clinic a simple colourful shirt is given to each new infant booked in, regular weighings recorded, and issues of U.N.I.C.E.F. milk, cod liver oil, vitamin D and calcium tablets are handed out freely.

Relaxation

In this climate this is one of the most important aspects too often neglected, to his detriment, by the hardened second tour soldier. East Africa in this respect offers more than most places. Here in Dar es Salaam the sports of the sea, swimming, sailing, goggling and deep-sea fishing all abound. Throughout the rest of East Africa, the once-in-a-lifetime opportunity for game photography or hunting should not be missed. The luxury, excitement and adventure of a visit to the fabulous “Treetops Hotel” can never be forgotten. This is a land of sunshine and colour photography.

Past, present and future

In conclusion, and looking back over the last eighteen months it is interesting to note what has been achieved, and what might be further achieved by future R.A.M.C. officers.

The most important achievement has been without doubt the establishment, where none previously existed, of a doctor-patient relationship between the African family and their European medical adviser. It is a complete breakaway
for the shy, simple *bibi* to come forward with personal medical problems, such as infertility, to a foreigner of the opposite sex. A lot of the credit must go to the African nurse-midwife who has acted as the indispensable mediatrix. The introduction of this post and the provision of full midwifery and other facilities in the families ward are all major advances.

The complete redecoration of the unit M.R.S. incorporating the latest in colour schemes, and the provision of new bed screens, individual overhead lamps, formica topped tables, are all improvements that have resulted from opportunity and progress.

The introduction of a complete ante-natal clinic with documentation and routine laboratory investigation comparable to that at home, has come about because the present medical officer has had a particular interest in this subject. It is hoped that a successor will continue this and introduce further innovations.

For the future, it is hoped to blood group every African soldier and then to encourage him to join the donor list; to pass the regimental stretcher bearers through the Red Cross first-aid certificate; and possibly to embark on a small research project, proving or disproving that on normal dosage régimes of anti-malaria drugs, enough of this passes through the mother's breast milk to protect her infant adequately.

Although this description has been of one particular K.A.R. station, it is a fair assumption that the others are for the most part similar. Perhaps then this article may give a better idea to those others, who, like myself at one time, knew little of a most rewarding and personally satisfying work with the K.A.R.

My thanks are due to Lieut.-Colonel T. A. Pace, O.B.E., A.D.M.S. East Africa Command for his suggestion that this paper should be written in the first place and for his advice in its preparation.
The M.R.S. Staff

Toto being weighed

The Askari

A.O.R. Ward
Win a DIPLOMA in the
ROYAL ARMY MEDICAL CORPS
Regimental Doctoring in a Battalion of the King’s African Rifles

C. A. Veys

J R Army Med Corps 1960 106: 55-e2
doi: 10.1136/jramc-106-02-02

Updated information and services can be found at:
http://jramc.bmj.com/content/106/2/55.citation

Email alerting service

These include:
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/