

**Nursing Services and Training in South Arabia
during the Late British Colonial Period: 1950-1967**

A thesis submitted in partial fulfilment of the requirements of
the Manchester Metropolitan University for the degree of
Doctor of Philosophy

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Declaration

No portion of this work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institution of learning.

Dedication

In loving memory of my father, Saeed Fareh Mohammed, "*Saeed Durrah*"

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Abstract

Nursing services and training in South Arabia during the late British colonial period: 1950-1967

The history of nursing in South Arabia (SA) during the late colonial period has not been well researched. This study aimed to provide a comprehensive account of nursing services and training in the region from 1950 to 1967, against the background of the colonial context and the local setting.

This research was conducted through the gathering of first-hand accounts. These were carried out in the form of oral history interviews with both South Arabian nurses and British nurses who worked as nurses in SA. In addition, the research draws on data obtained through documentary and archival research.

The study found that, although nursing services were enhanced and amplified in SA between 1950 and 1967 by the British colonial administration, there was a lack of government and institutional planning, and the provision of nursing services was variable and uneven. Nurse training was basic and variable, with males tending to receive more professionalised training than females. Furthermore, the benefits of colonial nursing services brought to the population as a result of the colonial presence was as much by individual endeavor and the work of charitable organisations (such as the British Red Cross), as it was by any sort of overall intention on the part of the colonial authorities. This research has shown that in addition to the absence of overall planning of the nursing services during the period of the administration, the colonial dominance was extended through nursing in many ways: the colonial nurses dominated the nursing workforce; the local expertise was undervalued; and nursing management positions were limited to the colonial nurses. This study contributes to our understanding of the history of South Arabia and should also be of particular interest to scholars who have an interest in the history of nursing during the colonial period.

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List of Abbreviations

AD	Anno Domino
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APL	Aden Protectorate levies
ARB	Air Raid Precautions
BCG	Bacille Calmette-Guérin
BP	British Petroleum
BRC	British Red Cross
CE	Common Era
CH	Civil Hospital
CF	Consent Form
CN	Colonial Nurse
CO	Colonial Office
CAN	Colonial Nursing Association
ENT	Ear, Nose and Throat
FAA	Federal Arab Army
ME	Middle East
NHS	National Health Services
ONA	Overseas Nursing Association
PIL	Participant Information Leaflet
PBUH	Peace Be Upon Him
PDRY	People's Democratic Republic of the Yemen
PMRAFNS	Princess Mary's Royal Air Force Nursing Service sisters
QEH	Queen Elizabeth Hospital
RAF	Royal Air Force
WRAF	Women Royal Air Force
RGN	Registered General Nurse
ROY	Republic of the Yemen
SA	South Arabia
SIM	Sudan Interior Mission
S.R. N	State Registered Nursing
TB	Tuberculosis
TPR	Temperature, Pulse, Respiration
TNA	The National Archive
UAE	United Arab Emirates
YAR	Yemen Arab republic
UK	United Kingdom
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting
UN	United Nations
UNICEF	United Nation Children's' Fund
WHO	World Health Organisation
WVS	Women's voluntary Services
WWI	World War I

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Chapter One: Introduction and Orientation

Introduction

Forms of human organisation cannot be properly understood by simply observing and analysing the way they appear to us today. The way we see them today is without exception but a 'snapshot' of what almost invariably happens to be a result of many complex events and changes which have occurred in the past. We also need to recognise that forms of human organisation will inevitably keep evolving and changing in the future. Therefore, as all human phenomena are the result of historical actions, in order to understand the present, we need to have a proper understanding of the past. And it is here where the importance of exploring the past rests.

With nursing as with any social, political and cultural (including religious) phenomenon, it is necessary and profitable to explore and examine its past, including issues that were critical in its development and played a major role in determining its status. In the west, for example, substantial and well-documented literature about the history of nursing, whether in America or in Europe, exists. Perhaps one of the most interesting areas of history of nursing which has been recently developed is the colonial history of nursing or history of nursing in the colonies. This new history is dedicated to take into account the life and experience of nurses, and mainly the Colonial Nurses (CN), outside the boundaries of the colonial centre, or in other words within the boundaries of the colonies (Rafferty, 2005). This study, however, in an attempt to explore the available nursing services and the initiation of nursing training in South Arabia (SA), considering only the period from 1950-1967 when South Arabia was under the British control. SA is allocated in the South part of the Arabian Peninsula. Since 1990 and as a result of the unification between the Yemen Arab republic (YAR) and the People's Democratic Republic of the Yemen (PDRY), SA has been part of the Republic of the Yemen (ROY) (Dresch, 2000). Prior to the deportation of the British, the PDRY used to be called SA. As this research is considering nursing history during the colonial period, only the region of SA will be considered. It will endeavour to explore issues in regards

to nursing and the establishment of nursing services and the training institutions within a colonial setting which is South Arabia. This history is currently absent from the published literature.

This chapter will give a brief account to the intention as well as the rationale for conducting this study, and set out the aims and the specific objectives. It will also give a summary of the design of the study.

1.1 The intention and purpose of the study

From the beginning, when this study was merely an idea or, more accurately, an enquiry in the researcher's mind, the key questions being considered were: when was nursing as a profession that needs training first considered in SA? And what are the historical and ideological foundations on which the nursing in Aden and the protectorates of SA, in the state we find it now. What other factors were involved? And what were the twists and turns of its development?

Knowing the history of a phenomenon such as nursing can uncover the reasons behind a multitude of present-day situations and, by the same token, can become a powerful tool to find meaning, direction and sense in present-day situations and powerful clues as in what direction apparently insoluble present-day problems may find a solution in the future. There is, therefore, a powerful incentive and, at the same time, a rationale to find out about the history of nursing in SA. However, although exploring the past is crucial for the present, my study will attempt to explore the early foundation of nursing services and training for the sake of knowing what happened in the past. This history is largely un-documented, and has not been considered in the literature or explored before. Hence, I decided to embark on this study in order to shed light on a small part of the history of nursing in this particular part of the world.

So whether it is a curiosity or merely an interest it is after all as (Elton, 200270) accentuates:

“The desire to know what went before, the desire to understand the passage down time. These are common human attributes”.

As mentioned earlier, the history of nursing not only in SA but in the whole region of Arabia in general has not been established or documented; it remains unidentified and neglected. Despite the fact that people of this profession (nurses) in this particular part of the world over the years have worked hard to develop and sustain its present form, many of them have been unable to explore its history and phases of its development. The demands on nursing and nurses in this part of the world as everywhere else are very great, leaving very little time for nurses to take much of an interest not only in the history of their profession but also in any nursing related research. In addition, nurses may not feel encouraged to do so, partly because of the very low status attached to the profession in SA. A further obstacle is the fact that there is little funding or interest in the nurse training institutions for conducting research of any kind. Finally, as has already been mentioned, nothing was written about the history of nursing in SA in general and during the British control in particular, and what is available is difficult to access.

In identifying the most important historical factors that have influenced nursing in SA, the work and experience of those who went before us in the nursing field are in the heart of this research. Certain convergences and trends in this discipline will thus be detected and explored within the appropriate, explanatory context. In SA, what people know about nursing in the past remains in their mind as memories. And this study will be one of the first in its kind to put these memories on the record.

The study might provide a grounding to teachers and students who are teaching or studying nursing in the Arab world in general and SA in particular. Furthermore, exploring the developmental stages and the history of nursing in SA, as in many countries in the region has never been of any particular academic interest, and it is the time for it to be properly and academically explored. In addition, it would be interesting to find any accounts on the history of nursing in this particular area since it has its own special cultural background

which could potentially give new insights which inform the history of nursing in general and history of nursing in the colonies in particular. There is no doubt that because of the uniqueness and pioneering nature of this research, a lot of interest will be generated, prompting others to carry this research even further and deeper.

This study therefore attempts and aims to explore and make sense of the history of nursing in SA. In SA and within its geographical and political boundaries and surroundings, nothing or at least very little has been written about nursing in the period 1950-1967. The study will primarily focus on the provision of nursing services and the establishment of the early nursing institutions while SA was under the British control specifically in the period from 1950 to 1967. Hence, the study will inevitably consider the colonial context of that period. In fact, it will predominantly examine this history of nursing within this exceptional setting which is the colonial setting. It will pay particular attention to the health, health services and nursing services and the training institutions established by the colonial power in the period 1950-1967.

1.2 The design of the study

The historical method or historical research, which is considered as one of the qualitative research methods, will be employed in this study. Such an approach has been chosen in order to answer the research questions, where a holistic, largely narrative and descriptive understanding of a phenomenon is required (McNeill and Chapman, 2005; Creswell, 2012; Flick, 2009). Oral history interviews as well as archival searches will be the main research tools that are used.

Furthermore, to arrive at the right philosophical perspective and methods by which to analyse these fundamental research questions, so as to arrive the researcher's own appropriate epistemology, requires in-depth research into a wide range of literature sources covering a range of other disciplines. Such literature research will also generate a personal awareness of the diverse

methodologies and the congruence or conflict with specific research methods, and may also avert any complications or mistakes that may occur related to lack of knowledge of certain techniques and research rules. It is indeed fundamental to explore whether other people share the same concerns about this particular topic if found. A great deal of literature has been found on research methodologies, for example: (Graziano and Raulin, 199); Abbott and Sapsford, 1998; and McNeill and Chapman, 2005). Creswell, (Creswell, 2012) work highlights the strengths and limitations of each approach. There is also copious resource material on the philosophy of history in general, such as the work of Hegel, 1956; Khaldun, 1967; Dray, 1989; and Lemon, 2003. There are many historical documents on the British colonial period in SA but these documents focus more on Aden the main city in SA for its importance as a Crown colony during the studied period of time. The ones of more interest to this study, especially those highlighting the political and the economic aspects of that period, have been described and discussed in one of the later chapters of this study. It is also crucial to mention that very little on the public services, and health services in particular, during that period were found. Some reasons for the dearth of such important material will be discussed at a later stage. This study therefore will attempt to answer the following questions:

1.3 Research questions

The specific research questions addressed by the study are as follows:

- i) Who provided nursing services in SA in the period 1950-1967?
Where and how was this provision organised?
- i) What was the role of nurses within the overall provision of health services in SA?
- ii) What do we know about the people who worked as nurses in SA in 1950-1967?
- iii) When did nursing training start in SA, and where did it take place?
- iv) What was the nature of the nursing training, and who provided nursing training in SA in 1950-1967?

1.4 The organisation of the thesis

This thesis is organised into nine chapters, including this chapter. Chapter two consists of three parts: part one, reviews the literature on history as a discipline and the writing of history. Part two then examines the early writings on the history of nursing in the United Kingdom (UK), taking into account Florence Nightingale as a legendary figure who dominated accounts on history of nursing in the UK and in the west in general, in addition to reviewing accounts on the history of nursing especially during the colonial period and within colonial settings. Part three of the literature review chapter is dedicated to review accounts on the history of nursing in the Arab World.

Chapter three provides a historical overview of SA, the setting for this study, focussing mainly on the period when SA was under the British control. Although in this chapter, I reviewed the literature in regards to the history of SA in terms of its political, economic and social dimensions, we had to use data obtained from primary sources in order to make sense of the social aspect of SA during this colonial period. This is because this perspective which is the social aspect of the colonised population is largely absent in the documented history that is available.

In Chapter four the methodological approach and the procedures used in order to answer the research questions are explained. Chapter five explores and discusses the health care services available in SA in the period of time under study. Chapter six defines and discusses the available nursing services in SA in the same period. Chapter seven explains and discusses nursing training available in SA in the period under review. Chapter eight sought to review issues that emerged as a result of reviewing this particular history of nursing in SA, and which inevitably existed as a result of the colonial presence: issues such as the colonised personal and society views towards nursing, the colonised culture and nursing profession, colonial nursing and colonial nurse terms to revisit. Chapter nine concludes the thesis and defines the limitations of this study and puts forward suggestions for future studies

Chapter Two: Literature Review

Overview of Chapter Two

This chapter will provide a review of the literature that is relevant to this study; it will provide an in-depth understanding of the topic of history of nursing and issues around it. It consists of three parts: Part one, will attempt to give an overview of the intellectual progression of history as a discipline, from the purpose of studying history to sets of propositions around its definition to where, as an academic discipline, history intellectually stands. This is examined by referring to contemporary debates, issues and questions in the field including debates around the writing of history. Part two, will critically examine the early writings on the history of nursing in the UK; it will also give particular consideration to Florence Nightingale as a legendary figure, and who dominated the accounts of history of nursing in the UK, her international influence and critique, in addition to recent accounts on writings on the history of nursing especially colonial nursing will be also examined. The last part of this chapter, will review accounts on the history of nursing in the Arab World

2.1 Part one: The Theory of History

This research is organised around three key words which are 'history', 'nursing' and 'SA'. This part of the literature review explores the first of these for it is important to understand what the term 'history' means and how it is used by different writers in the field, it is also important to understand the different methodological implications of some of the more influential definitions of history.

2.1.1 What is History?

In order to situate 'nursing' and 'SA' in their proper historical context, our attention will first have to turn to the meaning of history and on how history is different from the past. Jenkins (Jenkins, 1991: 6) in *Re- Thinking History* believes that one should understand:

"The difference between the past and history".

As the two are certainly not the same and that history is:

"A serious talk about the past".

(Jenkins, 1991:6)

And thus history is not the past itself, and that it is historians who give meaning to the past through their literature. In order to strengthen this viewpoint, Jenkins gives an example of a landscape as a phenomenon, which can be viewed and seen differently by different people, and thus understood and interpreted differently. Jenkins asserts that it is historians who create history and, as an utter truth, is *"unachievable"* (Jenkins, 1991:28) Jenkins believes that: *"Truth is always created and never found"*

(Jenkins, 1991:31)

Elton¹ (Elton, 2002) in the same vein asserts that history or studying history cannot possibly be concerned with studying the past itself; it is rather the studying of present traces of the past. History is every word, idea, behaviour or feeling, which has been said, thought, done or experienced by man in the past and which has left a present trace. The past according to Elton is finished. We can rebuild it, and make sense of it but no one can live it again (Elton, 2002). Elton is regarded by many as one of the devoted guardians of the conservative methods of history, and a powerful opponent of postmodernism. His book *The*

¹ Geoffrey Elton was a German-born British historian, who specialized in the Tudor period

Practice of History (Elton and Evans, 1967) has been viewed by many to be largely a response to Carr's book *What is History?* (Carr, 1961), which will be discussed in the next paragraph.

Perhaps one of the most famous and controversial debates on the meaning of history is the one conducted between Carr and Elton. The two historians not only thought, defined and viewed history differently but have also contributed to it in a different way. Carr, the English historian and journalist, for example, produced a distinguished contribution to the history of the Soviet Russia. His contribution consisted of a book of fourteen volumes entitled *The Russian Revolution: From Lenin to Stalin 1917-1927* (Carr et al., 1979). The English Historian was badly criticized for his input and apparent advocacy of the communist economy in addition to his philosophical examination of history (Cox, 2000). *E.H. Carr: A Critical approach*, a book edited by Cox and written in collaboration with other international historians, critically examined the life and work of Carr, putting more emphasis on his "unforgivable" contribution to the Russian revolution (Cox, 2000: 4).

Nevertheless, Carr's book *What is History?* (Carr, 1961) although it was first published in 1961, remains one of the most significant books on the history of knowledge in the twentieth century. In *What is History*, Carr defines history as:

"A continuous process of interaction between the historian and his facts, an unending dialogue between the present and the past".

(Carr, 1961:24)

Carr also states that the underlining roots of historical events should be historians' main focus, as the interpretation of those roots has the potential to serve future policy as history should be politically relevant. In fact, Carr's book provoked some historians such as Tosh (Tosh and Lang, 2006) to perceive Carr as a radical scholar. Tosh asserts that Carr's book is:

"Still unsurpassed as a stimulating and provocative statement by a radically "inclined scholar".

(Tosh and Lang, 2006:234)

Munslow (Munslow, 2006), on the other hand, suggests that the significance of Carr's book is reflected in the contemporary British philosophy discussions about the relationship between historians and the past. This book according to Munslow has been misperceived:

"I believe it to be lies in its rejection of an opportunity to re-Think historical practice"

(Munslow, 2006:1)

Moreover, in his *Re-Thinking History*, Jenkins who, incidentally disagrees with the description of Carr as a radical scholar, explores in detail the influence of the two opposing historians Carr, and Elton, and emphasises the fact that the two have indeed different philosophical ideas of history, but with a parallel weight. Jenkins points out that the two aforementioned books are what most of the British history students still study as an introduction to history. *"What is History?" From Carr and Elton to Rorty and White* (Jenkins, 1995) Jenkins not only critically analyses Carr and Elton but also refers to their ways of thinking about history. He argues that historians need to move forward and look beyond their contemporary thinking. Jenkins promotes the idea of replacing the two key figures in history by two postmodern theorists in the persons of Rorty and White. He emphasises that, as a result of different "posts", such as post-feminism, post-colonialism, post-structuralism, and post-Marxism and many other revisionist approaches, the number of historical theory texts have increased enormously, and that this has certainly reflected on the development of history and theory in the last 20 years (Jenkins and Munslow, 2003). Jenkins' book has caused a revolution against the way history used to be thought of, and written by historians such as Carr, Elton, Marwick, and Tosh. In addition, it has introduced a different kind of thinking about history, known as *"theorising history"* (Jenkins and Munslow, 2003:xvii). His advocacy of postmodernism² for

² See HASSAN, I. 1993. Toward a concept of postmodernism. *Postmodernism: A reader*, 152., O'MATHÚNA, D. P. 2004. Postmodernism & Nursing: After the Honeymoon. *Journal of Christian*

example, was very controversial and appeared to many as radical. The radicalism of thinking of postmodernism as an approach for instance, as viewed by Jenkins, to be only within the discipline of history. In other disciplines such as art, architecture, literature, sociology and many others, postmodernism and different other 'posts' were widely used and broadly employed.

The next section deals with another argument around the discipline of history, namely whether history is an art or science.

2.1.2 History: between art and science

The intellectual arguments among history scholars over the meaning and the nature of history have created more arguments around history as a discipline. One of the many issues, for example, centres around the debate as to where this discipline is intellectually placed. In fact, this question has also been raised about the discipline of nursing; one could consider this as a similarity between and towards the understanding of the two disciplines³.

Nineteenth century historians were criticised by scholars from other disciplines. Social scientists on one hand criticised the fragility of historical methods and described metaphors used by historians as basic and simple. They also claimed that historians often make vague assumptions, especially when they address sociological and psychological issues (White, 1966). Literary artists, on the other hand, believed that historians failed to explore the mysterious levels of one's perception, while at the same time criticising historians' reluctance to employ a modern literary image (White, 1966). As a result of these criticisms, many nineteenth century historians came up with a '*Fabian tactic*' (White, 1966:110). The '*Fabian tactic*' is a metaphorical indication of where history epistemologically stands to this day and this can be presented as follows. In response to the criticism of social scientists, historians of that time,

Nursing, 21, 4-11.2004; and COSGROVE, L. 2004. What Is Postmodernism and How Is It Relevant to Engaged Pedagogy? *Teaching of Psychology*, 31, 171-177.

³ See RAFFERTY, A. M. 2005. The seductions of history and the nursing diaspora. *Health and History*, 2-16., she critically examines the similarities between historians and nurses

declared that history cannot be purely scientific as history is based on instinctive as well as investigative methods, and that historical findings should not be assessed by criteria that apply only in 'positive science' disciplines based on mathematics and experiments. Clearly these claims in one way or another imply that history is an art, in other words, a 'soft' discipline within this context. The historian, therefore, had to pacify the disruptive literary artists who disagree with these claims, by declaring that history is a semi-science and that:

" Historical data do not lend themselves to 'free' artistic manipulation"

(White, 1966: 111)

White goes on to write that narrative formulation is controlled by the historical materials in hand and not by the historian himself. According to White, this strategy of defence employed by nineteenth century's historians has been successful in disabling history critics and has permanently granted history as a discipline its epistemological status in between art and science (White, 1966). In fact, within the discipline of history itself some historians such as Collingwood (Collingwood and van der Dussen, 1993) assert that history is both an art and science. It can be considered a science because fact is created inductively and is based on evidence, so history is indeed a science. On the other hand, history has always been seen as a 'narrative' or a novel aimed to reveal or provide facts about what happened in the past and this very often requires '*creativity*' and '*imagination*'. Historians ought to reconstruct within their own mind the views of historical images, extract lost data and examine the reliability of testimony from their own viewpoint, and this makes history undoubtedly an art (Collingwood and van der Dussen, 1993: 240).

Recent historians such as Jordanova (Jordanova and Jordanova, 2000) and Oakeshott (Oakeshott, 1989) assert that history is a holistic endeavour; it is both an art and a science. They argue that as history is a process undertaken as a research project using historical sources in order to make sense of past events, history then is a science. What makes history an art and science from Oakeshott's point of view is that history involves interpretation of historical findings, based on the historian's experience with the use of social science

theories in interpreting data that provide new understanding, styles and visions. Whereas, interpretation according to Windschuttle (Windschuttle, 1994) is about '*analysing documents*', this process according to him is always personal. The subjectivity of interpretation of historical texts or findings by the historian is what removes history from the list of scientific subjects (Windschuttle, 1994).

2.1.3 Discussion around the writing of history

Echoes of the debate, already hinted at in the earlier paragraph, about the objectivity versus subjectivity of historical accounting can be found in Keith Windschuttle's (Windschuttle, 2002) argument in the *History, Truth and Postmodernism* in which he comments on the Australian author Henry Reynolds' thesis in his book *Why weren't we told? A Personal Search for the Truth about Our History* (Reynolds, 2000). In this book, Reynolds makes the point that the meaning of any text is '*in the eye of the beholder*'; people from different ethnic, sexual and cultural backgrounds will read historical evidence in their own way, and that '*way*' will be different to people from other perspectives:

"How could I pretend otherwise? Historians do not shed their ideological clothing or their personal feelings when they venture back into the past seeking to hear the words and to enter the mind of their chosen subjects".

(Reynolds, 2000:3)

By contrast, Windschuttle, an author who is known for being very critical of the postmodernist position in general 'unsurprisingly rejects Reynolds' claim and asserts that the ideology behind this claim is what has caused many historians to make mistakes in seeking the truth about the past. The second claim in this debate centres around the assertion that:

"The writing of history is an unavoidably political pursuit in itself, as a matter of epistemological necessity".

Windschuttle believes that this claim is more acceptable than the first one as it implies that historians can avoid imposing their own prejudices and preferences when seeking truth about the past.

From Carr's definition of history, we can see that Carr closely associated 'history' with 'writing'. However, not all history needs to be based on writing. There is also oral history, which is evidence about contemporary events and phenomena which occurred during the life time of informants (Thomson and Perks, 1998). In cultures where there are no, or very few written accounts, oral traditions may also provide virtually the only connection to understanding the past, as they represent testimony transmitted verbally from one generation to another. This knowledge of the past may be contained in folklore or epic stories or songs and dance (Vansina, 1985). Vansina also differentiates between oral history and oral tradition; she describes the latter as no longer contemporary, as it passes from one person to another, for a period beyond the lifetime of the informants. Kirby (Kirby, 1997:45) in the same vein asserts that:

"The voices of individuals can offer a new perspective even on a well- documented event".

Kirby also points out that, over the last two decades, oral history has become more popular especially for individuals who are interested in areas which are less well-documented. In her article, Kirby lists some of these areas that have been described by Thompson and Perks as "*hidden worlds*". For her, one of the imperative hidden worlds that have come to the fore is that of the history of nursing.

In the past, historians and researchers tended to have scant regard for oral history, putting the reliability and objectivity of oral history into doubt. Written history, by contrast, is fixed and therefore reliable, as it can be verified objectively by independent scholars. Nevertheless, oral history can be very important. For this thesis, oral history is vital because in a region like SA there is a paucity of written accounts and records, particularly in the area of nursing.

However, this does not mean that this part of the world is 'without history'. Therefore, it would appear that one valuable source to retrieve that history is via interviews with people who worked as nurses in SA at different points in their lives. It is indeed the history of nurses whose deeds and labours have never been put into writing, but remains as memories in people's minds what this research has set out to explore. Oral history as a historical methodology will be further discussed in a later chapter.

In the next part of this chapter, discussions around the writing of history will continue, it will deal with writings of nursing history.

2.2 Part two: Writings on the history of nursing

Introduction

This part of Chapter Two sets out to review the relevant literature in order that the study can be properly situated. Four substantive areas will be explored and discussed as follows: (1) issues relating to becoming a nurse historian, including how and why a nurse might become a nurse historian. This area will also consider why some noted nurse historians decided to undertake historical research in nursing; (2) accounts of writings on the history of nursing in the west, particularly some of the early accounts of the history of nursing in the UK; (3) Florence Nightingale as a legend and a historical figure in nursing, her international influence and her critics ; 4) modern accounts of the history of nursing, including writings on history of colonial nursing as a contemporary scholarly activity.

As mentioned earlier, there is a scarcity of writings on the history of nursing not only in SA but generally in the Arab World, as there are no real attempts to document how nursing practice was in the past. Indeed, there are no consistent records, either on nurse training, ways of working and nurse management, or on stories and events that have occurred and affected the profession in this part of the world. There are two likely reasons for this lack of history: first, in SA, for instance, the status of nurses and the condition of their profession does not

permit or encourage any research within the discipline of nursing; research in this area is unlikely to attract what little funding might be available for research, and from the individual researcher's point of view, it is not an area of research likely to lead to a well-paid academic post. Nursing as a profession or occupation has not traditionally occupied a well-respected place in the society in this country. Secondly, doing historical research, whether in the field of nursing or any other fields, requires using historical resources such as, archival sources. There are limited numbers of archives in SA, and those that do exist are either neglected or run and managed by individuals who are not interested in history or by people who are not historians. Likewise, in the west, few records of nursing could be found which date from before the professionalization of nursing that took place in the nineteenth-century (Foster and Sheppard:1980). However, during 1950-1967, SA was under the British control, which, as the research commenced, meant that it was hopeful that it would be possible to find some documents with some references to nursing, or British nurses, or perhaps colonial nurses.

As I embarked upon this study (as a novice researcher), there were certain questions looming in my mind: i) in order to undertake a historical study, or in this case to write on the history of nursing for the first time, are there any particular skills a nurse ought to have or will need to gain in order to carry out a historical study successfully? ii) What are the different motives that tended to drive nurse historians to do or choose to study the history of their profession? The next part of this chapter will attempt to answer these questions.

2.2.1 Issues around becoming nurse historian

Questions such as "why history, why do history, or why become a nurse historian" are perhaps at the heart of every history based study on nursing. Since this study explores a small part of what can be called the concealed history of nursing in SA taking into account the colonial period influence in the period under study (1950-1967), as there are no previous academic attempts

to explore this history, the reasons other nurse historians have studied the history of nursing will be examined.

Chapter one of this study has already presented the reasons for undertaking this particular research study. This section will review some of the relevant literature in relation to nurse historians and their diverse motives for undertaking historical research in nursing. As nursing and history are a completely two different disciplines, discussion on how a nurse can get involved in carrying out a history based nursing study will first be considered.

Capturing nursing history: A guide to Historical Methods in Research, written by Lewenson and Herrmann (Lewenson and Herrmann, 2008) is perhaps one of the most interesting books that not only encompasses contributions of outstanding nurse historians but also stands as an exceptional work in historical methods in nursing research. It encompasses both experienced and novice nurse researchers and intends to equip its audience with tools essential for conducting historical research in nursing.

Lewenson and Herrmann believe that in order to get involved in the history of nursing, nurses should first appreciate the significance of history. In the same vein, D' Antonio (D'Antonio and Fairman, 2010) asserts that, "history matters". This means that exploring history of nursing should be at the heart of nursing research. D' Antonio (D'Antonio and Fairman, 2010:1) believes that history should be looked at as an "*overarching conceptual framework*" that enables us to better value the concept of nursing and its various knowledge.

From a slightly different point of view, Rafferty (Rafferty, 1998) suggests that a nurse becomes a nurse historian by doing a historical study in nursing. Nelson (Nelson, 2002) on the other hand, argues that one should bear in mind that history is an academic discipline and not merely a means of enquiry and it is crucial that it is seen and treated as such. Thus, nurses need a good grounding in history as academic practice before they can undertake historical studies. Hallett (Hallett and Fealy, 2009) agrees with Nelson on this point arguing that:

“It is true that good history cannot be written without a thorough training in the methods of historical inquiry”.

(Hallett and Fealy, 2009: 2681)

However, Hallett goes on to wonder, whether accounts of history of nursing can be written without a full understanding of nursing.

In fact this unintended debate between Rafferty, Nelson and Hallett, should remind us of the exceptional work of Abel-Smith⁴ (Abel-Smith, 1960) who was not from a nursing background and did not study history, yet he was an observer of nursing as a discipline and someone who devoted his time and efforts to the National Health Services (NHS) (Townsend, 1996). One would think that Abel-Smith should have thought twice before writing on the history of a profession to which he does not belong to; that he should have studied history before embarking on a historical research. However, what we are principally concerned with in this study is the role of a nurse as historian and not the other way round. The nurse historians’ story perhaps starts from or with nurses interested in the history of the profession, acknowledging history as a critical discipline, undertaking a historical research at the same time training themselves with the adopted historical method, and gaining experience by doing this more often. In a later chapter, I will discuss historical research as a method of qualitative enquiry.

Lewenson and Herrmann (Lewenson and Herrmann, 2008) assert that it is crucial that experienced nurse historians talk about why they became nurse historians, what were their motives and what attracted them to explore the history of their profession. In an article in their above mentioned book, Lewenson and Herrmann listed a number of nurse historians and their different stories on what made them choose the career of history of nursing. As an example, Carol Daisy bought Annie Goodrich’s nursing pin in a shopping trip and then she then decided to explore the life history of Ms Goodrich and hence

⁴ Brian Abel Smith was Professor of Social Administration at the London School of Economics ABEL-SMITH, B. 1960. *A history of the nursing profession*, Heinemann.

to continue exploring past events. As another example, Josephine Dolan, when she was a student nurse, attended a course which according to her was not interesting and too tedious for one attend. However, she was attracted to become a nurse historian by the story of a priest who went to Turkey and worked alongside Ms Nightingale in the Barrack hospital during the Crimean War by founding bakery and a laundry to clean the soldiers' clothes (Herrmann, 2008). Patricia D 'Antonio the current Editor of the *Nursing History Review* has a different story as she did a degree in history at the university of Virginia and as nursing was more appreciated and acknowledged in this university she decided to study nursing and succeeded in combining the two disciplines. Many other nurse historians such as Nettie Birnbach, Joy Buck, Isabel Stewart, have their own stories and motives for being what they are as noted nurse historians. Knowing and making sense of what made today's nurse historians has the potential to inspire and motivate future nurses. The majority would agree that history of nursing is important and as it is such, it is vital to develop those nurses who are willing to study the history of the profession (Lewenson and Herrmann, 2008).

The next section will review the most significant early accounts of the history of nursing mainly in the UK.

2.2.2 Early accounts on the history of nursing in the UK

The relative lack of literature on the history of nursing in SA or in Arabia in general is in stark contrast to the way things are in the west; where there is a well- established and documented historiography of nursing and outstanding nurse historians who continue investigating past events and life histories related to the profession of nursing. In spite of this, about eighteen years ago Hall (Hall, 1997) stated that, compared to medicine, nursing history, is less documented. The reason for this is similar to the one comparative scarcity of historiography in nursing in the SA, which is perhaps linked people's perceptions of what nursing is about, its status and what it involves.

Up to the 1960s, literature on the history of nursing can be described as 'Macro-histories' as historical accounts were written on a large scale (Bett, 1960). This approach to the writing of history with its wide view of history, looks at different societies and cultures over the course of centuries, using a great deal of data, some of which is proven but most of them at best estimated (Brown et al., 2000). It is generally recognised that in the UK, the first attempt at writing on the history of nursing goes back as early as 1906 when Sarah Tooley⁵ wrote her book *The History of nursing in the British Empire* (Tooley, 1906). Tooley clearly states that up to that point there were no accounts on the history of nursing, and from that point onwards many believed that the history of nursing in the UK started to shape and flourish. However, Williams (Williams, 1980) argues that the year 1897 had witnessed the first and many other accounts⁶ on the history of 'modern nursing' this was in celebration of the 60th anniversary of the accession of Queen Victoria to the throne.

In addition to Tooley's above mentioned book, this 'macro-histories' trend can also be seen in Nutting and Dock's book *A History of Nursing* (Dock and Nutting, 1907) which, covered nursing from the period of the eighteenth century until the development of modern nursing. This book consists of nine chapters, four of which devoted mainly to address important aspects of Florence Nightingale's life. This work is regarded by many such as Seymer (Seymer, 1933) as an asset to the knowledge of history of nursing. In her *General History of nursing profession* Seymer states clearly that Nutting and Dock's work will never be outdated for its unique input, and as nursing progressed and faced many challenges especially since 1919, her work is an attempt to highlight these challenges and the transformation that this discipline experienced. Nevertheless, the two works to some extent look similar as in both books a considerable part of their contents devoted to Florence Nightingale's life and achievements. The two books refer to Miss Nightingale's heroic work during the Crimean war, and her treasured dream that came true which is the

⁵ Tooley had previously written a book on the life of Florence Nightingale A TOOLEY, S. 1908. The life of florence nightingale, by sarah a. tooley. Cassell. In celebration of the jubilee of the nursing legend who left London in 1854 and who lived to witness this remembrance.

⁶ Written in *the Nursing Record and Hospital World* and the *British Medical Journal*

establishment of a school of nursing at St Thomas's hospital. Nutting and Dock (Nutting and Dock, 1907) in their fifth chapter praise the intellectuality of Miss Nightingale by referring not only to her theoretical and practical knowledge of the profession and her profound vision into health problems, but also to her exceptional role as a sanitarian teacher, which is reflected in her famous notes: *Notes on Nursing, What it is and What it is not*. Seymer in the same vein points to the same work by Nightingale and declares that:

“So arresting in its clear setting forth of the fundamental principles of nursing which remain as true to-day as when it was first written”.

(Seymer, 1954:5)

Adding to the list of the Macro-Historical accounts of nursing is the work of Dock and Stewart *A Short history of nursing from the earliest times to the present day* (Dock and Stewart, 1920) which considers the history of nursing, looking at nursing from the earliest time of this discipline. Another work that also uses the Macro-History approach and perhaps one of the most interesting books on the history of nursing written in the second half of the nineteenth century is Abel-Smith's *A history of nursing profession* (Abel-Smith, 1960). Abel-Smith who is not from a nursing background⁷, in his book focuses mainly on the history of general nursing. He argues that nursing, and general nursing training in particular, assessments, and the Royal College of Nursing made this profession a restricted cohesive profession. In his book, Abel-Smith gives a particular account to nursing registration and recruitment.

Yet, all the above mentioned accounts on the history of nursing without exception, shared one similar trend which is that they all contained at least one chapter that had extensively sacrificed mainly for Florence Nightingale's life,

⁷ See Katharine Williams WILLIAMS, K. 1980. From Sarah Gamp to Florence Nightingale: A critical study of hospital nursing systems from 1840 to 1897. *Rewriting nursing history*, 41-75. 'from Sarah Gamp to Florence Nightingale' in *Rewriting Nursing History* 1980, Williams differentiates between historical accounts written by nurses and those who are not from a nursing background.

notes, deeds and achievements. Clearly, many are impressed by Nightingale's character and her ability to influence the world through her achievements and courage. On one hand, she influenced those who were close to her and worked alongside with her, those who heard about her during her lifetime, and those who heard about her decades after her death. On the other hand, among those there were group of biographers who criticised her. The next section reviews Nightingale's international influence through her legacy as well as what her critics have said about her.

2.2.3 Nightingale's international influence

Florence Nightingale's legacy has continued to inspire nurses the world over. The fact that nurses all over the world celebrate the international nursing day on her birthday (12th May) is evidence for this. Moreover, people around the world continue to identify their nurse heroine by the name Nightingale, inspired by the lady and the lamp's bravery and determination, and her deep commitment to her calling (Cook, 1914). Over a century after her death, Florence Nightingale is still looked on as a model for nurses today; she certainly continues to be a legend.

Florence Nightingale's influence has touched many parts of the world, including the Far East. Japan, for example, is, of all the developed non-western countries, the one in which Nightingale is most admired. Hisama (Hisama, 1996) explains how a navy doctor who studied medicine at St Thomas's hospital was astonished by Miss Nightingale's influence on nursing at that time. This may be what inspired him to establish the first school of nursing in 1885 in Tokyo (Hisama, 1996). Saeki is another Japanese medical doctor who studied at St Thomas's hospital in 1890. During his medical course he was able to meet with Miss Nightingale and following his return to Japan, he decided to retire from the navy dedicating his time and life to the advancement of nursing education in Japan (Hisam. 1996). Ueoka, 1995) lists three agents that helped to promote Nightingale's methods of and approaches to nursing in Japan and they are as follows: 1- the Navy Military physicians 2- Christian educators and theoreticians,

and 3- leaders of the Japan Red Cross. This list is rather interesting as the three agents listed represent areas of activity which are essentially humanitarian rather than scientific. Moreover, Hisama asserts that the major influence of Nightingale on Japanese nurses has been in her character as a religious image, empowering nurses to endure the diverse forms of difficulties whilst they are doing their job (Ueoka, 1995).

In Australia, the story of Miss Nightingale's early influence on the Australian nursing is slightly different from the Japanese one, but nevertheless relevant to this study. Her influence in the southern hemisphere began to have an impact after a number of nurses were sent to Australia in 1868 in response to a request from Henry Parks⁸, in order to bring Miss Nightingale's style of nursing to the colony to help 'clean' Sydney's hospital and dispensary (Godden, 2006). Lucy Osburn was the head of the group of nurses who was sent to Australia for this mission. She was described by Godden (Godden, 2006) in her book *Lucy Osburn, a Lady Displaced: Florence Nightingale's Envoy to Australia*, as a dynamic and creative woman who acted as a senior nurse officer at the Sydney Infirmary. Miss Osburn was in one-way part of the colonial power, she was on a mission to bring better system and regularity to the colony, and hygiene and proper nursing to the hospital; in other words, she imported Florence Nightingale's style of nursing to the colony.

A similar scenario was repeated in 1875 when Maria Machin and a number of Nightingale nurses, thought to be four, arrived in Canada to work at the Montreal General Hospital (Godden, 2004; Helmstadter, 2006). Unlike Osburn who was English, Machin was a Canadian nurse, who had lived in and studied nursing at St Thomas' hospital. Again in a similar way to Osburn, she worked as a chief nurse and had undertaken a similar task to that of Miss Osburn, which was the improvement of nursing care in the colony and the promotion of better nursing practice (Helmstadter, 2006). Thus, in a similar way to Osburn, Machin contributed to the exportation of the colonial nursing knowledge. Helmstadter

⁸ a statesman and politician who is considered the Father of the Australian Federation Was Born in 1815 in Warwickshire. (Wikipedia, accessed on 21st /March 2013)

writes that Machin's nursing career is a good example of how "nursing participated in a major aspect of British imperialism, the export of professional expertise and administrative skills as well as the way nursing fitted into the rise of the new professionalism" (Helmstadter, 2006:249).

In an attempt to assess the implication of the use of Nightingale's approach of nursing in both Sydney and Montreal, especially in relation to the cost implications of nursing training, Godden and Helmstadter (Godden and Helmstadter, 2009) searched primary data from 19th century containing information about staffing levels and staff wages in both cities. One of the most significant findings of the study was that, at the time of the implementation of Nightingale's approach of nursing, there was clear evidence that the number of trained nurses had increased in both cities. In addition, another finding shows that in both cities, nurses' salaries had remarkably increased and therefore staffing cost had doubled.

The increase of the financial costs and of the number of trained nurses, and thus nurses' wages, are evidence that, at that time, nurses started to get better recognition and that their status and professional standing started to improve. This is indeed something that nurses at that time were struggling to achieve and fought hard to establish. Helmstadter (Helmstadter, 2006), however, reveals how the nursing frontrunners who tried to transform hospital nursing faced enormous restraints and opposition when attempting to introduce better standard of care for their patients.

So one can perhaps conclude that Nightingale's influence was not only through her distinguished personality, illustrious achievements and her commitment to introduce a modern well recognised nursing profession, but also that she had a long lasting indirect influence through the nurses that she trained who were sent out to convey her message to the colonies, and to other parts of the world, about what good nursing practice should be like: "what *nursing is, and what it is not*" (Nightingale, 1898).

2.2.4 Criticism of Florence Nightingale

Given all that Miss Nightingale had achieved during the Crimean war and after that period, from the enforcement of better care for the soldiers, to the re-organisation and reformation of hospital nursing services and training of civil nurses, to the involvement in public health statistics and many other remarkable achievements, it is hard to believe that the “*Lady with the Lamp*” has been criticised. According to Salvage (Salvage, 2001), some historians appear to be in a competition about who is able to provide the strongest negative claims against Nightingale. Smith (Smith, 2009) who is an example of one of these critical historians, notes some contradictions in Nightingale’s life. Smith refers to Nightingale’s control and influence over those who knew her very well such as her relatives, colleagues and nurses who worked with her. In her article, Smith scrutinizes four aspects of Nightingale’s thinking and behaviour. These were i) Nightingale’s view of the “identity” of women; ii) her viewpoint in relation to compliance within, nursing training managed by her; iii) her way of living; iv) and her “apparent breakdown” (Smith, 2009:5).

Gill and Gill in their work *Nightingale in Scutari: Her Legacy Re-examined* (Gill and Gill, 2005) pointed out to the remarkable achievements of Miss Nightingale in Scutari and how a thorough study of her work explains that during her life time she was regarded by the public as a legend for her outstanding role she played in saving the life of many soldiers during the Crimean War. Nevertheless, they argue that the steep decline in the numbers of deaths among the soldiers at that time does not necessarily link with or was related to her or her nurses’ outstanding nursing care (Gill and Gill, 2005).

Other historians question her of lacking experience and ability to look after the sick (Royle, 2000 and Lambert and Badsey, 1994). This is in contrast, however, to Gill (Gill, 2007) who asserts that there is a considerable amount of confidential and disseminated correspondence from nurses and surgeons, who served during the war, which confirms that Miss Nightingale was allowed by the army doctors to carry out wound care, and she was one of a small number of nurses who were permitted to do so.

Nightingale has also been criticised for having a very limited vision of a woman's potential role in the world. Although she might be regarded as having some feminist aspirations for example, she resisted the idea of marriage and insisted on staying single to maintain her independence (Attewell, 1998; Cohen, 1984; and Salvage, 2001). In her feminist essay, *Suggestions for Thought*, according to Smith (2009), Nightingale questioned the status of females in the family by claiming that: "Man is born into the world, woman into a family". It is also well known that Miss Nightingale did not support efforts of women to join the medical career (Showalter, 1981). In fact, she criticised the first American female doctor (Elizabeth Blackwell), and went on to emphasise that women, by entering the medical profession, are not developing themselves, rather they are only turning out to be poor imitations of men (Smith, 2009). Indeed, she believed that women within the health care system were much better working as nurses rather than being doctors. This stance by Nightingale makes one think of whether she was feminist in the first place. To decide not to get married and call for women's liberation and for women to find their own ways do not necessarily mean that she is feminist.

Nightingale thought women would achieve more as nurses rather than as other health professionals. Indeed, she felt that for a woman, nursing is one of the noblest types of work that a woman can undertake. However, surprisingly, she rejected the idea of nursing registration (Haigh and Jackson, 2011). She also believed that the primary objective of education for nurses was essentially to gain ethical principles, and that assessments examine one's ability to recall things and cannot establish an individual's moral character (Haigh and Jackson, 2011).

In their presentation *Florence Nightingale in the 21st Century: A critique*, Haigh and Jackson (Haigh and Jackson, 2011) provide a comparison between what Ms. Nightingale said and what nurses have to say in the 21st century. In relation to infection, they quote Nightingale saying:

“it cannot be necessary to tell a nurse that should be clean or that she should keep her patient clean seeing that the greater part of nursing consists in preserving cleanliness”

Of course, cleanliness is the one of the most essential elements of good health practice, both personal cleanliness and that of the nursing environment. However, this quotation brings us to the “germ theory” accusation. McDonald (McDonald, 2010) criticizes Nightingale for embracing the miasma theory, when new medical evidence supported the germ theory. McDonald notes that in 1880 Koch discovered the tubercule bacillus; Nightingale in the 1850’s was mistakenly asserting that unclean water and filthy drains were responsible for the spread of diseases. According to (Baly, 1997), Nightingale resisted the germ theory for the reason that this might make nurses and doctors relate sickness to germs, and that this might in turn stop them from adhering to cleanliness and hygiene.

Regardless of all the accusations and claims against the lady with the lamp, her supporters as well as her critics share the view that she was a passionate sanitarian, despite her views in relation to the germ theory, and that she was an outstanding hospital and nursing practice reformer. Her influence is certainly global, and despite what her critics say, she will remain a legend for future generations of nurses in most parts of the world. The next section in this chapter deals with modern accounts on history of nursing.

2.2.5 Modern accounts on history of nursing

In the west, especially during the eighteenth and nineteenth centuries, the professional recognition of nursing developed gradually following a long series of struggles. Likewise, historiography in nursing developed and has kept developing as an increasing number of historical accounts on nursing were written, especially during the last quarter of the twentieth century (Rafferty, 1997).

This development is reflected in the increasing number of nurse historians as well as the increase in approaches to historical enquiry and the diversity of topics on the history of nursing. One of the notable trends in nursing history is the decline in the production of historical accounts of the life of Florence Nightingale. Another more recent change, in the UK in particular, is that there is a new generation of nursing historians who no longer worry about issues such as regulations, registration or nursing's recognition and status in the society (Maggs, 1987). Maggs asserts that nurse historians are no longer part of movements to fight the battle of registration; they are now more interested in issues which have emerged post winning the battles.

Some historians such as Carpenter (Carpenter, 1980) are more concerned about the dominance of general nursing in history of nursing and not about the change of the themes within the writings on the history of nursing. In this work, Carpenter addresses the issues relating to 'asylum nursing' (currently mental health nursing) and states that at that time there are no or very few accounts on this branch of nursing and other specialities within the profession of nursing such as community, psychiatric and mental health nursing.

On the subject of branches within the discipline of nursing, one of the areas that have always been seen as one of nursing profession's branches is midwifery. Many accounts were committed to establish a line between nursing and midwifery as the latter has always been viewed as one of nursing discipline's branches. A very recent book that covers *Nursing and Midwifery in Britain since 1700*, written (Borsay and Hunter, 2012), contains a number of essays and has some unique analysis, which can be summarised as follows: first, it places the two professions as if running along a parallel lines, and it asserts that midwifery is a professional discipline on its own right; it is not secondary to nursing or one of its branches. Instead, the book emphasises the complementary position of the two disciplines to each other.

In the twentieth century, historiography in nursing moved on to cover broader themes, such as: politics, gender and feminism, religion, and recently and perhaps during the last decade, colonial and military nursing (Rafferty, 1997).

Accounts on colonial nursing or nursing in the colonies have started to attract the attention of many nurse historians. Previously in this chapter a mention was made on Jenkins's (Jenkins and Munslow, 2003) urging historians to look at history from beyond their modern thinking. He was an advocate of using the different 'posts', such as post-colonialism, in writing historical accounts. Nurse historians seem to have responded to Jenkins call as we can see an increasing historical accounts of colonial nursing or in other words, nursing in the colonies. The British colonial power is the main concern in this study, and it will be of the main focus in reviewing accounts on the history of colonial nursing. However, before reviewing these accounts, and since we are attempting to explore the history of nursing during the British colonialism of SA, it would be beneficial to review the term colonialism.

2.2.5.1 Colonialism

Colonial periods have been well considered by many writers and theorists among whom are Bhabha, (1990); Spivak and Harasym, (1990) and Memmi, (1991). In their writings these theorists have intensively and critically considered the process of colonialism as well as (Fanon, 1967; and Said, 1979) the relationship between the colonizer and the colonized (Memmi, 1991).

The term colonialism itself is considered as a notion with different perspectives; it has been defined and characterized differently. According to Williams (Williams and Chrisman, 1994:4) for example, the term colonialism is:

“A way of maintaining an unequal international relation of economic and political power”

In addition to the political and the economic subjugation, an ongoing programme of cultural colonisation was essential to support and maintain the hegemony of the colonized (Thiong and Apos, 1998). On the other hand, Chatterjee (Chatterjee, 1993:10) in the *Nation and its Fragments* describes the colonial process as:

“The normalizing rule of colonial difference, namely the preservation of the alienness of the ruling group”.

This difference from Chatterjee’s point of view represents the 'other' as inferior and radically different, and hence incorrigibly inferior. The idea of creating an 'other' has been further explained by Edward Said (Said, 1979) who believes that the colonizer or the imperialist powers needed to create an 'other' in order to define themselves as centre. Although the policies of colonialism varied from one 'centre' to the next, Said, believes that they systematically programmed colonized people to understand themselves as other, as marginalised, in relation to this centre. In this case how the two parts will work, interact and live together should be at the heart of any studies that consider the history of any phenomenon in the colonies during colonial era, such as this study. This study is attempting to explore a small part of the history of nursing in SA during the British colonial era specifically in the period 1950-1967. In the next section, studies or accounts on the history of colonial nursing will be reviewed.

2.2.5.2 Accounts on the history of Colonial Nursing

British Colonial nursing history is considered to have started with the establishment of the Colonial Nursing Association (CNA) in 1896. Since then more than 8400 registered nurses were sent abroad to provide nursing care for the sick and injured between the period 1896 until 1966 (Howell et al., 2011). Perhaps the main reason behind the foundation of the CNA was the concerns of Frances Piggott which were expressed in a number of public meetings. Mrs Piggott was at that time concerned about the health and the wellbeing of British men, women and children who had to live in the British

colonies. According to her, British settlers in the British colonies often lived in unhealthy environments, risking their lives and safety (Howell et al, 2011). Nurses sent to the colonies were hoping that they would be able to provide a more 'civilised' levels of care similar to what is available in their home land (Howell et al, 2011; 1159). Regardless of the motives behind the establishments CNA, some historians believe that nursing in the colonies enhanced the existence and control of the colonial state, by creating conflicts and struggles within the profession in the colonies.

Deacon (Deacon, 1997) and Marks (Marks, 1994), both biographers, wrote on nursing in South Africa during the Apartheid system. Deacon examined the history of nursing in South Africa from a colonial context. She describes three characteristics of the colonial medical history in the Cape of the period between 1846- 1910 and they are as follows: firstly, at that time, the government had almost no role in the provision of health services; secondly, the mid- nineteenth century, witnessed an increase of racism and the dominance of the medical profession; and thirdly, the Anglican Church's main role in the provision of health care in the infirmaries, as the colonial administration did not get involved in the welfare provision in the Cape. In this article, Deacon also assesses two issues which are gender and race within nurses in two different hospitals, the mental asylum and a leper hospital from the time of their foundation until their shutting down. Deacon (Deacon, 1997) suggests that racism in hospital employment did exist at that time and increased after the arrival of Nightingale's nurses in 1870s. The colonial state's sense of responsibility towards these nurses made them favour these nurses by providing them with, first the privilege of housing and then in the 1860s white nurses of better class were recruited in the new asylum as they were thought of as more respectable and better in delivering care. Consequently, by the early twentieth century, colonial hospitals in the whole country stopped recruiting black nurses. Furthermore, Deacon goes on to argue that by the late nineteenth century, doctors in Cape Town were regarded as 'agent of empire'; they were constantly coordinating with the colonial power and have had a high status in the society and full support from the government. Deacon notes that there was continuous apprehension in the colonial nursing service about what kind of women would be employed.

Marks (Marks, 1994) also in relation to South Africa wrote about *'divided sisterhood'* within nursing profession. Divided sisterhood to Marks means more than talking about history of nursing. It also uses this history to propose a clearer and more comprehensive view of the clashes and conflicts within the history of South Africa. In relation to nursing, Marks points out that nursing had a role to play in relation to the foundation of class in South Africa. As it was originally lead by middle-class English women and nursing sisters, it was also one of the most important jobs available for African women educated by missionaries, which transformed these women to become members of the middle-classes.

Nursing was also a means of the introduction of the colonial standards and approaches (Marks, 1994). Conflicts in controlling the profession of nursing existed between, middle-class mainly English- speaking registered nurses and the lower class, largely African women with nursing positions. These class conflicts were mainly concerning whether nursing staff should be regarded as health professionals like male nurses, or whether they should be regarded as health attendants or as lower paid workers. Here, one can hear the beginnings of echoes of gender conflicts, in addition to class conflicts. Furthermore, Marks (Marks, 1994) emphasises that questions such as how African women would be part of the nursing force, gave room to racial struggles within the profession. The class, gender or racial struggles and conflicts in the history of nursing profession in south Africa was never elucidated Marks on this blames the less skilled historians.

In India for example, Basuray (Basuray, 1997) examines the significance of ethno- history as a perspective in order to make sense of the nature of social subjugation in the colonies. Basuray (Basuray, 1997;15) asserts that:

“Nightingale’s model of nursing prevailed through Europe colonial and Post-colonial period. Nurse Miss Sahib in the title is intended as an icon of the juxtaposition of caring and social oppression in a cultural – bound education process in India”

She goes on to assert that the idea of Miss Sahib Nurses was used by the colonial power with the aim of eliminating the colony's traditional ways of health care and its providers. The icon of Miss Sahib Nurses took over that of the native nurses of the local culture and traditions (Basuray, 1997).

The Heroines of Lonely outposts or tools of the empire? British nurses in Britain's model colony: Ceylon, 1878-1948 (Jones, 2004) is an article written by Margaret Jones of the Wellcome Unit for the History of Medicine. In this article, Jones examines the life history and experience of two British nurses who were among the first to be sent to Ceylon to work as nurses in the colony's hospitals and to educate Ceylonese females in the profession of nursing. The work also evaluates these nurses' achievements and their roles in the improvement of the nursing profession in the colony. However, Jones's paper concludes that the existence of these nurses in the colony ultimately left an unclear legacy. As educators of the native females, the nurses contributed to the introduction of the colonial principles which enhanced and reinforced the dominance of the colonial power.

The accounts of colonial nursing have tended to focus on the issues of race, class and gender. This is especially true of accounts written by non-Western historians. Typically, the icon of the 'Heroine of the empire' is challenged and the nurses' positions as colonisers and their relationship with the colonised in a specific colonial context is explored (Rafferty 2006). Many of the critical accounts dealt with the situations in South Africa, India and Ceylon.

SA which was also colonised by the British for over a century, was the recipient of a number of British nurses during the colonial period. Colonial nursing in SA did exist and has a story that has never been told or ever revealed. However, while this research has not set out to challenge the positive image of colonial nursing, it will not exclude discussion of the issues of race, class and gender where these emerge.

Before we consider SA the setting of focus in this study, its profile, historical overview, including political history, and nursing, it is profitable to review some

of the historical accounts of nursing in the Arab world. The third and last part of this literature review deals with what has been written so far on the history of nursing in this region.

2.3 Part three: Accounts of the history of nursing in the Arab World

2.3.1 Introduction

“The untrained nurse is as old as the human race. The trained nurse is a recent discovery. The distinction between the two is a sharp commentary on the follies and prejudices of mankind”.

(Robinson, 1946)

When talking about history of nursing within any culture a common starting point is to say that nursing is very old and that nursing has always existed albeit, perhaps, in a dissimilar form. Prehistoric people practised it spontaneously without previous plans or training (Robinson, 1946). It is also generally believed that nursing began at the dawn of humankind as a social service or a practice carried out between and within families, arising from the instinctive sense of family protection and welfare (Henderson, 1981). The figure of the mother is thought to be first port of call mankind had to care for baby from birth, and to take care of the sick, wounded and elderly in the family and to help other women during the process of childbirth (Donohue, 1996).

Scholars have defined nursing differently but with some minor similarities at the same time. Nightingale (Nightingale, 1899:12) for example was one of the first to define nursing as:

“The act of utilising the environment of the patient to assist him in his recovery”

On the other hand, Virginia Henderson (Henderson, 1966:3) who is regarded as the first lady of nursing in America defines nursing as:

“The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge”.

Both definitions are concerned with actions or functions by the nurse towards a sick person's recovery or wellbeing. Nightingale gives more emphasis to the individual's environment while Henderson emphasises the nurse's role towards both the healthy as well as people in ill health.

What has also been noticed in the two definitions is that there is no hint that the nursing role or job is a 'woman only' preserve. Looked at from this perspective, it could equally be argued that the husband or male companion was the first port of call for a woman in need of help, during her labour, or in the first moments after childbirth at the time when there were no hospitals or trained birth attendants to turn to. This could actually turn the traditional picture upside down as the stereotype insists on identifying 'the nurse' with the 'caring female individual,' while the patient can be a female or a 'male in need of care'. Here the point or intention is not to discuss male nurses in history of nursing, but rather to bring to mind that the debate around "genderising nursing" is maybe as old as nursing itself. Men's role in history of nursing in SA is somehow different from that of many other countries. At this point, it is noteworthy to point out to the phenomenon that exists in most of the Arab and maybe the Islamic countries and certainly, in SA, which is the male dominance of the profession of nursing, in contrast to the situation in the west where females constitute the vast majority of nurses (El-Sanabary, 1993). It is well known that whenever patients, hospitals, and medicine exist some form of nursing must have existed too. The next section provides an overview of the history of medicine in the Arab/ Islamic world.

2.3.2 An overview of the history of medicine in the Arab/Islamic world

Accounts of the history of medicine in the Arab and the Islamic world⁹ are substantial, written by Arab or non-Arab biographers. They are unlike accounts of history of nursing in the same region, which, by contrast, are very scarce, mostly non-academic and written by non-nurses. A brief consideration of the history of medicine in the Arab/Islamic world at this stage is profitable. This will be undertaken as part of a discussion in response to Jansen's (Jansen, 1974) statement, in his article *Nursing in the Arab East*¹⁰, which asserts that:

"In the newly developing areas of the Middle East, particularly along the Arabian Gulf and in Saudi Arabia, nursing is a new idea".

He continues:

"Along the Levantine coast, nursing has a much longer history. It goes back to 1847- seven years before Florence landed at Scutari in Turkey during the Crimean war and founded secular nursing profession".

In his article, Jansen links the 'development' of this 'idea', which is nursing in the Middle Eastern (ME) countries with the refinement of the status of women in this region. He actually unfairly compared this situation with the situation in the west referring to the longer history of nursing that goes back to 1847, seven years before Florence Nightingale's arrival to Scutari to play her role during the Crimean War.

Jansen's Provocative statement could raise endless debates such as, for example, one which starts with the following statement: in relation to nursing as a new idea, firstly, nursing in the ME area as anywhere else in the world is

⁹ See Azmi AZMI, A. 2002. Salient features of Islamic medicine and its relevance to the modern world. *Studies in history of medicine and science*, 18, 35. on Islamic medicine and its relevance to the modern world; Syed SYED, I. B. 2002. Islamic Medicine: 1000 years ahead of its times. *JISHIM*, 2, 2-9. Islamic Medicine: 1000 years ahead of its times; Conrad CONRAD, L. I. 1993. Arab-Islamic medicine. *Companion Encyclopedia of the History of medicine*, 1. Arab-Islamic medicine; Shahine SHAHINE, Y. A. 1976. *The arab contribution to medicine: the fifth Carreras Arab Lecture of the University of Essex 4 November 1971*, Longman.; The Arab contribution to Medicine, Garrison GARRISON, F. H. 1921. *An Introduction to the history of medicine c. 2*, WB Saunders Company. An introduction to the History of Medicine and Campbell CAMPBELL, D. 1926. *Arabian Medicine*, 2 vols. London. Arabian Medicine.

¹⁰ Arab Eastern countries geographically consist of Kuwait, Saudi Arabia, Qatar, Oman, Bahrain, United Arab Emirates, and Yemen

neither a new idea nor a new practice. Jansen's statement makes no mention of trained nurses; as if that were the case, he probably would be right. Nursing as a discipline that needed training and qualifications was at that time (in the 1970s) a new idea in so many countries. But his statement cannot apply to nursing as an activity or practice. For as Robinson points out informed nursing has always been practiced (Robinson, 1946).

Another argument which may arise from Jansen's claim is that: before Florence Nightingale's historical place in nursing came to prominence, some form of nursing did exist in the UK in particular and the west in general (McDonald, 2010). Some and maybe most of the accounts of history in nursing in the UK, give a clear description of the status of nursing and nurses before Nightingale. McDonald (McDonald, 2010), for example, notes the status of nurses prior to Florence Nightingale's reformation of nursing which resulted in the establishment of modern nursing. The modern form of nursing, or in other words, professional nursing which needs training, qualifications and registration was a new idea not only in the Arab world but similarly in the west up to that point. The history of nursing in the West before, during, and after Nightingale has been so well researched and documented that it has become the main gateway through which people get to know about nursing and subsequently use it as the main source of information in their writings on the subject.

There is a dearth of both spoken and written accounts on the history of nursing in the ME region, but this does not mean that in the past there was no nursing in the Arab region and that nursing is a new idea in this region, only because there are no historical accounts of this discipline. At this stage, an overview of the history of medicine in the Arab/Islamic world is crucial.

Over 1000 years ago, Arabic/Islamic medicine was the most advanced in the world. Its accomplishments are still celebrated and studied in western universities (Campbell, 1926), and in a variety of academic disciplines such as medical education, clinical training, establishment of hospitals, licensing of physicians, as well as in subjects such as bacteriology, anesthesia, surgery, pharmacology and many more (Syed, 2002). Brewer (Brewer, 2004) asserts

that the Arabian control during the 7th and 8th century brought medical skills and remedies. In addition, the Arabs themselves were well-informed about Indian as well as Persian treatments. Around 1,000 AD, or, rather a couple of centuries later, the Middle Ages in the West¹¹, many students and researchers from different parts of the world outside the Islamic world were inspired and amazed by this science and hoped that one day they would be able to study in one of the Islamic universities whether in Damascus, Bagdad, Tunisia, Cairo, or Cordova¹² (Campbell, 1926). Campbell emphasizes that:

“The European medical system is Arabian not only in origin but also in its structure. The Arabs are the intellectual forebears of the Europeans”.

(Campbell, 1926:45)

In the same vein, Watt (Watt, 1994) in his book *The Influence of Islam on Medieval Europe* notes that the first hospital in the ME was built in Damascus (Syria) in 706 AD, by the Ummayyad Caliph. Al-Mansur and Al-Qayrawan hospitals were built in 750 CE and 830 CE sequentially in Bagdad. Mansuri hospital, which was considered to be one of the greatest hospitals at that time, was built in 1284 CE, contained 8000 beds. The staff included physicians and surgeons, including specialist practitioners. There were personnel who attended both sexes under a well-established management system (Watt, 1994).

Watt (Watt, 1994) notes that there were reports of hospital management, isolated areas for infection control, a pharmacy, a reading room and lecturing equipment. Watt believes that clinical education took place in the hospital, a

¹¹ “Latin translations of the 12th century were spurred by a major search by European scholars for new learning unavailable in Christian Europe at the time; their search led them to areas of southern Europe, particularly in central Spain and Sicily, which recently had come under Christian rule following their reconquest in the late 11th century. These areas had been under Muslim rule for considerable time, and still had substantial Arabic-speaking populations to support their search. The combination of Muslim accumulated knowledge, substantial numbers of Arabic-speaking scholars, and the new Christian rulers made these areas intellectually attractive, as well as culturally and politically accessible to Latin scholars (cited in Wikipedia web page visited on 01/11/2012).

¹² Cordova is part of Andalucía in Spain (it was part of the Islamic empire as Spain used to be part of it for more than 700 years)

practice not known in Europe until about 1550 CE. Watt also cites evidence of doctors visiting prisoners and treating them, as well as of the presence of mobile clinics to reach outlying rural communities.

Furthermore, in Baghdad the first hospital was built where there was a ward exclusively for patients with mental conditions, according to them the treatment included not only medicinal treatment but also adequate nutrition, and physiotherapy. In addition to therapeutic regimen, patients were entertained by music and Quran recitals (Syed, 1993). Herrmann (Herrmann, 1936) in his article *Early Arabian Medicine* quotes many stories about the standard of care and the qualities of these hospitals. One of which he quotes:

“(A.D. 1427. Persia) in this year, I came to Damascus with me was a gentleman of Persian origin, a man of talent, and one who talks a great deal. When he entered the hospital, he saw the food distributed there, as well as luxuries enjoyed by the patients, and he convinced the idea of remaining there, pretending he was sick, and did remain there for three days”.

(Herrmann, 1936: 115)

The above quote implies firstly that people came seeking medical treatment from as far as Persia for the advancement of medicine in this region, and secondly the standard of care in the mentioned hospital was outstanding. Standards of care could cover things such as the hygienic surroundings, to customer care including nursing care.

Herrmann (Herrmann, 1936) gives more accounts not only regarding the medical care in these hospitals but also the characters of the physicians at that time in that particular place in the world. He particularly admired the character of Rhazes¹³ who was in addition to his role as a physician, was the head of the physicians in the main hospital in Bagdad (Brewer, 2004).

¹³ Abu Bakr Muhammad bin Zakaria al-Razi, better known as Rhazes, was born in Ray, Persia (now Iran) and was well known for his contributions to Islamic medicine. Rhazes was a Persian physician,

Brewer (Brewer, 2004: 186) explains that:

“The creation of hospitals fulfilled one of the five tents of Islam, charity for their benefactors. The Waqf, a trust that helped the poor to cover costs, meant that good hospitals could be richly endowed and fulfill their role in caring for the needy infirm”.

Brewer believes that Cairo which replaced Alexandria as Egypt’s main town was the Arab world’s richest city and had many good hospitals. Evidence shows that in Morocco, and in Marrakesh in particular a hospital that was built in the 12th century was designed in the same way as the one in Cairo. Brewer (Brewer, 2004: 186) describes this hospital as follows:

“It was sumptuous and had woolen carpets with silk and leather drapes”.

In this hospital patients received 30 Dirham a day, a considerable sum to have during their rehabilitation period.

Moreover, Miller (Miller, 2006) illustrates in a broader view of how the early people of Arab/Muslim world brought together the traditional medicine of different lands and cultures such as the Persians, Greeks, Indians, Jews, and many more into what he calls ‘an innovative product’ that would enhance medical schools, archives, and practitioner licensure (Miller, 2006: 616). Miller emphasizes the importance of recognizing the role that others played in the development of the modern medicine; here he refers to the Arabs/ Muslims contribution to medicine. In the same vein Brewer (Brewer, 2004) states that the legacy of Arabic medicine care is still with us today and deserves understanding and greater appreciation”. Miller asserts that:

“Our near- and middle-eastern colleagues were true visionaries and the founders of the academic medical center

philosopher and religious critic STROUMSA, S. 1999. *Freethinkers of Medieval Islam: Ibn Al-Rawāndī, Abū Bakr Al-Rāzī and Their Impact on Islamic Thought*, Brill..

(Miller, 2006:617)

Gregg (Gregg, 1963) in *The State of Medicine at the Time of the Crusades* notes that certainly in Al- Mansuri and Al-Qairawan hospitals, Arabs had single sex wards, each ward had its own drugstore. Miller (2006:618) adds that:

“men and women occupied separate but equally equipped wards and were attended by nurses and orderlies of the same sex”.

This implies that female patients had female attendants or nurses and the opposite was likely to have been true for male patients. This is still the norm in Arabia and within the Islamic culture up to the current time. Women preferably should be looked after and medically reviewed ‘if possible’ by female doctors or nurses. Women as patients and practitioners in medieval Islam were considered by Pormann (Pormann, 2009) in the *Female Patients and Practitioners in the medieval Islam*. In this article, Pormann focuses mainly on this group of women as according to him there is little mentioned in the literature about them. He points out that physicians who dominated historical sources were all men, despite several indications that females contributed to the provision of health care (Pormann, 2009). Pormann is mainly referring to female physicians (tabiba), but we should suppose that this argument can also be extended to female nursing practitioners.

In view of all that has been mentioned so far, one may think, if medicine in the Arab/ Islamic world in the early centuries was the most advanced, and there were many hospitals, and as nursing and medicine have been closely intertwined throughout the ages, then nursing also had an important role to play. Within this context I agree with Maggs (Maggs, 1987) who believes that it is imperative to correlate between the development of nursing to the development of hospital care and medical knowledge.

2.3.3 Accounts on history of nursing in the Arab world

Despite the noble objectives of nursing as a practice throughout history and within different cultures, nursing has kept evolving and changing by being influenced by different factors, such as social, political and cultural and religious factors. Therefore, different societies or cultures have different stories and narratives about how nursing was in the past and the emergence of nursing and hence the history of nursing. In the Arab world, and in the early development of medicine in this region, not much is mentioned in the literature about nurses as practitioners, their role, status and struggle as well as nursing as a profession and as an important component of health care.

According to Jan (Jan, 1996) the foundation of modern nursing is attributed to Florence Nightingale and this was in the 19th century. In the Arab/Islamic world, the first 'professional' nurse is considered to be in the 11th century Rufaida Al Aslamiya. Rufaida is recognized for looking after the injured during war time. She cared for the injured, carried water with other women and attended to the hygienic needs of the ill and the injured (Brewer, 2004; Miller, 2006). Brewer (2004) suggests that Rufaida established a training school to train women to nurse the ill and as such, established rules for better nursing practice. She lived in Al-Madinaha¹⁴ province with her father Saad Al- Aslami who was an outstanding healer in the province. Rufaida aided her father and gained the desire and the skills to nurse the sick and the injured (Jan, 1996). Al-Maliki (Almalki et al., 2011) argues that nursing as a practice became stronger and well recognized by the community when groups of women looked after the wounded and the sick people during the early years of the Islamic age. At that time these women were called 'Al-Asiyat' or 'Al-Awasi', the singular for this word is 'Asiyah'¹⁵ (Almalki et al., 2011). Rufaida's original name was Kuaibah but because of her nature as a caring person, who provided help and support to others, she was given the name Rufaida¹⁶.

¹⁴ A province of Saudi Arabia, located on the country's west side, along the Red Sea coast

¹⁵ These words came from the Arabic verb 'aasa' means caring for (it mainly refer to the emotional support (Al Thagafi 2006; Tumulty 2001) Nowadays, in Arabic the term 'Momarredhah' is used to refer to a female nurse and 'Momarredh'¹⁵ for a male nurse

¹⁶ This word is derived from the Arabic verb Rafada which means assisting and supporting others.

Beside the skills and knowledge that Rufaida gained from working beside her father, she had certain traits such as patience, endurance, and determination (Almalki et al., 2011). The well organized and the systematic care she provided during wars and in the time of peace, as well as her distinguished role as a community leader, and educator of women and girls, all this was enough to draw the Prophet Mohammed's (PBUH)¹⁷ attention to her role in the community. The Prophet (PBUH) then encouraged her to keep training women and young girls on nursing and permitted her to raise a tent inside the mosque for nursing care and training at the same time (Hussain, 1981). Rufaida believed that nursing is one of the noblest careers for Muslim women; she continued to train and educate women in nursing until very late years in her life. After Rufaid's death many women decided to continue what they learnt from her, women such as Nusaibah bint Ka'ab (Kasule, 1998).

Rufaida continued to be a role model in nursing or an inspiring figure. Her position or status in the Arab and the Islamic worlds is perhaps similar to that of Nightingale's to the west. Part two of this chapter shows how the early accounts on history of nursing in the West focused on Nightingale's life and achievements as a memorable figure on the history of nursing. Some writers (Hussain, 1981; Jan, 1996; Kasule, 1998; Brewer, 2004); Miller-Rosser et al., 2006 and Almalki et al., 2011) who are interested in nursing in the Arab/ Islamic world have started to consider writing on the history of nursing and considering Rufaida Al-Aslamiya's life and role as a founder of the Arab/Islamic nursing.

Another historical account on the history of nursing is entitled *Nursing in the United Arab Emirates: an historical background* (El-Haddad, 2006). This study examined the different aspects that might have contributed to the lack of nurses who are nationals of the United Arab Emirates (UAE). In this article, El-Haddad suggests that in order to be able to determine the different factors that made women of the UAE disregard nursing as a possible career for them, it is crucial to review the historical background of UAE as a country, women in Islam and the development of nursing in the UAE. The study concluded that there are

¹⁷ Mention of the prophet Mohammed is always followed by the acronym PBUH as a sign of respect.

few females from the UAE in the nursing sector due to the low status of nursing in the country as well as the cultural insight of the profession. The study is very important as its findings could be generic ones due to the commonalities shared between the Arab countries and people. The title of this article indicates that this study is a historical study, however, the methods and the methodology employed is ambiguous. Moreover, the conclusion of this study presented facts rather than useful results. It does not actually add anything to the history of nursing in the Arab world as nothing new was explored or uncovered in relation to nursing in the past in the UAE.

In *The healing hands of Qatar*, Gotting (Gotting, 2006) suggests that the first Qatari nurse was a male; he worked in Al-Jasra hospital in the 1950s. Nothing was mentioned in this book regarding this male nurse's training or where he studied nursing or any other details about his role and nursing conditions at that time. Gotting herself emphasizes that not much is mentioned about nursing and the role of nurses whether male or female nurses in Qatar in the literature. Some related this to cultural background (Gotting, 2006; and Mobaraki and Soderfeldt, 2010).

Miller-Rosser (Miller-Rosser et al., 2006) undertook a study entitled; *Historical, Cultural, and Contemporary Influences on the Status of Women in Nursing in Saudi Arabia*. This study identifies three eras of the history of nursing in Saudi Arabia from the time of the Prophet Mohammed (PBUH) until the contemporary time of nursing, and they are as follows:

The Islamic period: 570-632 AD, there were no references to nursing or nurses before this period of time. However, within the Islamic period, the Islamic literature made a mention of a female nurse who provided nursing care and education clearly long ago before Florence Nightingale which was Rufaida Al Aslamiya. The post- Prophetic Era: 632- 1000 AD, the literature on the provision of health in general in this period had mainly focused on the role of physicians. Miller-Rosser suggests that physicians at that time also took on nursing tasks. Late to Middle Ages, 1000-1500 AD: this period of time witnessed the advancement of medicine and the building of hospitals across

the Islamic countries. However, as mentioned previously a mention was regarding male nurses nursing male patients and the same was true for the female patients. Yet nothing else was mentioned about their role and their training (Miller-Rosser et al., 2006).

Miller-Rosser then went on to name a number of female nurses who are regarded as pioneers in the history of nursing in Saudi Arabia. After Rufaida, a mention was made about Lutfiyah Al- Khateeb, who studied nursing in 1941 in Cairo. After returning home, Al- Khateeb dedicated herself to the development of women's education in general and of the nursing profession in particular. In this article, Miller-Rosser's aim from this historical review of nursing in Saudi Arabia was to give an insight into how nursing developed in this country, and as a crucial step to the understanding of the challenges facing the Saudi nurses.

In a general sense, in almost every Arab nursing related article or academic piece of work regardless of the main focus of the study, a brief mention of Rufaida Al-Aslamyia as the founder of nursing in the Arab/Muslim world can be found. This is similar to the way early literature on nursing in the west frequently makes reference to Florence Nightingale. History of nursing in the Arab/ Muslim world is an unexplored area. A lot of work needs to be done by scholars especially nursing scholars. They need to start taking what we already know further. Nurses do not have to start exploring the past from a particular period of time. They need to identify what needs to be explored and attempt to explore it. This study attempts to do just that by exploring a small part of the history of nursing in SA, taking into account the important and distinctive characteristics of SA as a colonial setting when it was under the British control.

The next chapter will give a historical overview of SA its location, geography and climate, political history, historical accounts on nursing in this former British crown colony.

Chapter Three: South Arabia, Historical Overview

3.1 Introduction

Part two of the previous chapter provided a critical examination of some of the important early writings on the history of nursing in the UK. Part three of the same chapter, reviewed accounts of the history of nursing in the Arab world. This chapter presents a historical overview of SA, the region which provides the setting for this study, focussing specifically on the period when SA was under the British control and protection and when Aden, the main city in SA was a British crown colony. The chapter will begin by providing an account of SA's geographic and demographic profile. It will then go on to give an account of SA's political history, with particular emphasis on Aden the British crown colony on the period under British rule, as this study has been conducted within this context. The period 1950-1967 will be covered in greater detail, mainly because this period was the formative period during which nurses in SA started to be taught and trained and when the profession began to take shape. The final section of this chapter will provide a review and analysis of some of the more important written accounts of the history of nursing in SA.

This chapter draws on both primary and secondary sources. Thus, whilst some important literature is reviewed, because certain primary sources are utilised, the material has not been included along with the rest of the literature review. The methodology for selecting and analysing the primary source material used here is explained in more detail in the next chapter on methodology.

3.2 South Arabia: Geographic and Demographic Profile

South Arabia is situated in the Middle East region, existing in the south-western and southern end of the Arabian Peninsula. SA is bordered by Northern Yemen to the North and the Red Sea to the west, and Gulf States to the east (Figure

1). Its strategic port is the port of Aden situated in which is the second largest city of what is now known as the Republic of Yemen (ROY), normally referred to simply as the Yemen. Yemen is bordered by Saudi Arabia to the North, Oman in the East, the Arabian Sea in the south, and the Red Sea in the west. (Figure2). According to Searight (Searight, 2003) the Protectorate of SA was formed in 1935. Independently, there were two British protectorates (known as the Eastern and Western Aden Protectorates) contained 24 Emirates, sheikhs and sultanates under British protection under the treaties (Searight, 2003).

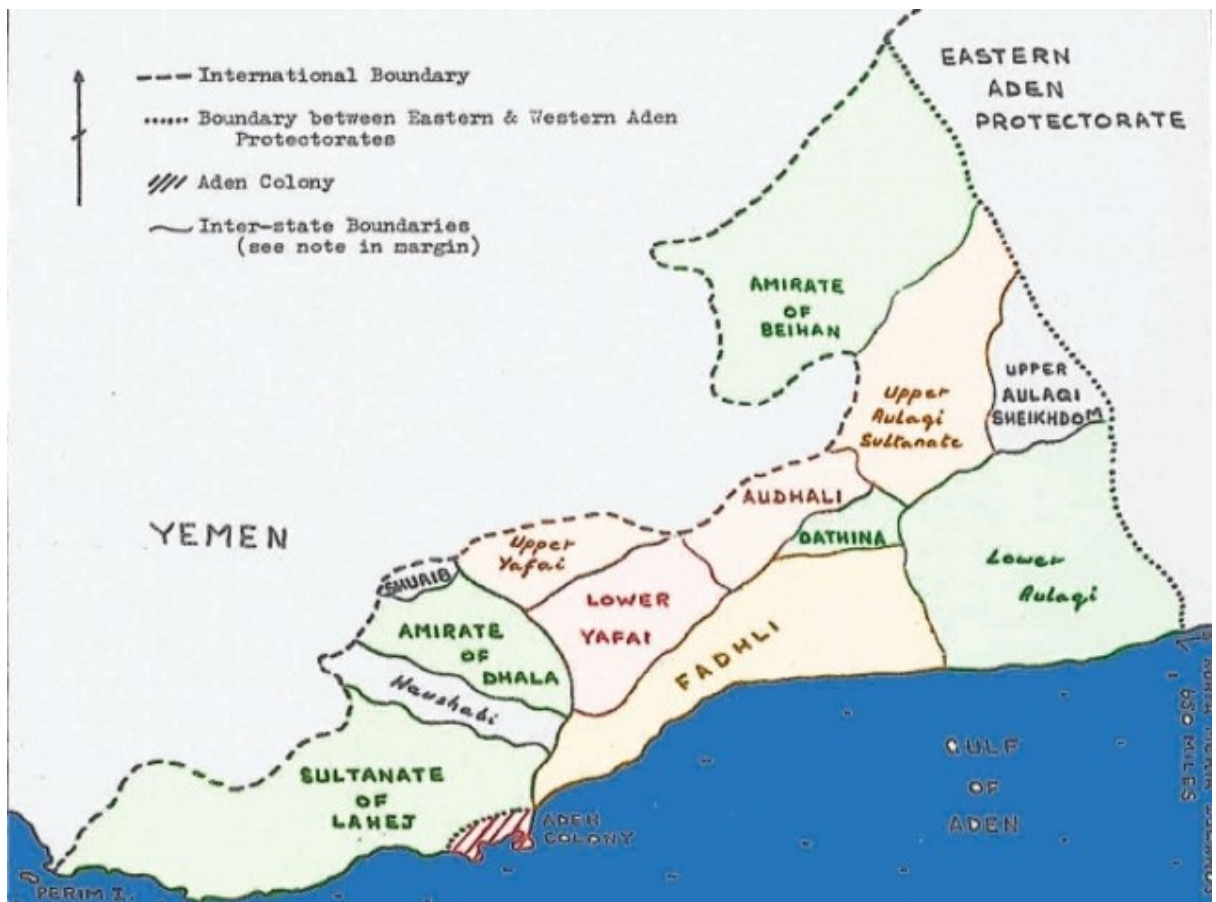


Figure 1: South Arabia, Aden and the Protectorates. (Source: UNICEF, *The State of the World's Children 2011*).

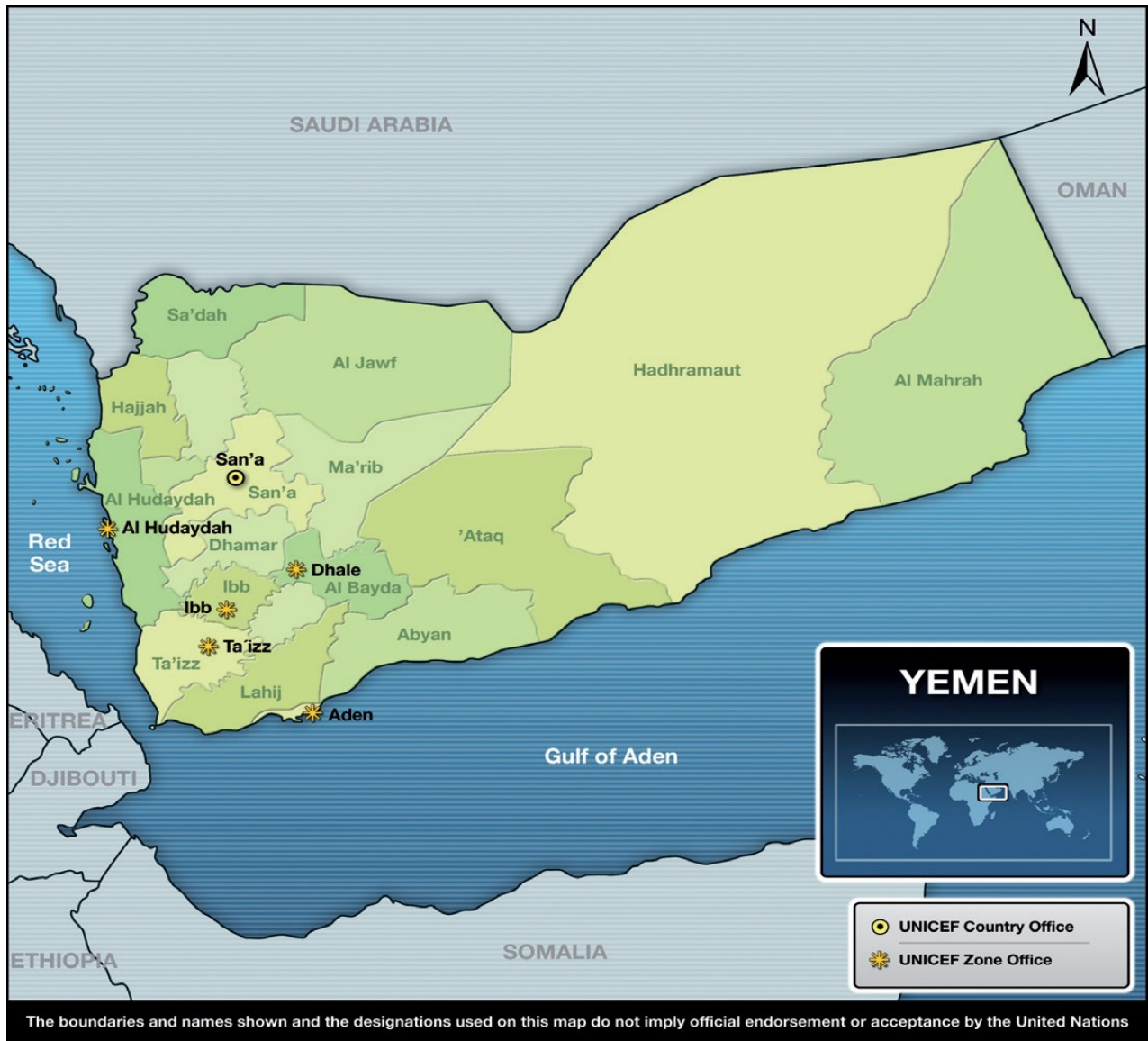


Figure 2: *The Yemen* (Source: UNICEF, *The State of the World's Children 2011*).

3.2.1 South Arabian Culture

SA is considered a Muslim, Arab Middle Eastern region which is now part of the Republic of Yemen. It is also one of the most conservative countries in the region not only in terms of religion but also in terms of traditions, values and customs. The South Arabian culture is a distinctive one. When we write on culture here, we use the definition given by McKay (McKay, 1981) and Pinderhughes (Pinderhughes, 1989) who believe that culture is socially constructed and devised to explain human behaviour and interaction. According to them, culture is the sum total of the ways of living built up by a

group of human beings and transmitted from one generation to another. South Arabians regard their distinctive civilization as a unifying force among the many tribes that make up the population. The South Arabian population is composed of two culturally opposite groups: nomadic and sedentary, the nomadic population, who are well known as Bedouins, nowadays are comparatively few in number. They have integrated with their sedentary cousins in the towns and cities (Morgan, 2006). This is because of the provision of food, water and all life necessities; they do not have to travel and move any more from one place to another for scarce resources and water. They can be seen mainly in the Eastern and Western part of SA. The sedentary population, some believe, covers the majority of the South Arabian people. Among them there are people who live in the coastal areas as fishermen, or in the valleys as farmers (Morgan, 2006).

Religion remains an almost universal attribute of cultures (Murphy, 1979). We can see this clearly not only in the country's law which mixes tribal customs (known as 'urf'), Moslem religious statutes (sharia), executive decree, and parliamentary legislation (Gerber, 1999). It has codified some traditional procedures, while introducing new concepts regulating commerce, labour, nationality, taxes, and civil rights. Outside urban areas, justice and law are still largely administered by traditional figures such as religious judges and tribal leaders (Gerber, 1999). Religion for South Arabians is a way of life; it directs the way they think, behave and act. This means that the SA customs, traditions, and in a wider sense culture, to a great extent determine and control the way the people perceive and view things (Buskens, 2000). This makes us think carefully of how this contributes to the social view towards the nursing profession in that particular society.

3.2.2 History of South Arabia

South Arabia's history is very under researched. According to Hickinbotham (Hickinbotham, 1958) the political and social history of Aden among all the Southern Arabian towns has been well considered in the literature. This is

probably because Aden had a unique status comparing to the rest of SA. Yet, even Aden's history according to Hickinbotham is very difficult to put together and grasp as a whole.

The SA region and Aden in particular in travellers' tales was very important in the past as it has been always known for its splendid coasts. The city of Aden used to be one of the most prosperous cities in the Arab world. Its deep-rooted history is believed to go back thousands of years. It is also believed to be mentioned in Mousnad inscriptions¹⁸; and some say that it is mentioned in the Old Testament as "Eden" (Hamidullah, & Muhammad, 1982). Fleet (Fleet, 2009), on the other hand, went far beyond this and claimed that Cain and Abel were buried somewhere in the town of Aden.

Perhaps the most fascinating part of SA's history is its economic history. Historically Aden's economy has always relied on resources such as the rich self-possessed property owners, merchants, agents, and free-lancers. What presented these people with such valuable opportunities was Aden's unique location as we can see from the map (figure 2). Its exceptional location as a vital harbour linking the Indian Ocean, the Red Sea with the Mediterranean, has also sustained Aden's status as one of the most important and distinguished early Arabian bazaars. This is despite the fact that Aden had experienced many historical upheavals most of which were political. Moreover, Aden has also witnessed a lot of trade between the East and the West: Asian goods would come to the Aden port of Sirah bay, from where they were transported by the Yemenite merchants to the north to be distributed from there to the ancient Orient and from there to the most important cities of the Mediterranean (Kour, 1981).

In the 16th, 17th and 18th centuries, SA was an economic base of the coffee trade through the port of Mocha. Its prosperity and wealth has always attracted other

¹⁸ Pre-Islamic Arabic inscription said to be the oldest inscription and estimated to be from the first century BC and it was written in what is called the Mousnad script which was used by ancient Arabic communities HAMIDULLAH, M. & MUHAMMAD 1982. *A Letter of the Prophet in the Musnad-script Addressed to the Yemenite Chieftains*, Hamdard Islamicus..

powers. Some believe that a new chapter of the history of the Red Sea and the Indian Ocean was opened when the Portuguese sailor Vasco da Gama discovered the route around the Cape of Good Hope in 1497 AD (Playfair, 1970). Some years later another Portuguese, Captain Affonso D'Albuquerque understood the strategic significance of Aden and tried to take possession of it. But Aden at that time was a well-fortified city under the rule of Bani Taher (1455-1518), one of the most powerful dynasties in the history of Aden. In 1504, the Portuguese returned to the Red Sea, but this time their king decided to have an Eastern Empire to enhance their power and presence in one of the most important regions in the world, the Middle East. First he started by exploring Arabia; he sent a ship to the Red Sea, which captured an Arab ship and treated its crew in an inhuman manner (Playfair, 1970). According to Playfair, this act was meant as a message to be sent from the king of Portugal to the people of the area of Shihr in Hadramout governorate in the eastern protectorates of SA informing them of his country's presence in the region or perhaps power of sovereignty in the area.

Alarmed by the presence of the Portuguese in the Red Sea, the Egyptians occupied the Yemeni Tihama, but they failed to take over Aden. Aden finally fell into the hands of Pasha al-Khadim, Commander of the fleet of Suleiman the Magnificent in 1517 AD (Kour, 1981).

Aden, however, was used by the Ottomans as a base for their operations against the Portuguese settlements on the west coast of India (Kour, 1981). From Aden, the Ottomans reached Mocha and established their authority along the coast of the Yemen. It is from this point that Aden is believed to have become associated with the Yemen due to the fact that the Ottomans had finally captured Sanaa and conquered the whole country including the city of Aden. Not very long after, in 1540, the Adenies rose against the Ottomans and forced them to leave Aden. Later, when Aden had already been under the British occupation since 1839 and from the early 20th century Britain started to gradually control the whole region of SA (Kour, 1981).'

3.3 SA under the British Rule 1950-1967

3.3.1 Political and economic aspects

For some, SA's modern history began with the occupation of the harbour of Aden by the British Captain Stafford Butterworth Haines from the Indian Navy in January 1839 (Gavin, 1975). This occupation took place when the British East India Company landed Royal Marines at Aden in order to stop attacks by pirates against British shipping to India. Those pirates were believed to inhabit the regions around Yemen. However, the principal reason of the occupation of Aden was for its strategic location (Gavin, 1975). Since that landing, Aden was to remain under British control as part of India until 1937 when Aden became a Crown colony. When the British arrived, Aden was a small fishing village with only 1289 inhabitants.

Different writers advance different ideas regarding the motives behind any colonisation. Brysk (Brysk et al., 2002) believe that the best explanation of any colonisation is economic and that capitalist European societies were driven to foreign expansion by their objective needs for markets and raw materials. In contrast, other scholars such as Gavin, 1975, Cohen and Books, 1973 believe that the main reason behind colonisation is the competition for power between European states. In this particular case, Gavin (1975) asserts that the motive behind the occupation of Aden by the British was Anglo- French competition in the Middle East. He reminds us of the Egyptian ruler, Said Pasha, who awarded the French a special privilege to achieve the visionary project of connecting Europe with the East by a canal across the Isthmus of Suez. This had become a realistic prospect by 1856. As a result, the British began to consider the states bordering the Red Sea. For them Aden's location would play the most important role in opposing France's plans in North-East Africa and Arabia and according to that account, Aden became an important cornerstone in the British strategy. Despite the rivalry over power in the Middle East, Gavin also points to the good relations and the mutual understanding in the form of an undocumented agreement between Britain and France between 1841 and 1846 which had aimed to avoid any conflict between the two countries.

Another motive behind the British or the foreign occupation of SA and initially of Aden was mentioned last century in a joint meeting held by the Middle East Association and the British-Yemeni Society in 1998¹⁹. In this meeting, Captain Roy Facey stated that the importance of Aden to the British or other powers was not so much Aden's political as its economic importance. He emphasizes that Haines was right when he predicted that Aden could become a major trading centre, as Aden has many advantages for shipping. Facey believes, that this, in addition to Aden's strategic location, made it a regional distribution centre.

Furthermore, in addition to its importance as a trading centre, as mentioned several times, Aden's location made it, in pre-aviation days, a popular exchange port for mail passing between places around the Indian Ocean and Europe. In the early days, the postage stamps of British India were used, with no special identification of Aden. This changed in 1937 when Aden became a crown colony, and a series of pictorial stamps inscribed 'Aden' were used. For the British, Aden was a virgin land, its wealth and resources had not been explored and were waiting to be exploited. The economy of Aden was also based on the port facilities, especially after the development of the oil refinery, which was built in Little Aden, and depended more on migrant labour (Gavin, 1975).

SA under the British consisted of two parts. First, the Colony of Aden (see figure 3) covers an area of 70 square miles and consists of: i) the port of Aden; the Khormaksar area, which contains a British airfield and an oil refinery; the town of Little Aden and the Crater district, which housed around 700,000 of the inhabitants (Mawby, 2005). From a population of about 500 it grew to about 140,000 in 1955 census year (Mawby, 2005). The second part was called the Aden Protectorate. This included the Eastern Protectorate which consisted of the Arab Sheikdoms of Hadramout, the island of Socotra and small parts of

¹⁹ See the British Yemeni Society

(<http://webcache.googleusercontent.com/search?q=cache:UF8xeV06tEYJ:www.al-bab.com/bys/articles/facey98.htm+&cd=1&hl=en&ct=clnk&gl=uk>)

west Oman with Mukalla the capital and the Western Protectorates which consisted of the area of Dala, Lahaj and Upper Awlaqi, with Lahaj the Capital.



Figure: 3 *The Colony of Aden 1962* (Source: www.psywar.org)

3.3.2 Social conditions during the later colonial period

During the later colonial period (1950-1967), Aden society was characterised by high population growth; a flood of immigrant labour and the problem of accommodation. This was in addition to the failure of public order and the growth of nationalism. Nevertheless, it can be argued that an understanding of these factors is important if we are to understand perhaps one of the most important dimensions within the social life of any given population and this is the health dimension. To cover this period, some contemporary records have been used from The National Archive (TNA) in London; these primary sources give a unique description of the social and political situation when Aden was under British rule in the period being studied.

A consideration of Aden's social conditions is crucial in any attempt to explore the history of nursing in Aden for two main reasons. The first reason is that at the end of this section one should have gained some insight into the social life in Aden during the period in which nursing as a profession started to be considered first as an academic field that needed to be taught in educational institutions, and second as an occupation or vocation. Furthermore, in this thesis, it is hoped that information about the social conditions will increase our understanding of the motives behind the growing interest in nursing as a profession in terms of the establishment of nursing institutions and the systematic development of educational attainment of nursing qualifications in the period under study.

3.3.3 The Chinn report

In 1953 Chinn (TNA, 1953) the Social Welfare Advisor to the Colonial Secretary at that time described the living conditions in Aden as appalling (TNA, 1953). Chinn's visit was not to all SA, he visited only Aden and prepared a report on the social welfare of the colony to the British Government. In this report, his main concern was the deterioration of the social conditions among which were poor housing conditions. He regarded this as one of the most important consequences of the influx of immigrant workers. This should be viewed in the context that Aden was becoming one of the busiest harbours in the world during the period of British colonial rule. The growth of Aden brought with it large numbers of migrant workers from other parts of North Yemen, Somalia, Pakistan and India. This increased the burden on the administration, which had to cope with maintaining social services for the population while facing an uncontrolled flood of migrants. Thus, this influx of immigrants increased the pressure on all public services including health services.

3.3.3.1 Immigrant labour and the Problem of Accommodation

In 1951, a committee was established to discuss the flood of immigrant labour, as this in turn had aggravated the housing problem (TNA, 1953). Until the writing of his report, Chinn believed that since 1951 little had been done to

alleviate this hardship. In the same report, Chinn declared that there was lack of statistical information on the population and existing housing. Here one cannot exempt information on the health of this population. The committee, which had been dealing with this problem, had given some reasons for this situation and made some practical recommendations in order to relieve the problems.

However, Chinn believed that the problem of immigrant labour should have been dealt with as part of the general scheme of social and economic development. He acknowledged that more consideration by the government had been given to building the labour side at the expense of social welfare implications. If the colonial power at that time was aiming for the development of the population of the colony, the element of housing which was described by Chinn as unsatisfactory would have been dealt with immediately before it became an acute problem that led to other social and health problems²⁰.

The continuous growth of the population in Aden and the problems that resulted from this growth obliged the colonial administration to seriously consider the social welfare of the colony. However, there may have been additional reasons why the British began to take a greater interest in the social aspects of the colony at that particular time. Chinn's report suggests that there may have been certain political and security reasons that made the administration reconsider the importance of managing people's social lives and improving their standard of living. Evidence for this is that, although SA had been under the British rule since 1839, it was not until 1951 that an officer specifically dealing with social welfare was appointed, writes Chinn (TNA, 1953: 3). It is also important to bear in mind that this period more or less corresponds with the emergence of Arab nationalist movements across the Middle East. Chinn finds support for this by pointing out that it was in 1938 that Aden became a crown colony but it was only after the WW2 that social problems had begun to receive more attention.

²⁰ See Martin MARTIN, C. J., PLATT, S. D. & HUNT, S. M. 1987. Housing conditions and ill health. *BMJ*, 294, 1125-1127. Housing conditions and ill health and Dunn, JR DUNN, J. R. 2000. Housing and health inequalities: review and prospects for research. *Housing studies*, 15, 341-366. Housing and Health inequalities: review and prospects for research

Before 1951, social welfare had been dealt with by an Adeni officer who was appointed and trained by the colonial administration to deal mainly with 'immature individuals with criminal behaviour' (TNA, 1953).

Another potential motive behind the recognition of the importance of social welfare in the colony of Aden may have been the introduction in Britain, by William Beveridge of a system that resulted in the foundation of the welfare state in 1942 (Colwill, 1994). The central rationale of this system was the provision of social services on the same basis as the public services (Atkinson, 1995). This system was set up to ensure that the national government of the United Kingdom took responsibility for the social security, housing, education, health and welfare of the population. One specific outcome of Beveridge's proposals was the establishment of the National Health Service (NHS) in 1948. As a result of these developments, the British government may have felt the need to initiate similar policies in its overseas colonies in order to tackle problems such as the spread of diseases, social security, housing and health issues.

3.3.3.2 Social Security

In his report, Chinn (TNA, 1953) claimed that crimes of serious nature, to his surprise, were low in the colony, yet were increasing in number. Most of the crimes in Aden were committed by young people. The majority of them were migrants, who came to Aden from different parts of the country for a better life and work opportunities. Reasons behind the increase of crimes probably vary; one reason for the increase in crime, for example, may have been unemployment, another contributing factor may have been the rapid rise in population. The very high levels of illiteracy may also have been an associated factor. This could be the case in Aden at the time this report was written after nearly 114 years of colonialism and around 98 years since Aden was made a crown colony. Chinn confessed that the crimes committed by those young people were a strong indication of the social life in Aden, saying that there was clear evidence of a "tragic waste of young lives". As there were many young boys thought to be at risk of offending, the colonial power decided to set up an

institute for children. This institute according to Chinn was meant to cover the different aspects of child welfare in the Colony.

Education was another of the social projects that that the colonial power decided to undertake. Education during the colonial period in SA will be examined in the next section.

3.3.4 Education

The pre-colonial education in the Middle East including SA was mainly the responsibility of Mosque schools (maalama) and was thus permeated by religion. It relied heavily on studying and memorising the Qur'an, and the use of religious scriptures, texts or stories to teach ostensibly secular subjects, such as geography or history (Asad, 2009). The individuals who provided or presided over those services were religious scholars who saw the education of young boys to be one of their many religious duties in the community; and they were not full-time teachers. This type of non-formal education was directed towards the development of the individual's personality, and provision of the best quality of life, not merely in relation to an individual's future practical needs, such as knowing how to read and write and do basic arithmetic, but also in relation to his/ her moral behaviour, and attitudes.

The colonial penetration of SA, introduced a new model of Western education. According to Starrett (Starrett, 1998), at that time this model was also new in the west,

“It was not until 1862 that British law made the efficient teaching of reading, writing and arithmetic, rather than doctrinal matters, the acknowledged centre of the curriculum and the subjects qualifying a school for government grants-in aid”.

(Starrett,1998:32)

The handfuls of schools created in SA mainly in Aden by the colonial administration were designed to produce the educated personnel needed mainly for the colonial bureaucracy. Thus, the establishment of the British educational model and its institutions in SA was used as a tool for serving the colonial socio-economic and political system. Kelly and Altbach (Kelly and Altbach, 1984:2) state that:

“Colonial schools sought to extend foreign domination and economic exploitation of the colony”.

Since the colonial administration was only interested in producing the raw material for the benefit of its imperial project development, it bore no relation to the development needs of the wider population of the colony. Nevertheless, this project faced different responses from the population of the colony. There were those who accepted what the colonial power introduced and there were those who refused and rejected this opportunity. This should remind us of what Albert Memmi (Memmi, 1991) pointed out to in relation to the colonised person who accepts the colonial situation and the person who refuses to be colonized. In this particular case, probably not all the population of SA responded positively to this type of education and this is perhaps what made Hickinbotham (Hickinbotham, 1958: 154) claim that:

“In all rural areas, education seems to be of secondary importance to the inhabitants and the Aden protectorate was no exception to this rule”.

It might be useful for us to ask whether an Eastern/Islamic educational model, which introduced to the West under an Eastern colonial administration would have fared any better; how many people in the west would be interested in such educational model? The rejection of the educational project offered by the colonial power in SA was probably due to the fact that the model minimized the amount of time devoted to religion in the schools. It was not based on religious faith, and was not taught through the medium of religious texts (Starrett, 1998).

Nevertheless, education is considered as the most important means to develop nations, the most powerful weapon for improving a person's status as well as the most potent force for social change. Furthermore, the term education process according to Carmen (Carmen, 1996:64) is often used as a synonym for the development process. The acceptance of this western educational model by a small number of people worked very well for the colonial administration's interests as the colonial power probably was not very keen in educating or developing the whole population. This view point has been supported by Ajayi, Goma and Johnson (Roberts, 1997) who assert that at all events the prevalent attitude of the colonial regimes was to neglect education for the masses or, at any rate, seek to limit its provision.

On the other hand, and according to the records of the Colonial Office, in the education proposal that was introduced by the government of Aden in 1958-1959 (TNA, 1958) and contrary to what Hickinbotham (Hickinbotham, 1958) claimed, there was a strong need and desire for education among the people of the protectorates. Those people were mostly people of the Western Protectorate, one of which is a state ruled by the Fadhli family, who were considered as one of the closet allies of the colonial power.

The aforementioned colonial education proposal (TNA, 1958: 10) alleges that:

"In 1958 education on modern lines is a very recent development indeed in this protectorate and that at that time there were very small number of local people with sufficient educational background".

In the same vein, Hickinbotham (1958) believed that there was a lack of sufficiently well-educated and trained men to staff their own schools. Such belief, however, is probably a fairly typical idea in the mind of the coloniser who tends to perceive himself as superior in terms of educational background, regardless of how relevant this educational background might be to the culture of the colonised. A relatively similar picture has been drawn by Paulo Freire (Freire, 2000) in his famous book the *Pedagogy of the Oppressed* in which he introduces the 'banking' concept of education, in which the 'scope of action'

permitted to those who receive education widens only up to the level of receiving. Freire suggests that knowledge in this case can be seen as a donation or a reward from those who consider themselves 'knowledgeable' upon those whom they consider to know nothing.

“Projecting an absolute ignorance onto others, a characteristic of the ideology of oppression”

(Freire, 2000: 46)

Here I will not attempt to embark even further on writing on the colonial achievements on education in SA. I think it is rather more important at this stage to mention that the colonial education proposal in the Colony was not organised and implemented by the Director of Education until the 1950's. The core objective of this proposal was to make the most of local talents in order to carry out any development schemes that may have been envisaged (Hickinbotham, 1958). The need for personnel in certain areas like health was a necessity in order to combat the spread of diseases and meet the population's health or medical demands. The next section will attempt to review health and health services in SA in the period under study. What we know so far about nursing, whether as a service, or occupation in the period when SA was under the British rule, will be also reviewed.

3.4 Health and Nursing Services in SA (1950-1967)

3.4.1 Introduction

Medical health and nursing services are both understood to be part of the wider colonial medical project introduced by the colonial power to the colonies. In the past thirty years or so, an initially small but ever increasing number of historians of medicine have started focusing on disease and health care issues in the former British colonies. This has resulted in an appreciable compilation of literature on colonial medicine and health in these colonies. Among those, two important accounts stand out in terms of the increasing attention given to

medical issues in the colonial period as an important research area. These are *Disease, Medicine and Empire Perspectives on Western Medicine and the Experience of European Expansion* by Roy MacLeod and Milton Lewis, published in 1988 (MacLeod and Lewis, 1988), and *Imperial Medicine and Indigenous Societies* by David Arnold (Arnold, 1988), published in the same year. In the first book, the two authors who are medical historians, while focusing on colonial medicine, demonstrated how the medical profession during the colonial era represented what they refer to as an 'imperializing cultural force' (MacLeod and Lewis, 1988:1). Arnold's work, on the other hand, is a collection of ten papers by different authors. The contributors to Arnold's book share one important theme in their articles: they address the question as to how colonial medicine reacted to the spread of epidemic diseases in their respective areas of study.

Imperial Health in British India is another important work, by Ramasherubban (Ramasubban, 1988) that also focuses on the various epidemic diseases prevalent in India during the period 1857-1900. Although this study also focuses on epidemic diseases such as malaria, cholera, dysentery and diarrhoea, it stands out by its elaborate demonstration of how the spread of these diseases influenced the living conditions of the colonial officials and their families, which had the effect of making the British feel that they needed to design comprehensive tools to prevent and treat the rapidly spreading epidemic diseases. In contrast, the Indian response to the British proposals to overcome health issues are considered in the *Colonizing the Body*, in which David Arnold (Arnold, 1993) explains why, after a century and a half of British rule, western medicine was resisted by the Indians. He believes that this was most likely due to the fact that western medicine was always seen as coloniser's product. Nursing, whether in the form of services or education, cannot be excluded from the scope of this analysis, as nursing always is an integral part of medicine. In the same vein, Farley, (Farley, 1991) argues that colonial medicine existed primarily to make the tropics fit for the colonisers and their families to inhabit. He suggests that medical services were intended, first, to preserve the health of the colonisers, including the colonial officials and their families, troops and the local elite; and second, to contain disease among the colonial economy's

support workers, be they indigenous labourers or immigrant workers. This viewpoint should remind us one of the reasons behind the establishment of the colonial nursing association, which has already been explored in the last chapter: it was to a large extent set up to serve the needs and interests of the colonisers. This would imply that the story of the establishment of health services or nursing services during the colonial period in SA was perhaps similar to that of education; the coloniser's needs and interests came first.

Moreover, in Africa, in her book, *Curing their Ills*, Megan Vaughn (Vaughan, 1991) investigates the colonial administrations and African sickness in British colonies between the 1890s and 1950s. Vaughn explores how the colonial administrations worked. She suggests that colonial power depended to a large extent on 'repressive' methods, a common trait of pre-modern regimes, whereas missionary medicine, according to Vaughn, focused mainly on the psychological as well as the physical health of populations.

“Healing, for medical missionaries, was part of a program of Social and moral engineering through which ‘Africa’ would be saved.”

(Vaughan, 1991: 202)

Thus, in this analysis of medicine in colonial Africa, we once again see that the motives for providing services to the local population were partly in the interests of the colonisers, or at any rate in the interests of the prevailing ideology of the colonisers, in other words, the spread of Christianity.

In the next section health conditions in SA during the studied period will be the next to examine.

3.4.2 Health Conditions in SA (1950-1967)

According to Kour (Kour, 1981) SA and Aden in particular was not on the whole an insanitary land. The rarity of rain, and the porous nature of the rocky subsoil through which all moisture percolates, as well as the hot climate, all contributed to the limited spread of infectious diseases in the town. In Aden in January 1841, according to Mignon who is the first Bombay European Regiment for example, there were 1763 cases who suffered some sort of illness among the British and the Indian troops with only 88 cases of severe conditions. Mignon emphasises that the monthly number of cases of illness among the troops in Aden was much less than that in Bombay. This contradicts his claim that Bombay station was a better and healthier environment compared to Aden (Kour, 1981).

Kour asserts that diseases were mostly transmitted to the colony by the shipping industry and by soldiers coming from India and elsewhere outside the colony. Thus the three apparent sources on which the spread of disease in Aden can be blamed are, first, the increasing contact between the people of SA and people from the other colonies of the British Empire (such as Somalia and India). Second, as mentioned by Kour, the constant travel by armies between the British colonies, and, thirdly, the displacement of people or in other words immigration for reasons of job opportunities, as discussed earlier in the section on the Welfare in Aden. These three factors not only enhance the spread of disease but also contribute to the introduction of new ones (Hartwig and Patterson, 1978).

Overcoming epidemics imported from the outside remained a priority. For prevention purposes, and in order to reduce the chances of the spread of diseases in the colony from the outside, the colonial government established what was called "Harbour Police" (Kour, 1981:17). The main duty of its members was to inspect all ships before they reached the port and ensure that the crews had acceptable health checks from their initial point of departure. However, as regards to the increase of immigrants into SA and especially into Aden which is the most important factor for the colonial power, there is no

evidence that the colonial administration in SA decided to control the flood of immigrants to the colony.

There is lack of information and accounts on diseases and the spread of epidemics in Aden and the western and eastern protectorates under the British. Most of the obtained accounts were found in non-academic Yemeni journals written by individuals interested in the history of Aden during the British colonial period rather than public health and medicine in the colony at the time.

However, Hussain (Hussain, 2012) in an attempt to examine the history of health services in SA in the period 1843-1967 believes that although Cholera, for example, was not an endemic disease, Aden in particular witnessed many outbreaks. The first outbreak according to Hussain was in 1846. The cause of the spread of the disease was thought to be due to the accumulation of waste in the city of Aden, the heavy rains in May 1846 and the lack of modern sewer services at the time. The epidemic lasted for 33 days and the final outcome was 500 deaths, including 20 British (Hussain, 2012). The second and third outbreaks of Cholera in Aden were not as bad as the first outbreak; what helped the non-proliferation of the diseases was the reduced periodical rain falls and the absorption of the rain that did fall by the layers of absorbent bedrock. Furthermore, Kour (1981) believes that the two most common types of diseases in Aden especially during the hot season were ulcers and skin diseases (Kour, 1981). These types of diseases were mainly the result of the lack of fresh vegetables and sanitation. Smallpox was also prevalent in the city in general due to lack of health education. Tuberculosis was also common and largely attributed to poor accommodation as mentioned earlier. Health services as clinics and hospital community health services are crucial. The next section will give account on what health services existed in SA in the period under study.

3.4.3 Health Services in SA

Very few studies on health services and the colonial achievements on health were conducted by the colonial administration during the colonial period.

However, in an article written by Van Meures and Wylie (van Meurs and Wylie, 1948), for the British Medical Journal (BMJ) entitled *The colonial medical services in Aden*, the authors emphasise that it is 'only recently' that authorities started to give more consideration to health services. They criticised what they called 'backward conditions' of the health service and hoped that their article would not be a reason for dispiriting other doctors to travel and work in SA; rather the article was written to encourage an urgent response to the appalling health situation in the colony. The two doctors worked as officers in charge of the medical and surgical divisions at the Royal Air Force (RAF) hospital; both had to work for six months as surgeons and as anaesthetists in turns as the Civil Hospital in Aden had neither.

The Civil Hospital, which was built in 1843, is thought to be the first hospital to be built in the history of Aden. At that time, it was merely a small building with one ward which contained 24 beds; thus it was difficult to split it into male and female wards. This prevented many women seeking medical treatment (Hussain, 2012). Due to the poor condition of the hospital, the lack of proper ventilation and sanitation and shortage of staff and domestics, the doctor in charge had to write to the colonial office explaining the situation and suggest building a new hospital with all the necessarily equipment and a complete crew of staff such as doctors, nurses and health providers. Playfair (Playfair, 1970) who was the colonial officer at that time formed a committee to collect donations for the new hospital. As a result, the new hospital was established in 1861 with new medical equipment and several departments and specialities. Since then the hospital continued to serve all people from the colony and its surroundings. In 1948, Van Meures and Wylie (van Meurs and Wylie, 1948) described the capacity of the hospital as frighteningly poor as, at that time, it had to cater for a population of 80,000 with the same capacity as it had in 1897. Indeed, in the same year, although the Civil Hospital accepted emergency patients, they had to be nursed on the floor as all beds were occupied. Furthermore, all of the wards lacked up-to-date equipment and the general situation made it impossible for the overworked staff to keep the environment and the patients clean. Crucial supplies such as blood, plasma, saline and oxygen cylinders were supplied by the RAF hospital; sterilisation was also carried out by and at the

RAF hospital. Van Meures and Wylie (1948) hoped that the government were planning to build a new hospital and that this, should improve the situation, however, they emphasised that the problem was not something to do with merely the buildings. They concluded their article by asserting that:

“It is worth remembering that Aden is a “shop window” for Great Britain and that there can be no poorer advertisement than the existing medical arrangement”

(van Meurs and Wylie, 1948:369)

The 1950s witnessed important events in terms of the reformation of the Civil Hospital and the construction of the British Petroleum (BP) Hospital in 1952 and the Queen Elizabeth Hospital in 1954. By 1958, the Civil Hospital and the Queen Elizabeth Hospital (QEH) together provided 611 beds. They served all people in the colony, the protectorates as well as patients who came from the North Yemen, while the BP or the Aden Refinery hospital was a private hospital with 130 beds that served the employees of the Aden refinery and their families who were mainly British (Aulaqi, 2008)²¹. In addition, the RAF hospital, which was considered as the one of the oldest buildings in Aden, with 180 beds, served all the British forces in the Aden protectorate and their families.

Moreover, there was also the Khormaksar hospital Beach which was a small hospital offshoot of RAF Hospital with another smaller hospital mainly used by the natives. This hospital was completed in Jan 1965 with a helicopter landing pad and was used to treat mostly urgent surgical cases of the British forces only (Aulaqi, 2008).

Unfortunately, there is lack of data on hospitals or health services in general in the rest of SA. This demonstrates that Aden has had more attention than the rest of SA as a British Crown Colony.

²¹ An article presented to the British Yemeni Society at the Middle East Association on 15th May 2008 entitled *The Aden Refinery’s Medical Division 1978-1982 (2008)*.

3.4.4 Nursing Services

Relatively little is known about nursing in SA in the period under study. We do know that there were a considerable number of British nurses who worked in SA and mainly in Aden alongside British doctors in this period of time. We also know that during this period of time nurse training was given more attention and enhanced by the colonial power. However, only a few academic articles and British parliamentary papers have mentioned nursing services, education and training when the British ruled SA and these references and accounts tend to be quite superficial.

Saroori for example, in "*A brief reading in the history of the Republic Teaching Hospital and the reality of the evolution of the nursing profession in Yemen (1958-2001)*" (Sorrory, 2001), points out that his book is the first attempt to review the past, present and the future of the Republic Teaching Hospital (known as QEH, during the British colonial period), for the critical role it played in the health services in SA and in Aden in particular. Saroori went on to illustrate how this hospital contributed to the treatment of many infectious and epidemic diseases, even though since its establishment, it relied heavily on British doctors and nurses. Although Saroori's book gives us a unique account of the history of the health services from after the British withdrawal from SA in 1967 until 2001, he seems to have found it difficult to cover in any depth the earlier years. This is probably related to the lack of information available about this period. Nevertheless, he underlines the fact that the British doctors and nurses who witnessed the early days of this hospital worked side by side with Somali and Indian staff and a small number of native workers. From the title of Saroori's book, one would expect a considerable reference to nursing services or training from at least 1958. Yet the book provides no accounts on nursing services, or training. The rest of Saroori book deals with the nursing profession in SA in the post-colonial era. In particular, he focuses on the reality of the status of nursing from the withdrawal of the British in 1967 until 2001. The book is recommended to those who want a good reference on post -colonial nursing in SA, but it does not fill our gap in knowledge about the nursing profession in SA during the colonial period.

One source of information that is available to the researcher is online records of the British parliamentary business known as Hansard. The Hansard records make reference to nursing in SA and to the training of nurses in 1961 in particular. One of the reports considered nursing training for Arab girls in Aden (Hansard, 1961), suggesting that bursaries should be offered to the girls in the colony of Aden to study nursing, however, there is no mention to such thing in and for other parts is SA (Hansard, 1961). In the same report a mention was made on the available training facilities, but there was no reference made to where the training would take place or to who provided the training. The report emphasised that the number of trained nurses and nursing trainees in Aden was insufficient, but no further data regarding the number of trained nurses in the colony were given nor were any recommendations as to how to overcome this situation. The Hansard online resources have no more information regarding nursing or nursing training during the rest of the studied period.

Important questions therefore remain about the nursing services in SA and its surrounding areas from 1950-1967. These are as follows:

- i) Where the nursing services were provided and who were able to access them?
- ii) Who provided these services and how was the provision organised?
- iii) What was the role of nursing within the overall provision of health services?
- iv) What did the training of nurses consist of and who provided this training?

The next chapter will present the research process and the methodology of the study.

Chapter Four: Methodology and Methods

Introduction

This chapter reports on the steps that were taken in carrying out this research. It begins by describing the overall design of the study. It then moves on to explain the rationale for deciding to undertake a historical approach, before giving an account of the specific methods adopted for data collection, the sampling and data analysis. Ethical issues and the limitations of the study will also be considered.

4.1 The Design of the Study

It would be very difficult, if not impossible to answer the research questions about the history of nursing in SA by relying on classical quantitative methods. These types of methods are derived mainly, if not only, from the 'scientific inquiry' paradigm, which relies on data in the form of numbers and quantifying relationships between variables. Qualitative research in contrast can be:

“Any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification”.

(Strauss and Corbin, 1990: 17)

In qualitative research, the data are not in a numerical form as they consist of spoken words, actions, gestures and documents. Qualitative research, therefore, is considered to be an important methodological option for conducting research, particularly in the social sciences and other human science disciplines; its methods are often used inductively, for exploration, theory building and description, and mainly focus on the lived experience, interaction and language of human beings, which is particularly relevant to the challenges of conducting this research study. Moreover, qualitative methods can be used to better understand any social or human phenomenon about which little is yet known (Strauss and Corbin, 1990). Although there are differences between

qualitative approaches (Creswell, 1998), it is sometimes difficult to find clear distinctions between them, even though these may be important.

This is the first study which is concerned with the history of nursing in SA. It is therefore by definition a historical study and historical methods have been adopted. Furthermore, as this study will operate predominantly in the field of the social sciences, qualitative methods have been deemed to be the most appropriate as well as the most effective to deliver results. Hungler and Polit (Hungler and Polit, 1999), in this regard, believe that it is up to the researcher to choose the appropriate method for their research. Nevertheless, it is imperative to remember that the nature of the research question may serve to determine a particular research method.

4.2 Historical research

The historical method of research can be applicable to all academic fields, as historical inquiry encompasses the origins, the growth, the theories and all aspects related to the chosen field, profession or phenomenon (Marshall and Rossman, 1999). Historical research also sheds light on the present and gives guidance to the future (Jordanova and Jordanova, 2000). All these reasons have motivated myself to embark on a historical research project in an attempt to reveal a small part of the history of nursing in SA and how this helps explain current systems and behaviours. An important question at this stage is the one asked by D'Antonio (D'Antonio, 2008:12) which is:

“How do historians actually do historical research?”

Historians follow different stages in conducting historical research, however, according to Lusk (Lusk, 1997) similarities do exist. Similarly, Austin (1958) believes that the steps of conducting historical research in nursing are no different from those of any other discipline. Austin (Austin, 1958) and Lewenson (Lewenson and Herrmann, 2008) who represent two different and distant eras

of historiography of nursing, both present guidance and means for carrying out a historical research project in nursing by nurse historians, suggesting certain steps in doing historical research. In her article, *Historical Methodology for Nursing Research*, Lusk (Lusk, 1997) identifies ‘stages’ in outlining her preferred approach for conducting historical research. Table One compares the stages of historical research delineated by these three influential analysts.

Table 1: *Comparing Austin (Austin, 1958), Lusk (Lusk, 1997) and Lewenson’s (Lewenson and Herrmann, 2008) steps or stages in historical research*

Austin (1958)	Lusk (1997)	Lewenson (2008)
<ul style="list-style-type: none"> • Identifying a particular problem • Reviewing the literature relevant to the studied topic • Analysing the data • Reporting 	<ul style="list-style-type: none"> • Choosing a Topic • Finding and Gaining Access to resources • Analysing, Interpreting, • Reporting 	<ul style="list-style-type: none"> • Identify Area of Interest • Raise Questions • Formulate Title • Review Literature • Interpret Data • Write the Narrative

Although, Lusk (1997) and Lewenson (2008) and many other historians such as Reverby (1987); Glass (1989); and Nancy et al. (1993) believe that historians do not share a particular methodology to pursue historical research, they agree that, regardless of differences, there are common methodological points shared between all historical research. This in one way or another implies that, there is no one single historical method to follow. However, novice historians have been advised by Austin (Austin, 1958) and later by Hamilton (Hamilton, 1993) to equip themselves with the best available techniques of historiography.

Austin and Lewenson’s steps for carrying out historical research lack perhaps the most important step, which is the data collection, without which nothing can be analysed, and no conclusions can be drawn. Lusk’s stages, in contrast, would appear to be easier to follow even though the data collation stage was tentatively mentioned and replaced by “gaining and accessing resources” which

is rather general and does not necessarily cover all forms of data collection. Furthermore, for Austin, the first step of conducting historical research in nursing was “identifying a particular problem”, something which might not be necessarily be the case in all historical investigations. In Lusk’s (1997) and Lewenson’s (2008) schemes choosing or identifying an area or topic as a first step seems more comprehensive and therefore could be applicable to most if not all historical studies. Bearing all this in mind, in this study I have decided to conduct this research using a methodological approach derived from synthesising the three historians’ schemes for conducting historical research. The diagram below, therefore, is a schematic representation of the steps which were followed in the current study.

Choose topic of the researcher’s area of interest



Formulate the research questions



Review the Literature/ Identify knowledge gaps



Access resources and collect data



Analyse and interpret data



Report and discuss findings

Figure 4: Methodological approach used in this study

The next part of this chapter offers an in-depth description of how this research was conducted, starting from the process of data collection, including the

access to primary and secondary sources. Sampling and the undertaking of oral history interviews and the interviewing technique will be also considered. The chapter will then move on to give an account of the data analysis and the adopted approach to interpretation. The first part in the section that follows is concerned with gaining ethical approval.

4.3 Ethical considerations

Applying for ethical approval for research needs to be an early step in conducting any research project, especially when it involves human beings. For the purpose of conducting oral history interviews in this research, ethics application (1147) was completed and submitted to the Faculty of Health, Psychology, and Social Change Academic Ethics Committee at Manchester Metropolitan University. Minor amendments were suggested by the committee, which also asked the researcher to clarify a number of points (See appendix No 1 for questions asked by the Ethics Committee and the answers were supplied by the researcher). Approval was granted, and the research process commenced by contacting the participants (see appendix 2 for faculty ethical approval).

4.3.1 Consent

The Participant Information Leaflet (PIL) and the Consent Form (CF) are important documents to ensure that participants in a research project are aware of the nature and the objectives of the study, why they were selected and the voluntary nature of their participation. They also should state clearly that participants have the right to withdraw from the study at any time. The participants need to be given enough time to decide if they would like to participate in the research project or not (Denzin and Lincoln, 2000).

Yow (Yow, 2005), examines the procedures for obtaining consent for oral history interviews and how this has been very controversial. This is because participants who are involved in creating historical accounts are chosen

because of who they are and what they know about the past, in other words, they are purposefully sampled. Thus, oral history interviewees need to be identified for sampling purposes even though in the research report they may be referred to anonymously (Yow, 2005). However, this may depend on two things: first, the nature and the purpose of the research itself, and second if protecting individuals' identity is essential for safety reasons. Consideration must also be given to the views of the participants on the question of anonymity.

In this study, I have contacted the participants and provided them with the PIL and the CF (see appendix 3 and 4) and enough time was given to the participants to carefully read these documents. The participants were then asked to contact myself should they decide to be part of this research project. More regarding the consent process will be mentioned later in the interviews techniques.

4.4 Sampling

Sampling should always be grounded by the specific aims and questions to be addressed by the study. It should also specify the characteristics of the population as well as determining the relationship between the selected population and the sampling strategy. Weiss (1994); Creswell (1998); and Mason (2002) outline several different strategies for selecting a sample of informants depending on the scope of the study, the amount of time the researcher is willing and able to spend on data collection, and the tradition of inquiry used for the project. Creswell (Creswell, 1998) also describes sixteen types of sampling and the rationale for selecting each strategy.

According to Patton (Patton, 1990), purposive sampling is considered as one of the most dominant sampling strategies in qualitative research. It seeks out rich cases which can be studied in depth, and selects subjects or sites due to specific characteristics or phenomena under study. By adopting the purposive strategy of sampling I chose to target people according to what appeared to me or from my point of view ought to have been able to provide me with valuable,

rich and the descriptive information; in other words, according to the needs of this study. Furthermore, it is important to mention that purposive sampling is the most commonly used method of selecting participants for oral history research projects (Boschma et al., 2008).

In this case I believed that Adeni nurses as well as British nurses who worked during the studied British colonial period in SA, should be selected as 'key informants' (Johnson, 1990). It was expected that these people would prove to be a rich and valuable source of information on nursing during the period under study and it was assumed that they would be able to provide data that would shed light on this history. I was convinced that only those people who witnessed and experienced that period of time and who provided nursing services, when it is thought they were first developed and formalised, would be able to provide rich and reliable information about the past.

With respect to the nurses from SA, I could not isolate myself from the process of selecting the informants whom I felt would serve the study objectives. Although there were few concerns at the outset about finding the relevant people, indeed some of them were already known to myself, there was some doubt about whether they would be prepared to participate in this study or not, and about whether they would be able to provide information relevant to all of the research questions (Mason, 2002).

Interviewing British nurses who worked in SA during the period under investigation was a greater challenge. The following questions were of concern to myself: how could these British nurses be found? Would they be able to take part in this study? And, if they could be found, would they agree to take part? The search for these nurses was the most challenging part in the sampling phase of this study but I was fortunate to find the two British nurses and even luckier to be able to interview them. In an event related to my work with the Yemeni Development Foundation in 2001, I met with a person who worked as part of the colonial administration in SA in the 1960s as a political officer. A mention was made of this study and questions were asked about the possibility of contacting British people who worked as nurses in SA in the period when he

served with the colonial administration. As a result, two British nurses were identified and I was provided with their email addresses.

Although sampling in qualitative research is concerned less with the actual number of participants in a given study and more with the contribution that each informant makes in producing valuable knowledge, at the beginning of the study I aimed for a certain number of interviews in the preliminary plan for the data collection process. In the original research plan, it was intended that 22 nurses from Aden would be interviewed, as we could not identify other nurses from the rest of SA, and the same number or slightly fewer interviews with British nurses would be conducted. In the end, information gathered from 12 interviews with Adeni nurses (4 females and 8 males with a mean age of 65 and two British nurses (both females with a mean age of 75) were obtained for this research (see table no 2). More interviews with British nurses would have been preferred but unfortunately, no more British nurses could be identified.

Table 2 Characteristics of the oral history interviewees

Interviewee initial	Approx. Age	Gender	Nationality
MM	65	Male	Adeni/ South Arabian
PB	60	Male	Adeni/ South Arabian
CK	65	Female	Adeni/ South Arabian
AU	65	Male	Adeni/ South Arabian
ML	70	Male	Adeni/ South Arabian
VC	65	Male	Adeni/ South Arabian
WM	70	Male	Adeni/ South Arabian
PR	60	Female	Adeni/ South Arabian
JD	65	Female	Adeni/ South Arabian
FA	65	Male	Adeni/ South Arabian
MP	65	Female	Adeni/ South Arabian
AA	65	Male	Adeni/ South Arabian
GG	75	Female	British Nurse
FF	75	Female	British Nurse

Note. Approximate ages (to the nearest 5 years) have been given in this table to help ensure anonymity.

Blanken et al., (1992) believe that the kind of snowball sampling used in this study offers certain practical advantages. One of these is where identification through social networks is more reliable than identification through formal or official lists which are no longer current. Since the key informants in this study was composed of South Arabian and British retired nurses who worked and

trained during the British colonial period in SA from 1950-1967, most of whom have now withdrawn from the public life, using social networks proved to be effective and practical in identifying the participants.

The next section will give an account of the methods of data collection employed in this study.

4.5 Methods of Data Collection

The data in this study have been collected from various methods of data collection. Interviews and archival sources were used as primary sources and secondary sources from existing literature were also used.

4.5.1 Literature Review as Secondary Source

Reviewing literature is considered as one of the most important steps in conducting any research project. It is vital to have the background information of the project prior to embarking on the different steps of a research project (Martin, 1995). Researchers need to be aware of almost all the existing literature on their studied topic and works that are considered relevant to it.

In this study, reviewing the literature was conducted at each step of the research process; it was not undertaken only at one particular stage of the study, rather each step of this study was supported and enriched with relevant background information (Lewenson and Herrmann, 2008). This approach is supported by (Martin, 1995) who emphasises that reviewing the literature can be undertaken before, during and after the undertaking of a research project.

Historians tend to avoid emphasising the secondary literature in their research work, preferring to focus on the primary sources. It is not clear why, but it is very important to point out here that reviewing the literature as a secondary

source does not provide new or unique information. Nevertheless, it is rather important as it rounds out and supports the research ideas.

In this study, the researcher believes that the literature reviewing chapter served to prepare the readers for the new historical account of nursing, which is the history of nursing in SA. In addition, it helped to put before the readers information not hitherto known to many, in particular the history of nursing in the Arab World. The first part of the literature review on the theory of history serves as a supplementary knowledge of the studied topic, since creating history is new to the nursing profession not only in SA but also in the whole region of Arabia. Part two reviews the principal writings on the history of nursing in the UK for its strong connection to nursing in SA as a former British colony, while part three of the literature review provides accounts of the history of nursing in the Arab World. Much of this is new information to readers in the field of nursing in the UK; thus, it provides interesting new material relating to the heart of this topic and is indeed in need for further research. The three parts all together were used to provide a background to the accounts on the history of nursing in SA; they provided literature that ought to underpin the initiative of an account of the hidden past of the profession of nursing in this part of the world.

With respect to the search for previous accounts of the history of nursing in SA, the researcher undertook an extensive and thorough search. Firstly, a wide literature search about history or accounts on history of nursing in South Arabia, using a variety of methods was conducted, to reveal only two relevant non-academic accounts. The other relevant literature was sought from electronic databases, citations, reference lists and the library catalogues of both the Manchester Metropolitan University and the University of Manchester. In addition, an electronic search in Medline and CINAHL Plus databases was also carried out. The Manchester Metropolitan University electronic search engines were used to search multiple information resources simultaneously. The databases searched encompassed literature, published and unpublished, in history, nursing, colonial nursing, nursing in SA or Aden such as Hansard (parliamentary unpublished documents). Significantly, this literature search

has revealed two things: firstly, it underpins the significance of this study, and secondly it stresses the importance of the primary sources as substantial tools for historians to develop an understanding of the studied event, or phenomena.

4.5.2 Primary sources

Primary sources are original records created at the time events occurred or well after events in the form of memoirs and oral histories. They may include letters, manuscripts, diaries, journals, newspapers, speeches, interviews, memoirs, documents produced by government agencies (Martin, 1995). They also serve as raw material to interpret the past, and when they are used along previous interpretations by historians, they provide the resources necessary for historical research. This study used the two traditional and commonly-used methods of data collection, which are the archival sources and the oral history interviews.

4.5.2.1 - *Archival documentary evidence.*

McGann (McGann, 1998), has given a useful account of the archival sources for the history of nursing mainly in Britain. She lists the main archival sources that can be consulted for the history of nursing, but these archival sources of history of nursing are confined mainly to nursing in the United Kingdom; she makes no mention of the sources which provide information on the foreign history of nursing during certain periods of time, such as the British colonial period in certain areas of the world, like SA. Nevertheless, I still believed that the archives listed by McGann were worth researching. This material is an important source of information that will help to generate answers to the research questions.

The researcher visited the following archives in the UK:

- The National Archive (TNA) in London
- The Overseas Nursing Archive (ONA) held at the Bodleian Library, University of Oxford

- The Royal College of Nursing (RCN) Archive in Edinburgh
- The British Red Cross (BRC) Archive in London.

In SA the following archives were visited:

- The Idris Hanbala Centre in Shaykh Uthman in Aden
- The Branch of TNA which is housed in the Palace of the Sultan of Lahej.

The four UK archives provided me with valuable data for my research enquiry. Prior to visiting the ONA and the BRC archives, I had contacted the archivists who were responsible for these two archives in order to make me an appointment for the visit. The archivists retrieved all the available documents in relation to the research questions and informed me which section I needed to search in order to find more documents related to my research topic. The visits to TNA and the RCN Archive needed no advanced arrangement. These resulted in 3-4 days of sequential visits to each archive, and each visit lasted for approximately 4-5 hours.

The visits to the archives in SA, one in Aden and the other one to Lehej in the Western Protectorate, were undertaken during a visit to this part of the world. I had to make the visit to the two archives without making any arrangements with the archivists, and one reason for this was that I had no contact numbers or contact details for the two archives. I also had to ask the locals for the address of the two archives as both archives had no webpages to introduce people to their archives, or to advise them about the available services and use of their archives. The two visits proved to be unfruitful as there were no records on health or nursing services during any period of colonial presence time, including the period of time of this study. Although this fact was very disappointing, I somehow was prepared for such result. It has already been mentioned in the literature review, for example, that there is a dearth of archives in the country as a whole and the lack of appreciation of nursing profession as an area of research in this part of the world.

In this study, I have chosen to analyse my research data thematically. Thematic analysis is a way of getting close to the data which enhance developing deeper

appreciation of the content. This process of data analysis is most commonly used in analysing qualitative data (Holloway and Todres, 2003). Next, follows a description of how the archival documents used for this study were analysed.

Step 1: Analysing Data: Organising data

Huberman and Miles (Miles and Huberman, 1994: 432) suggest that:

“Valid analysis is immensely aided by data displays that are focused enough to permit viewing of a full data set in one location and are systemically arranged to answer the research at hand”.

For me the first step in analysing my archival records consisted of organising and collating the data systematically. Copies of the original documents were taken from the archives. These copies were organised chronologically which enabled me to make sense of the information as it described events over time. After this, I was ready to go to the second step which is coding.

Step 2 Analysing Data: Coding and Categorising

After organising my data, I then spent a considerable period of time reading, and trying to make sense of the contents of these documents. While I was reading, I started to identify key words and phrases which were used recurrently in the texts. These recurrent words and phrases were then given an identifier, this process known by coding (Herbert and Rubin, 1995). Finding connections and links between the codes enabled me to start identifying patterns in the data. I was able at that stage to start searching for themes by collating codes into potential themes gathering all data relevant to the particular identified. Perhaps the final stage of data analysis is the production of an academic report of the analysis (Tuckett, 2005).

4.5.2.1.1 Interpreting archival documents

Interpreting historical data has been very controversial. Traditionally historians have been largely engaged in searching for documentary evidence, and interpreting this evidence. However, there has arisen a methodological disagreement between the empiricists who believe in the importance of focusing on the facts within the texts with minimal modifications (Elton and Evans, 1967) and the relativists who assert that the interpretation of a text is crucial as there is no absolute truth (Carr, 1961). There are also other approaches to interpreting documents, such as the hermeneutics, discourse analysis, and postmodernism²².

In this thesis, following Carr, I have placed myself in a position of an interpreter rather than a supplier of truth. My interpretation might not be necessarily presenting the only truth of the past events; it also might not be the only possible interpretation of these events. This has inevitably created room for subjectivity that I had sincerely endeavoured to avoid for the sake of seeking the truth about the past.

One of the primary sources used in this study is a source of data increasingly used by nurse historians in their nursing historical enquiries: what follows, is an in-depth description of the oral history interviews.

4.5.2.2 Oral history method

“Oral history certainly can be a means for transforming both the content and the purpose of history. It can be used to change the focus of history itself, and open up new areas of inquiry”.

(Thompson, 2000:3)

²²To read more on Postmodernism see CORRADI, C. 1991. Text, context and individual meaning: Rethinking life stories in a hermeneutic framework. *Discourse & Society*, 2, 105-118. in Text, context and individual meaning; BERTENS, H. & FOKKEMA, D. W. 1997. *International postmodernism: Theory and literary practice*, John Benjamins Publishing.) in International Postmodernism: Theory and Literary Practice and JØRGENSEN, M. W. & PHILLIPS, L. J. 2002. *Discourse analysis as theory and method*, Sage. in Discourse analysis as theory and methods.

In part two of the literature review concerning the writing of history, mention was made of oral history. This part of the methodology chapter will discuss oral history as a method of data collection in historical research.

Boschma (Boschma et al., 2008) suggests that as a historical methodology, oral history enables the narrator to communicate liberally, and the productive ideas and thoughts extracted from oral history interviews tend to be more detailed than may be found in written documents. Grele (Grele, 2007), on the other hand, explains how historians often use oral history to compensate for what is still missing from the written documents, producing large sum of oral history collections. Others have seen it as an integral part of social history that stands to generate the history of normal individuals' lives, and not merely to fill existing gaps (Kerr, 2003). Burke, (Burke, 2001) and Sharpe (Sharpe, 1991) support this idea and believe that oral history serves to empower ordinary people to speak out, to participate in creating history; it is not merely for those who are dominating a particular group, discipline or nation.

However, in nursing research it is only within the last 20 years that oral history has started to be increasingly used Mackintosh, 1997; Rafael, 1997; Fairman, 2002 and King and Erickson, 2006. It is regarded, as an important method in revealing nursing's history, especially when there is little is known about this history.

In this particular case, written documents on nursing in SA in the past and more specifically during the British colonial period were found but these were insufficient to complete the whole picture of the studied past, therefore, the use of oral history as a method of data collection for this project was felt to be significant.

4.5.2.2.1 Oral history interviews and interviewing techniques

Prior to me reaching my interviewees, an interview guide was already prepared. This included an outline of topics or issues to be covered in the interview, but also allowing the freedom for me to vary the wording and order of the questions according to the individuals themselves and their different experiences and

stories. An interview guide is very beneficial in interviews with semi structured-open-ended questions. This is related to the fact that these types of interviews give greater freedom of expression and more in-depth data, the interviewees are able to talk and continue talking (Abrams, 2010, Ritchie, 2014). Nevertheless, this can be extremely time consuming especially if the interviewees started to embark on irrelevant issues. Although questions in the interview guide appear structured, I was able to ask some other more probing questions, and this was according to the response of each interviewee. The interviewees had different characteristics and experiences, and asking different questions was essential at certain times. The CF was given and signed by the participants' prior to commencing the interviews.

The interviews took place in different venues; this because I wanted to give the interviewees the freedom to choose where to meet and when for ethical reasons. Some of the interviews were conducted either in the interviewees' houses, places of work, or in public places. One of the British nurses who was part of this study lives in Australia. A journey to Australia was not an option, so the interview was conducted using Skype. There was no limit for the time of each interview, but the decision was made to time each interview and ensure they did not exceed 3 hours. None of the interviews reached that limit as most of them lasted for between one and a half to two hours. All interviewees agreed to have their interviews tape recorded apart from two Adeni nurses who preferred not to. Their wish was respected and they were satisfied with me taking notes. There are also some interviewees who agreed to be interviewed on condition that no mention would be made of their names. This was mentioned previously in the consent process; therefore, the decision was made to anonymise those who asked for their names not to be mentioned.

4.5.2.2.2 Analysing the oral history interviews

Following the collection of the data through the archival resources and the oral history interviews, I had a considerable number of primary sources from both methods of data collection. The next part of this chapter will illustrate the adopted approaches to analysing the oral history interviews.

Transcripts Process

I decided to transcribe the interviews in their entirety. I did not foresee the amount of time that each interview took, which was considerable. Overall over 30 hours of interview was transcribed, and in some cases translated as well. Moreover, I was also anxious how I was going to analyse these raw data. Finally, I felt the most logical way to do so was thematically, an approach favoured by Holliday (Holliday, 2007). After transcribing, I reread the transcriptions many times, and then I started to identify core themes from each paragraph of the transcripts according to what emerged, constantly revising these themes was essential. What is noteworthy is that the interviewees mentioned some irrelevant issues that from my point of view would not benefit the study. On the other hand, there was also some irrelevant information given by the interviewees that were useful for the study even though this information was unsolicited and unexpected. This reminds us of what Holliday was suggesting when he wrote researchers often know the character of their data regardless of any formal analysis (Holliday 2007:10). However, the next step was to work on these themes, by linking and making connections. This I believe was the stage when a dialogue develops between the emerged themes and the mind of the researcher (Holliday, 2007).

4.5.2.2.3 The use of Nvivo

Nvivo is a qualitative software product, which is developed, manufactured and distributed by QSR International. Nvivo became one of the most popular pieces of software for qualitative data analysis. It can be used not only by social scientist researches but it has been also used by researchers of anthropology, sociology, and psychology. Nvivo does not actually analyse the data for the researcher, rather it permits the person who is using it to a) store original records in full texts, b) keep or organize thoughts and ideas through making nodes, c) set up documents attributes or node attributes, in addition to adding memos, building up models, editing codes, and find links among them (Smith and Hesse-Biber, 1996).

Using Nvivo in historical research or on historical data cannot be any different than using it in any other research discipline or research data, since we are dealing with data regardless its source and not the method itself. The idea for using Nvivo in this research project was largely due to the evident increased use of this software by researchers in the field of nursing (Thompson et al., 2001; McCaughan et al., 2005; Andrew et al., 2008 and MacPhee et al., 2012) According to many of these researchers, the software helped them in organising and managing their data. Therefore, I decided to use Nvivo in managing my data. I also thought it would helpful if I used it for both data obtained from the oral history interviews and the data obtained from the archives. After I started importing the interview transcripts into Nvivo I have decided not to use Nvivo for organising and managing the data obtained from the archives for two reasons. These were: it proved to be a very time consuming and there was a particularly high volume of these data from the archives. Therefore, I limited the use of Nvivo only to the oral history interviews.

Although a life history approach to the oral history interviews had been conducted, a large amount of data that was not needed for this study had to be discarded. I then imported the interviews transcripts from word processed documents into Nvivo. I then started to familiarise myself with the contents of the transcripts and entered the codes, which had already been identified. Coding was made visible in the margins of the documents so the codes could be seen easily. As I started to get more attached to the data, I was also able to write memos about particular parts. Appendix 5, shows the creating of nodes and sub nodes in using Nvivo for managing and organising oral history interviews transcripts of this study (Richards, 1999b).

The advantages and disadvantages of Nvivo

Nvivo was used in this study for the sake of exploring the use of a qualitative software for the process of analysing oral history interviews. The reason Nvivo was chosen over other packages is because according to (Richards, 1999a) Nvivo had overcome some of the problems of other packages such as the

difficulty of handling Non-Numerical Unstructured Data. The decision of using Nvivo was also made based on colleagues' recommendations.

In regards to the advantages of Nvivo, according to (Richards, 1999a), is in relation to the idea of using such a software in data analysis process is likely to add rigour to qualitative research. On the other hand, Nvivo is not easy to use. Researchers will need to familiarise him/herself with the software and how to use it, this means an individual will have to spend some time only to train him/herself in how to use Nvivo and how to manage the data in it. From my experience using Nvivo can also be very frustrating especially when it comes to using the system in two different computers or in the event of the expiration of the used version.

Chapter Five: Health Care Services in South Arabia 1950-1967

Chapter Five: Health Care Services in SA 1950-1967

Chapter Six: Nursing Services in SA 1950-1967

Chapter Seven: Nursing Training in SA 1950-1967

Chapter Eight: Nursing, Culture, and Colonial Nursing

Introduction

This study set out to examine nursing services and training in SA during the years 1950-1967. However, during the course of the study, in particular during the examination of nursing services, it became apparent that very little was actually known about the health conditions and health services in SA during the period of time at the centre of this study. It was therefore decided that the information which came to light concerning health conditions and health services in SA should form part of the findings of this thesis. Therefore, before reporting our findings regarding nursing services and training during the period 1950-1967, the following section reports on and discusses the following three areas:

- i) The common health concerns in SA during 1950-1967;
- ii) The available health care institutions and services in SA during this period;

iii) The different foundations and organisations that supported and funded health services 1950-1967;

5.1 The Health Concerns in South Arabia 1950-1967

What follows starts by providing key findings and discusses issues in relation to diseases and the ill health of the population.

5.1.1 Diseases and out breaks

Data from the ONA and the British Red Cross BRC archives show that in the 1950s and the 1960s, numerous common diseases were present in SA. These diseases included: Malaria, skin infections and sepsis arising from trauma or infections. Furthermore, Bilharzia was common mainly in remote areas, which explains why this disease had not been dealt with intensively. However, according to the archival records, there were a number of other diseases that are thought to have been imported from abroad as a result of the colonial presence and the consequent trade and flow of people. Smallpox has for instance, always been regarded as a colonial legacy (Lasker, 1977) ;(Phua, 1989) (Lal, 1994). This disease, according to the above records, existed mainly in Aden, probably due to its industrial and mercantile activity. Records also show that 1859 cases of smallpox were reported in the year 1952 alone; thereafter, minor outbreaks in Lahej and the Lower Aulaqi states were reported, but quickly dealt with. Yet, although some smallpox conditions did exist prior to the 1950s, there is no evidence to suggest that this disease existed prior to the British colonial presence, bearing in mind that the British existed in SA since 1883. Writers who are either interested in public health in the colonies or in health services in the colonies (Manderson, 1987) (Mohamed, 1999) (Mukherji, 2011) assert that colonies suffered from smallpox and that the colonial administrations should be accountable for this.

In an annual *Medical and Health Report* produced by the colonial administration (ONA,1953), which was accessed in the ONA, it is mentioned that Tuberculosis

(TB) was a common disease in the colony of Aden. According to this report, in 1952 TB wards in Aden continued to function in a satisfactory way and the disease's death rate had been falling steadily in the years preceding the report. The report mentions an urgent need to appoint a full time TB officer; the need was to invoke the assistance of the World Health Organisation (WHO) to undertake a TB survey of the colony of Aden. This report made no mention of the rest of SA, which implicitly highlights the unique status of Aden as a crown colony to the colonial administration. The *Medical and Health report* (ONA, 1954) presents a document written by a person called Moller, states that the WHO and the United Nation Children's' Fund (UNICEF) had undertaken a Bacille Calmette-Guérin (BCG) vaccination campaign in Aden which started in January 1952. This campaign was coordinated by Dr Cochrane, who was the Director of the Health Services in Aden at that time. The campaign targeted merely one fourth of the population of Aden half of whom were children of school age (ONA, 1953). The campaign report made no mention of other targeted regions but reported that female attendance was poor.

In the 1954 issue of the *Medical and Health Report* (ONA, 1953:17) a mention was made of the appointed "TB officer, Dr G. Ashe". The report concluded that appointing a TB officer had led to better coordination in the treatment of TB cases. Nevertheless, from the records it is evident that TB continued to be the main health problem that caused the most concern. However, it is not clear from the records what other preventive measures were undertaken by the government to overcome this health problem apart from the TB vaccination campaign. The government did put some sort of curative measurements in place, such as the establishment of TB wards. Yet the chance to eradicate the disease would have been better if the colonial administration had considered preventive measures rather than curative measures, as the latter made little difference other than to perhaps give rise to increased concerns about TB as a disease. In reality, any solution to the TB problem was very much connected with poor housing and poor sanitation in addition to low levels of health education; these three broader factors have been discussed in an earlier chapter.

In 1956 there was a small outbreak of Cerebro-Spinal Meningitis. According to the *Medical and Health Report 1956* (ONA, 1956), there was a previous outbreak of this disease but no mention was made of when this occurred nor how serious it was. The above mentioned report had also concluded that within this year there was no outbreak of any major epidemic diseases. Nevertheless, the health standards of the community was maintained at its previous levels. This may be due to the fact that there had been no change in the services that may well have underpinned the improvement of the health of the population, services such as housing, and sanitation.

5.1.2 Maternity and Childcare

The records accessed from the ONA archive suggest that the high maternity and child mortality rates were a prime concern to the British colonial administration in the 1950s and 1960s. The colonial administration's attempts to improve the wellbeing of the mothers and babies might also be part of the broader efforts to win the hearts and minds of the local population. The motives behind the broader shift in the colonial government towards the health of the public in general were discussed previously in the earlier chapter, focusing on maternal and child wellbeing is likely to be part of this shift.

This study has found that in the year 1952 sick babies, who were mainly diagnosed with malnutrition, were called marasmic²³ babies when they were seen by medical staff. Yet, according to the *Medical and Health Report* (ONA, 1953) there was a general impression that there was a slow steady rise in the numbers of healthy infants in the colony. Provision for sick and marasmic infants at that time, according to the report, was a major problem. However, it is not clear what the difficulties were nor how they could be overcome. But it would be reasonable to assume that the problems could be anything from difficulties in having a health professional attend those babies at early stages,

²³ Marasmus: is an extreme form of malnutrition and emaciation (especially in children) which can result from inadequate intake of food or from malabsorption or metabolic disorder (The Free Dictionary accessed on the 18th March 2014)

to poor communication with the parents, to not having the appropriate and adequate trained staff to attend to this group of patients.

Nevertheless, the same report concluded by stating that the unit where those children were seen did not meet the demands, and this could perhaps be the main problem or one of the main problems towards the provision for sick and marsmic infants in Aden.

There is a gap of knowledge in the health of children of other age groups; the health reports that have been viewed in this study tend to focus mainly on mothers and babies. Nevertheless, it was reported that in 1955 children attending out-patient clinics had doubled in the previous five years, but the colony's infantile death rate was still high.

“And will remain high until the attitude towards children changes”.

Medical and Health report (ONA, 1956: 26)

This comment makes me wonder who actually wrote these annual reports and what their backgrounds were. It is not actually clear what the words the “attitude towards children” actually means and this opens up room for a lot of speculation. One question, which arises, is: was it the families' attitudes towards their children or the attitude of the administration towards the provision of proper health services to children? However, the most likely assumption is that it was the latter, as the state takes the ultimate responsibility of social welfare including maternity and child welfare.

The *Medical and Health report* reported that neonatal deaths in hospital were 25 per thousand of which 75 per cent were in premature infants. Stillbirths in hospital amounted to 42 per thousand of which 33 per cent were due to prematurity, and the hospital maternal death rate was 4.1 per thousand total births (ONA, 1956: 26). The efforts of the colonial state and measures to improve maternity and child health were not clearly mentioned in any of the health reports of the colony which were examined in this study; although a

mention was made of the very high demand for medical and nursing professionals. In or about the same period of time, a similar focus did exist across the British Commonwealth, but many scholars such as; Summers, 1991; Geiger et al., 2002; Jennings, 2006 and Van Tol, 2007 believe that differences in the policies and the practice of maternity and child care in the colonies did also exist.

Women's health issues in the period of time that is the concern of this study were centred on gynaecological, maternal and childbearing issues. In the 1957 *Medical and Health Report*, a table contains figures on admissions to the Maternity Clinic during the period 1953-1957. It shows that a large proportion of the births taking place at the hospital are abnormal ones and that during the year 1957, 34 abdominal sections were performed, which included 21 Caesarean Sections (ONA, 1957: 19). The report stated that the maternal death rate was very much higher in the colony of Aden than that which applied to the colony as a whole. This is in spite of the fact that no mention was made of maternal death rates in the rest of SA. The reason for such high maternal death rates was thought to be due to the larger number of abnormal cases arriving at the hospital in dire obstetrical distress. Admissions to the maternity hospital 1953-1957 included 1505 Arabs, 490 Indians, 406 Somalis, 29 Jews and 70 other races (ONA, 1957:19). The latter information leads one to the conclusion that this hospital served mainly the non- British women, and also raises many questions, among which is: what sort of measures were there to prevent the increase of maternal deaths? and: what were the maternity death rates among British women in the colony during the same period? Other questions include: What sort of nurses looked after both groups of women and were there any particular personal specifications for the nurses who looked after each group? Another related issue concerns the equity of the provision of nursing care in a colonial setting like SA. This latter point will be considered in a later section of this thesis.

According to the government medical reports, there were many obstacles towards caring for this group of patients:

“Apathy, mismanagement and ignorance, rather than poverty

and overcrowding, are the main factors”

Medical and Health Report (ONA, 1955: 26)

In addition:

“Early marriage frequent child bearing and interference by ignorant grandmothers all play their part”.

Medical and Health Report (ONA, 1955: 26)

Echoes of conflicts between colonial health care professionals, nursing professionals in particular, and the traditional medicine practitioners are another dimension of the complicated issues such as class, race, and gender which arise in colonial settings (Sweet and Digby, 2005).

5.2 The available Health Care Institutions in SA in 1950-1967

In SA and in the period of time which is the concern of this study, health care institutions or hospitals were many, and varied in terms of the purpose of their establishment. Records from the ONA show that most of these hospitals were situated in Aden, the crown colony, especially the military and the missionary hospitals. In the rest of SA, small hospitals were built in the larger towns and cities, such as Mukalla, Sayun in the eastern protectorates and in Lehej in the western protectorates. The reports make a mention of health units which were distributed randomly in certain villages in the eastern and western protectorates.

The next section will review these health care institutions or hospitals which existed in SA in the years 1950-1967.

5.2.1 The Civil Hospital

The Civil Hospital, from its establishment in 1843 up to 1958, was considered the main hospital in the colony of Aden with 360 beds of which 138 were devoted to the treatment of TB and 10 for mental cases. It was administered

by the colonial medical department. According to a one of the Adeni nurses interviewed in this study (AU, *Interview*), the Civil Hospital, which was situated in Crater contained male TB, medical, surgical, orthopaedics, Ear, Nose and Throat (ENT), and eye wards and similar ward provision was made available to the females. He goes on to state that the staff were medical doctors and senior nurses from England, and medical doctors from India. Technicians, hospital assistants and nursing orderlies were Adenies. This Adeni nurse who was interviewed made no mention in his transcript of the year to which this data refers, but it is clearly applicable to the period of this study since the period of his involvement in nursing practice was from 1956. However, on the same topic another document accessed from the ONA entitled *Medical and Sanitary Report* (ONA, 1951) lists the numbers of appointments which took place during 1951 for the Civil Hospital which were: A Director of Medical Services, a Medical superintendent and 3 nursing sisters (ONA, 1951:2). From this, one could determine that British nursing personnel had a leading role in the delivery of health and medical services in SA especially in Aden in the period of time of this study. It is also evident that the colonial administration hired considerable numbers of medical and maybe nursing staff from other parts of the world to help in the delivery of health and medical services. Important topics relating to this, such as the distribution of power within the health services, and nursing services in particular in SA will be explored later in a different chapter.

The *Medical and Health Report* of 1952 (ONA, 1952), states that the Civil Hospital continued to work despite the unsatisfactory structural conditions, under which it had to function. A mention was also made on the high figure of bed occupancy in the hospital. This indicates the pressure of bed occupation in this hospital in the year 1952. This is perhaps what made an American visitor to comment on this condition by saying:

“Gee, they’re all sick in this hospital”

Medical and Health Report (ONA, 1952:28)

The writer of the report commented that:

“Nothing could be more true than this observation”

Medical and Health Report (ONA, 1952:28)

The comment of the American visitor as well as the writer of the report implies that only the very sick attended this hospital. The thing that the writer of the report makes no mention of is who the American visitor was and what the reason for his/her visit was. Nevertheless, this is not the kind of comment that a patient is likely to have made. Given the figure of bed occupancy, surprisingly there is no mention of the nurse or doctor to patient ratio in this report.

The report goes on to assert that the problem of allocating beds to patients had forced staff to admit patients and nurse them on the floor. A similar scenario was discussed earlier in the third chapter in this thesis in the same hospital but four years earlier, in the year 1948. This perhaps leads one to conclude that: 1) there had been no improvements, even slight ones, in the hospital's conditions in regards to number of beds or capacity in general, and 2) that the number of patients attending the hospital was somehow the same if not increased than the previous years.

The *Medical and Health Report* of the year 1954 (ONA, 1954) reports that due to an allocation of funding for special maintenance work, various improvements to the facilities of the hospital were carried out. According to this report, these improvements included re-decoration, the building of compound walls, and fences around the perimeter, the laying of asphalt surrounds to the wards and the construction of ramps and asphalt paths to allow easy access of trolleys. In addition, a new air –conditioning plant supplying the theatre and the X –ray rooms was also installed. It is commendable that such improvements were made, but the most important problems in the hospital remained unaddressed. All the mentioned maintenance can only be seen as accessories or maybe additions. They might have helped in terms of maintaining the security of the hospital, or making the surroundings of the hospital look better, or maybe alleviating the intensity of the hot weather for the staff. They probably appeared

to have made things look and feel better for certain individuals but not for the patients who represent the vast majority of the hospital users. In the light of the hospital's main problems at that time, some of the investment available would have been more appreciated by the hospital users. The improvements should have been directed towards increasing the number of beds and maybe towards building more ward areas.

5.2.2 The Maternity Hospital and Clinic

In the ONA and the BRC records, a mention is made of a maternity hospital in Crater. There is also a mention of a maternity and the child welfare clinic as well in the same area. At first, it was not possible to establish if the hospital and the clinic are the same thing and that the two words were used interchangeably or that the two were parts of one organisation situated in the same location:

“The work of the maternity and the child welfare clinic and hospital continued to increase”.

Medical and Sanitary report (ONA, 1951:1)

The writer of the report goes on to declare that:

“It is from this centre that future progress in ante and post-natal care and in the advancement of child health must disseminate into the homes of the people of Aden”.

Medical and Sanitary report (ONA, 1951:1)

However, from the two quotes one plausible deduction is that there was a centre in Crater that contained a maternity and child welfare clinic as well as a maternity hospital. However, from the perspective of this research, knowing this is crucial in order to determine the nature of the services available in this centre and how these services were organised and delivered.

The same *Medical and Sanitary report* suggests that the available beds for mothers and children was 50 beds and that work was on going on a new wing

which would increase the total number beds to 90 (ONA, 1951). It was noted that, at the same time, there were intensive efforts to extend the maternity and child welfare work into the homes of the people which faced enormous difficulties due to cultural factors such as what was named in the report the "Purdah"²⁴. Nevertheless, from the report we learn that these efforts led to the introduction of the home visitors. This particular element which is the cultural element will be further discussed in addressing obstacles that nursing and nurses confronted in SA during the period under study (ONA, 1951).

The same report named some services that were delivered to expectant mothers, services such as screening for TB and blood examination for syphilis. The latter according to the report was proved to be of a great value in the detection of patent or early signs of the disease. In addition to this, women had access to consultations for gynaecology cases, delivery units and there was a special unit for complicated cases (ONA, 1951).

With respect to the medical staff who worked at this centre from early in the year 1951, one was an expatriate, a "lady Medical Officer" who was in charge of the maternity clinic and hospital up to the latter half of the same year (ONA, 1951). The maternity and child welfare clinic and hospital since then continued to work without the services of a medical officer and there was no mention of other medical officers working with mothers and children apart from the lady medical officer who left. Nevertheless, in the year 1953, the colonial authority established three lady assistant medical officers' posts for the maternity clinic. However, for most of that year only one was employed because of difficulties in recruitment at this grade (ONA, 1953). The *1953 Medical and Health Report* in this regard explains that the deficiency of a medical officer in the maternity hospital was covered up by the close cooperation with the civil hospital. Such covering up, according to the report, was to be deplored. One consequence of this was that the impetus and initiative of the work became bogged down and complaints became inevitable.

²⁴ **Purdah** or **pardah** (from [Persian](#) : پرده, meaning "curtain") is a religious and social practice of female seclusion prevalent among some [Muslim](#) communities in [Afghanistan](#), [Pakistan](#) and [Northern India](#). More simply, it is the practice of preventing men from seeing women. <http://en.wikipedia.org/wiki/Purdah> accessed 24/03/2014

The records accessed show no evidence of other similar maternity hospitals in either the eastern or western protectorates. However, a mention was made that, during 1957, the colony of Aden's maternity clinics took in labour complications, over 90 of which were sent from Lahej and Abyan area by car or from the remoter parts of the protectorate by local security forces and the relatives and dependents of soldiers who constituted, according to the report, a large tribal group (ONA, 1957). The hospital and the clinic took in and treated a number of cases of political importance on special request (ONA, 1957: 3). This perhaps explains why it was decided in 1955 to limit the number of consultations for only gynaecology cases except those strictly purdah women who could not be examined elsewhere. The cuts in the number of the hospital attendants seem to have targeted the poorest and least powerful people, and those who had no advocates within the colonial political arena. Furthermore, the consultation restrictions seem unreasonable as the vast majority of the native women were practising what's named "Purdah", the decision to cut back on these services, therefore, would be ineffective.

On the other hand, it appears that this important branch of medicine during the period of time under study, in SA and certainly in Aden the crown colony, was mainly supported and run by volunteers. According to the 1954 *Medical and Health Report*, the Aden Women's Voluntary Services (W.V.S.) is one of the many voluntary sources which contributed significantly to the work of the clinic and hospital. It was a British women's organisation established in Britain in 1938 in response to a public announcement and appeal for volunteers to discuss the threat of war, and for the Air Raid Precautions (ARP) (Beauman, 1977). Beauman (Beauman, 1977), in her book *Green Sleeves: the story of WVS/WRVS*, extensively reviews the objectives, structure and achievements of the W.V.S. Although it was a voluntary organisation it was the British government who set out its objectives, this may be related to the nature of its operations and roles in civil defence. Beauman points out how the British government always viewed the role of the W.V.S as constituting a part of the civil defence and how this role is very similar to that of the auxiliary services of women within the armed forces of the crown. So a government might be

tempted to see their potential role in the colonies as an extension of colonial power and influence. The presence of the W.V.S in Aden and no mention was made about this organisation operating anywhere outside the colony of Aden, can be understood in two ways: Firstly, those women were there to provide support to the already few medical and nursing staff in the colonies. However, within this context, Graves (Graves, 1948) emphasises that although much of these women's work was to do with social welfare, their organisation had also recruited workers for the Civil Nursing Reserve, and their role involved a much broader range of work than was initially foreseen. By the end of the year 1938 this organisation was known as the WVS for Civil Defence. Secondly, the great transformation of this organisation's operations from a voluntary to a civil defence role can also be seen as a means of utilising this noble and humanitarian work of these women as an agent to further enforce the colonial presence.

Nevertheless, the health reports mention that the W.V.S's assistance was valuable and without them, the processing of medical cases would have been much slower, as they took the responsibility of recording the outpatient and inpatient statistics. They also ran what was called the milk clinic (ONA, 1954). Furthermore, all the accessed annual health reports suggest that the work of the W.V.S was greatly appreciated both in the children's clinic and in the antenatal clinics by the medical staff. Their gifts of clothes and sweets and soap had been joyfully received by the local women and their help in clerical work, visits and donations were appreciated by everyone. It would be interesting to know more about the work of this organisation in the colony of Aden and if its objectives working in the colonies were somehow different than working at their home land.

In addition to the W.V.S, a mention was made in the *Medical and Health report* of the year 1954 of the Sudan Interior Mission (SIM). SIM is an international mission foundation established in 1889, by a Canadian and two Americans who worked and lived in Africa as missionaries (Eshete, 1999). SIM still exists under the same abbreviated acronym but the initials now stand for Service in Mission instead. The same accessed report notes that children of the child welfare

clinics owe much to one group of the SIM members for their wise supervisor but, no name was given as to who this person was. The hospital was also greatly indebted to the SIM members for help in clerical work, in catering and for gifts of clothes and furnishings. This help was much appreciated not only by staff but also by patients who valued the kindness and interest so carefully shown (ONA, 1954).

Surprisingly, in all the accessed health reports there was no mention of the midwives, and their role or their achievements and the difficulties that this group of professionals were facing, especially when there was a lack of properly qualified medical professional. The only mention that was made about midwives, however, was in the *Medical and Health report* issue of the year 1954. This was made in connection with the future development of the services:

“It would seem that the most economical method of furthering the cause of good midwifery would be institutional rather than domiciliary”.

Medical and Health Report (ONA, 1954:16)

The writer of the report goes on to explain that with the present “*Purdah*” system it would be difficult to get trained Arab girls to go out into the houses and deliver babies. The report or the subsequent reports made no mention on how this was overcome and whether the situation had changed. I will endeavour to explore this further later on.

The *Medical and health reports* also mention what have been labelled as non-governmental medical institutions, among which were:

- The Royal Air Force (RAF) hospital
- The British Petroleum Hospital (BP)
- The Keith Falconer Hospital

It seems that Keith Falconer Hospital is a non- governmental organisation. However, whether the first two institutions are completely non-governmental is debateable. Certainly, within the British government’s structure, the RAF and

BP would have been considered independent organisations. However, from the perspective of the local people, the first two institutions would almost certainly have been seen as governmental, representing as they do the economic and security interests of the colonisers. These two health institutions were briefly mentioned in the Third Chapter, what follows is what this study has revealed about these institutions.

5.2.3 The Royal Air Force (RAF)

In Chapter Three a mention was made of an RAF hospital, and although the accessed archival documents had briefly mentioned the two RAF hospitals, little else about them was mentioned. Nevertheless, we are told that their presence was thought to be important and valuable.

According to a document accessed from the ONA, there was the RAF Steamer Point Hospital, which was situated in Tawahi (ONA, 1955). Its building, according to Aulaqi (Aulaqi, 2008) was considered to be the oldest building in Aden. Some believe that its origin is lost in history, while others suggest that it was built by the Turks and was initially a hospital which belonged to the Indian Medical Services (Aulaqi, 2008). It seems that this hospital was the main RAF hospital, as it consisted of a 180-bed hospital serving all British Forces in the Aden Protectorate. It is also assumed that the same applies to those who are based in other places in SA as well. In addition, the wives and children of the servicemen as well as European Merchant European seamen were able to use these facilities (ONA, 1955).

The *Medical and Health report* of the year 1958 suggests that the hospital was run by the RAF Medical Service doctors, the Princess Mary's Royal Air Force Nursing Service sisters (PMRAFNS) and the Women Royal Air Force orderlies (WRAF) (ONA, 1958:42). According to the same record, there was collaboration between the RAF medical staff and the Aden authorities in the solution of public health problems, which according to the report were common to both services. The reason behind this collaboration is most probably due to

the fact that most of the public health diseases were transmitted by either the seamen or the military forces who were treated in this hospital and maybe, for many, the hospital was their first destination when they arrived in Aden.

The *Medical and Health Report* of the year 1959 mentions an expansion program in the RAF Steamer Point Hospital. This involved building a new 40-bed block. It was believed that the additional beds would help to ease the strain on the present 50 available beds for women and children. Interestingly, the expansion program included a 12-bed maternity unit; a bungalow on the highest level of the hospital, where about 15 babies were born each month, a bungalow on the same level was an isolation wing for women and children, who suffered medical or other health problems, the majority of them patients suffer from dysentery. The maternity unit of this hospital served only the British women who has connection with the British forces. It was not possible to establish from the accessed documents about the standard of care in this hospital, nor whether this hospital suffered from a shortage of staff and equipment.

The other RAF hospital was called the RAF Khormaksar Hospital Beach, situated in the Khormaksar area (TNA, 1961). It was a small hospital and considered to be a branch of the main RAF Hospital. It also collocated with the Queen Elizabeth Hospital (QEH) the latter mainly used by the local people. This RAF hospital was also called the RAF Khormaksar's Medical Centre, it had a helicopter-landing pad and was used to treat mostly urgent surgical cases and covered response to incidences in the protectorate especially during what was called the crisis (TNA, 1961). In Chapter Three, a mention was made of the emergence of the nationalists from the late 1940s, which caused unrest and instability in the whole SA in general and in Aden the crown colony in particular. The times of the unrest and instability was called crisis by the colonial personnel in colonial reports (TNA, 1961).

With regards to its medical personnel, the staff included the Princess Mary's RAF Nursing Officers running the Unit's Theatre and wards. Moreover, the main reasons for admission to this hospital were dysentery and occasionally gunshot

wounds. It was also used as an important "Emergency Stop Over" for the injured forces serving in South Arabia (TNA, 1961). It was also called the Aden Protectorate Levies (ALP) hospital. This is maybe because this hospital had also treated the APL personnel. According to Edwards (Edwards, 2003), the APL also was known as the Federal Arab Army (FAA). A later National Archive document shows that the FAA had their own Federal Arab Army Medical Staff who ran the Arab wards and these people were trained by the British medical staff (TNA, 1961).

5.2.4 British Petroleum (BP) Hospital

Among all the hospitals mentioned in this study, the archival documents which were accessed and examined said very little about this hospital. This might be because the hospital had fewer problems than the other hospitals and being a private organisation had a smaller number of patients. The *Medical Health Report* (ONA, 1958) refers to it as the BP Company's Refinery Medical Services, which situated in the area of little Aden, with 130 inpatients beds and outpatient clinics treatments provided for employees of the Aden Refinery Company and their families who were mainly British (Aulaqi, 2008).

The above mentioned report also refers to this hospital's services as a non-government health service; the same report however, mentioned that the government was responsible for the inpatient treatment of the families. The fact that the government had some sort of input into the delivery of health care within this medical institution suggests that this health institution was not a completely non- government medical or health institution. Furthermore, the documents accessed and studied made no mention of the health personnel, including nursing staff, working in this hospital. However, it is most likely that the majority of staff who worked in this hospital including nursing staff were British. It is also important to note that the Aden Refinery was considered one of the colonial administration's achievements in the colony of Aden, when it was established in 1952 (Aulaqi, 2008). The foundation of this Refinery represents a strong model of colonial exploitation of Aden's natural resources. Thus, any health

organisations or establishments attached to this economic achievement should a) have a strong government support and some sort of privileges perhaps not available to the other health organisations in the same area, and b), personnel who worked for such health organisation might also have had certain benefits.

5.2.5 The Keith Faulkner Hospital

The Medical and Health Report of the year 1956 made a mention of the the missionary hospital, which was known as Keith Falconer hospital, and referred to it as Keith Falconer Hospital of the Church of Scotland Mission (ONA, 1956:21). It was constructed in the beginning of the twentieth century, and is situated at Sheikh Othman a city district in Aden. Ion Keith Falconer is believed to be the founder of the mission (Robertson, 1995).

Although this hospital was also referred to as a non-government medical institution, according to the same report, it was financially supported and assisted by government grant. The *Medical and Health Report* (ONA, 1956: 21) states that:

“The Keith Falconer Hospital of Church of Scotland Mission situated at Sheikh Othman continued its good work both in the Colony and in the protectorates”

We may understand from the above statement two things: first, that there were smaller branches of this hospital created somewhere else in the protectorates. This suggestion was supported by an article written by Robertson (Robertson, 1995) who points to the nineteen dispensaries, which were established by the mission and scattered at distances from 60 to 200 miles from Aden. The second suggestion is that people from across the protectorates came to this hospital seeking medical care. This later reading is underpinned by the number of reported ill cases in the year 1956 which were 23, 258. There were also out-patient visits to the hospital including 6,028 new cases (ONA, 1956:21). Domiciliary visits made by the mission staff totalled 786. In total, patients admitted to the hospital numbered 1,117 and a total of 559 operations were performed including 333 major and 226 minor operations (ONA, 1956:21).

The subsequent *Medical and Health reports* (1957 and 1958) inform us of a steady decline in the number of outpatients attending this hospital from 26,066 in year 1957 to 17,972 in year 1958 (ONA, 1957; ONA, 1958). The succeeding *Medical and Health Reports* for the years 1959, 1960 and 1961 made mention of this hospital as it continued its work but no mention was made of the numbers of patients attending this hospital (ONA, 1959; ONA, 1960; ONA, 1961). This is maybe related to the sharp decrease in the number of patients attending this hospital, due to the establishment of a bigger hospital in the region which is the Queen Elizabeth Hospital, and if this was the case in the other branches across the country. It is noteworthy at this point to remember what was mentioned earlier in this study of the increasing unrest in SA in general during this period of time which, may have contributed to the decrease in the number of patients seeking medical care from this hospital, and this may have been the case with other hospitals. With regards to this hospital's medical personnel, the reports which were examined made a mention of the mission medical staff, which in a general sense should include doctors and nurses. However, there is no information about who cared for the patients nor about how many nurses worked in this mission hospital.

5.2.6 The Queen Elizabeth Hospital (QEH)

Although some maintenance and refurbishments were undertaken in the Civil Hospital in the year 1954, a decision was made in the same year to establish a new and bigger hospital to replace this hospital (ONA, 1954). In April 1954, Queen Elizabeth II visited Aden as part of her Royal visit to a number of different Commonwealth Countries. During this visit, the Queen laid the foundation stone for the construction of a new hospital, which was named at that time as the Queen Elizabeth Hospital (QEH). A transcript written by an Adeni nurse interviewed in this study notes that the QEH was an architectural masterpiece building, overlooking the Beach of Abyan, and contained all the necessary medical supplies and facilities, as well as private accommodation for doctors and physicians, Arab, British, and Indian nurses (MM, *Interview*). In addition, the same nurse points out that it was believed that the QEH was the largest in

the Middle East and the first in the Arabian Peninsula to contain an air conditioning system. He went on to report that:

“It contained number of departments and specialties such as: a general surgery and orthopaedics ward, a medical ward, an Ear, Nose and Throat (ENT) ward, a gynaecology and obstetrics ward, a TB ward, a paediatrics ward, a dental diseases ward, an accident and emergency department, pharmaceutical services, the department of medical equipment and physiotherapy”.

(MM, *Interview*)

This seems to be an impressive list, raising questions about the relative status of other hospitals in the same region in the 1950s, especially Saudi Arabia and Oman. Were the standard of health services in these countries differed significantly from the ones in SA during the same period of time? It would also be worth trying to find out more about the most common diseases and the types of ill health that existed in these two countries at that time, and also whether there were any similarities or differences in the way they were dealt with. However, this is not what this research is trying to answer; hence, it can be considered for future research.

In August 1958, the QEH was officially opened with 445 beds, replacing the old Civil Hospital, taking special cases that could not be adequately dealt with in Protectorate hospitals. It is believed that this hospital played a central role in the establishment of the nursing profession in SA, and had an important role in the foundation of nursing training. This point will be extensively explored in a later chapter.

5.2.7 Other health care institutions

In addition to the health care institutions which have already been mentioned, the archival documents which were accessed in this study referred to a number of other health institutions and these are as follows:

5.2.7.1 Bai Jerbai Charitable Dispensary

According to the *Medical and Health Report* (ONA, 1956:21) this dispensary, about which relatively little is known:

“occupy premises provided by Messrs Cowasjee Dinshaw and Bros”

The building of this dispensary consisted of a dispensary and business premises on the ground floor, surmounted by flats on the upper floors (ONA, 1956). The series of this report made no mention of the location of this dispensary in Aden nor the nature of the health services it provided. However, according to *The Medical and Health Report* of the year 1956, the income from renting the associated business premises and flats was devoted to the endowment of the dispensary (ONA, 1956). Therefore, by 1957, this dispensary was declared to be financially self-supporting and required no assistance from the government (ONA, 1957). All the reports examined for this particular institution made no mention of the nursing and the medical staff who worked in this dispensary. However, from the name of this charitable dispensary, a traditional Indian name one may infer that it may have been established to serve the large Indian community, which existed in Aden at that time. The existence of this large community would certainly have justified the presence of such charitable foundation of this nature.

5.2.7.2 The King Edward VII Dispensary

This dispensary was the health institution mentioned least in all the reports that were studied. Although the reports from the years 1956- 1959 did make a brief

mention of this dispensary, no mention was made before or after this period of time. The reason for this could be that this dispensary operated for a just short period of time. What has also been noted is that every time this dispensary was mentioned in the reports, it is within the context of the continuity of the financial support from the government. It is not clear what we can conclude from this, but it may suggest that the financial basis for this dispensary was not secure.

5.2.7.3 Other hospitals

The archival reports examined in this research made a brief mention of a number of other hospitals named as the Protectorates hospitals and these are as follows:

In the East: The Mukalla Hospital is mentioned in some reports. This included a TB wing which was opened in 1954. Furthermore, there are also two hospitals which were in a state of transition from being health units to having district hospital status at Duan and Shihr (ONA, 1958). The Tarim Al Kaf family hospital in the Kathiri State, the Shibam Hospital and the Sayun Hospital, which was also called the Tarim Medical Centre, all served the remote areas. Also, in the East but closer to Aden, was the Makhzan Hospital, situated in Abyan province (ONA, 1958). In the West: the only two hospitals mentioned in the Western Protectorate are the Lahej Hospital, which was established in 1958, and the Loder Hospital (ONA, 1963).

No data is available to provide information on how these hospitals operated, who ran them, or whether they were general hospitals, maternity hospitals or of a particular speciality. Nevertheless, a table in the Medical and Health report of the year 1958 shows the distribution of hospital beds. This table informs us that every hospital outside of Aden had only a small number of beds. This might explain the reason why the Aden hospitals took so many cases from the Protectorates. It not only had better medical care, but it also had more hospitals and more beds (ONA, 1958:20).

The colonial administration did contribute to the establishment and construction of the health institutions in SA in general and maybe more in Aden in particular but there are other funders who contributed to a large extent in the establishment of health institutions and these funding groups would have had their own reasons of doing this. The next section reviews funding provided by sources other than the colonial administration for the establishment, or construction of health institutions in SA in the period under review.

5.3 Sponsors of Health Services in South Arabia 1950-1967

Health services and health institutions in Aden, and in the Western and Eastern protectorates, were financially supported by different parties. Funding did not include merely the establishment of these health institutions but also staff salaries and training, accommodation as well as maintenance and redecoration.

From the records which have been accessed, it appears that the colonial administration in SA in the period under review received a great support from different sources to run and fund the health institutions and to provide health services. Sources varied from charitable foundations, such as the British Red Cross (BRC), and the Danish Red Cross, to the colonial administration's allies including South Arabian sultans and princes of different regions, in addition to some wealthy individuals and families of SA. It is also important to include the activity funded by the United Nations (UN) in the form of the WHO and the UNICEF.

The formation of the BRC in Aden was originally made in preparation for the Suez Canal crisis, in order that any emergencies that might arise could be met without difficulties (BRC, 1958). Towards the end of 1957, it was agreed to proceed with the formation of an active branch of the BRC in Aden (BRC, 1958). The BRC started gradually to be active not merely in the humanitarian operations but also in providing support and help to the people of the colony in many other ways such as in education and training. Nevertheless, one important form of support that was provided by the BRC was financial support.

The BRC in Aden held its first ball in March 1958, when the sum of £508 was raised. The balls were the BRC main fund raising effort in addition to the annual donations and raffle prizes. The balls were carried out/organised yearly and all who contributed were BRC members (BRC, 1958). The BRC's funding was not directed towards building health institutions, but rather it was spent on staff recruitment and training. The BRC had their own health personnel who had a role to play in the provision of health services and trained personnel in Aden in the period under review. This role will be further explored in the next chapter, particularly where it relates to the provision of nursing services.

It is important at this point to mention that the records which were accessed from the BRC suggest that there was only one BRC branch in SA, which is the Aden Branch. The same records show no evidence that the BRC had operated anywhere else outside Aden despite the fact that Aden, as we know now, had much better healthcare provision than the rest of SA which would clearly have benefited from more of the BRC support. This, in fact, brings us to the main reason of the establishment of this branch in Aden in the first place which was, according to the accessed records, in preparation for the Suez Canal crisis.

A letter written in 1953, by the Colonial Health Advisor Dr. Corkill to the Nuffield Foundation concerned a grant of £2000 from the latter to the government of Aden (TNA, 1953). This grant was to be for equipment necessary for building up the health and medical services for the protectorates. In the letter Dr. Corkill went to explain that the materials on which the grant will be spent are:

“Buying training and educational material, including cinema projectors models, and posters”

(TNA, 1953:3)

Another form of financial support was given by the regional and local allies of the colonial administration, among whom was the Sultan of Qu'aiti State in Mukalla. In 1956, the Qu'aiti Sultan, who was in fact one of the colonial

administration closet allies, paid £1,450 towards the costs of the training hostel and hospital reconstruction in Mukalla in the Eastern Protectorate and £45 towards the cost of two new health units (ONA, 1956). The same *Medical and Health Report* of the year 1956 suggests that the same year had witnessed the opening of the Shibam Hospital, which was built and staffed from the Qu'aiti state fund. Moreover, the Qu'aiti state took the responsibility of paying for the house of the Medical officer at Du'an, his salary, vehicle and recurrent costs (ONA, 1956).

There exists quite a lot of information on the financial support for the establishment of health services especially in the Eastern Protectorates in the 1950s. In the province of Hadramout, for instance, financial help was given by a wealthy Hadrami²⁵ person, who lived abroad and returned to revisit his birthplace. This person donated funds to establish a T.B. wing to the Mukalla Hospital (*Annual Medical and Health Report*, 1956). In the same year, in the Tarim area of Hadramout, the al-Kaf, family, which was another very wealthy family in the region purchased and installed x-ray and other electrical equipment for the Tarim Hospital, and this was open for the treatment of all people for free (ONA, 1956).

A letter was written in January 1956 by the Governor of Aden to the Secretary of State for the Colonies entitled: *WHO/UNICEF Aid to the Protectorate Health Service*. An application was enclosed with the letter for a colonial development and welfare scheme for the protectorate's health services proposing to obtain WHO/UNICEF assistance (TNA, 1956). The letter mentions that the Governor of Aden has been in correspondence with the two organisations and that he has made preliminary enquiries from which he understood that they might be willing to assist with a project over the years 1957-1960. Previously in this chapter, a mention was made of the support given by the WHO and the UNICEF (TNA, 1956). However, we have no evidence that this proposed application was accepted and granted. This application was meant for the Aden Protectorate and not for the rest of SA, even though, the health services in Aden were

²⁵ Refers to a person from Hadramout (Eastern Protectorate)

superior to the rest of the colony, with more hospitals and staff. To reduce the pressure on the health services in Aden, one would think it reasonable to aim to establish better and stronger health care services in the Eastern and the Western protectorates; unfortunately, this was not the case.

5.4 Summary

This section of this thesis has given an account of health services in SA in the period 1950-1967. Understanding and making sense of the main health concerns and common diseases in SA, the available health institutions, and the different sources of funding of these services and health institution in SA in the period under review was thought to be highly relevant to this research. It has provided us with an understanding of what sort of diseases nurses dealt with, and what the main health concerns were in SA at that time. It has also been important for us to understand where nurses worked, what health institutions existed during this period of time, who established and maintained these health institutions, and who paid the nurses' salaries and training. This chapter has thus provided a context for the questions that this thesis is attempting to explore, which is the nursing services and training in SA in the period under review.

A number of important findings have emerged from this section of this thesis; one of which is the nature of the most common diseases presented in SA at the time. The colony of Aden and the Western and Eastern Protectorates had many health problems and the people suffered numerous health conditions and diseases. These diseases, although arising from differing causes and methods of transmission, were dealt with in a very similar way by the colonial administration, which was clearly in favour of curative measures rather than preventive ones. Thus very little was done about the prevention and spread of these diseases. For the British colonial administration, ill health or poor health of the South Arabians was a problem and a hurdle, but this was mainly for the reason that it threatened the colony's sustained economic development and the stability of the colonised population.

Moreover, with regards to dealing with these diseases and health problems during the period of time under review, there was a clear emphasis by the colonial administration on focusing on internal medicine, maternity facilities and paediatrics. At the same time, the colonial administration seems to have paid much less attention to certain important areas, these being: public health, preventive medicine, and health education and promotion. These initiatives are likely to have cost less. And it is thought that they would have been more effective in sustaining the health and wellbeing of the population, yet they were not implemented or taken into consideration.

On the question of the provision of health institutions, this thesis has found that SA had many hospitals; however, most of them and the better ones were in Aden rather than the rest of the country. Hospitals in Aden, in particular, were established for different purposes, had better infrastructure and were likely to have been better staffed. The reports accessed for this study seemed to report more favourably when referring to Aden's health institutions. They certainly had more to say about these. Furthermore, not many British colonial personnel lived outside Aden; this would probably help to explain why Aden's hospitals and health institutions in general received more attention from the colonial administration and the editors of its publications. Hospitals outside Aden, whether in the Eastern or Western Protectorates, served mainly the local people, and do not appear to have received much attention in the colonial literature at that time.

This part of this thesis also shows that there was lack of funds available for the provision of health services and the establishment of health institutions especially when it comes to the need of these projects in areas away from Aden. The colonial administration spent more on Aden than the whole of the rest of SA. Evidence of this can be clearly seen in the fact that most of the health services and initiatives that were provided were centred in Aden and in one or two other larger centres. Financial support provided by various sources did help to underpin the provision of health services in SA but could not conceal the fact that, overall, these services lacked infrastructure and governmental planning. It is argued that colonial systems were organized primarily for the

purpose of realizing profits. Thus any form of health services including nursing services provided by such systems had, to some extent, to conform to this overarching objective.

The health services in SA during the studied period seem to be unorganised and lacked proper planning by the government. However, nursing services, which were part of this health services, will be examined in the next chapter.

Chapter Six: Nursing Services in South Arabia 1950-1967

Chapter Five: Health Care
Services in SA 1950-1967

**Chapter Six: Nursing Services in
SA 1950-1967**

Chapter Seven: Nursing Training
in SA 1950-1967

Chapter Eight: Nursing, Culture,
and Colonial Nursing

Introduction

The purpose of this chapter is to present and discuss key results of this research project in relation to nursing services in SA in the period 1950-1967. In order to do so, the chapter will be divided into three sections, each of which will answer one of three main questions. These are as follows:

- i) Who provided nursing services in SA in 1950-1967? And where, and how was this provision organised?
- ii) What was the role of those nurses within the overall provision of health services?
- iii) What do we know about the people who worked as nurses in SA in the period under study?

Answering these questions will provide a clear view of nursing services available during this specific colonial period in SA. Up until now, Australia, Africa and India are the main focus of the written accounts of history on nursing during the British colonial period. This thesis however, is attempting to add the history of nursing in SA to the list of existing historical accounts of nursing in the British colonies. In this way, it will make an important contribution to our understanding of this historical experience.

The first part of the chapter therefore reports the findings in relation to the provision of nursing services in SA from 1950-1967, and how the provision of these services was organised. In this thesis, the findings are discussed as they are presented so reference will also be made to the existing literature.

6.1 Part 1: The provision and organisation of nursing services in SA in 1950-1967

We learnt from the previous chapter that health services were crucial in an area such as SA during the period of time under examination. The chapter also explained the main health concerns in the colony at the time and described the health services that were provided to meet the health needs of the population. Nursing services are an integral and important part of any health care system and this was no less true in SA during the later colonial period.

One of the most important findings in the last chapter concerned the role of health services providers in SA and that in the period under study nursing services were actually provided by various sources. The health service

providers would also have been responsible for providing nursing services as part of their provision of health services. However, the reality was that not all health services provided nursing services. The accessed records from the ONA, the TNA, and the BRC archives, suggest that only some of the previously mentioned health service providers provided nursing services.

The records from the archives that were examined in this research have also shown that there were three types of patient care provided in SA during the later colonial period, and this depended on who the service providers were. The three types of care delivered were as follows: i) patient care delivered by individuals who trained and attained a nursing certificate and who were called qualified or registered nurses. This type of patient care is known as nursing care. ii) The second type of patient care was delivered by individuals who had some sort of training and nursing skills and who were engaged in the work of nursing. Nevertheless, they were not fully qualified registered nurses. These people were called orderlies which is a term that could be used interchangeably with the term nurse assistant. iii) The third type of nursing care for patients was provided by group of people or individuals who may have had some caring and housekeeping training but it seems that this was much less formal than the latter type. Regardless the differences between the three types of care provided to patients, it appears that they were all under the umbrella of the provision of nursing services (ONA, 1951-1962). What is of more interest to this research is the type of work delivered by these three different groups; this will be explored later on in this chapter in order to review the role of nurses within the overall provision of health services in SA in the period under study.

The next section will explore the different organisations which provided nursing services in SA during the period under study. It will start first with the CNA, which according to the records which were examined, seems to have been the prime provider of nursing personnel and its staff consisted of the vast majority of the trained, qualified and registered nurses in SA (ONA, 1951-1962).

6.1.1 The Colonial Nursing Association (CNA)

In the literature review, a mention was made of the CNA. In collaboration with the Colonial Office, this association sent British nurses to SA as it did to many other British colonies.

The records indicate that, in SA the Colonial Nurses (CNs) worked mainly in what appeared to be called at that time government hospitals such as the Civil Hospital, the maternity hospital and clinic as well as the QEH in Aden. In addition to Aden, the CNs even though in much smaller numbers than Aden also existed in other main hospitals in SA such as the Mukalla Hospital and Makhzan Hospital in the Eastern Protectorate (ONA, 1951-1962). The same records show no evidence that the CNs worked in other hospitals such as the RAF, BP and the Keith Faulkner hospitals or in any other charitable dispensaries.

Recruiting CNs to work in government hospitals, which predominantly served the indigenous population, somehow contradicts the purpose or the reason behind the establishment of this association, which was to serve mainly the British men, women and children who lived in the colonies. Nevertheless, as nursing services are in the heart of the delivery of any health care service, it would have been impossible to imagine the absence of trained and qualified nurses in government hospitals. The colonial administration would probably have used alternatives to CNs to meet the nursing needs of patients from the indigenous population if these had been available. However, there are two possible explanations for this: the first it could be that, the colonial administration was in the situation where there were a number of relatively modern health institutions and an urgent need to equip them not only with the necessarily equipment but also with suitable qualified nursing staff. Any long term plans to employ from the local people to work as nurses would need a proper training programs to provide a service that would meet the colonial administration's expectations of how nursing care can be delivered. The

second possible explanation for the colonial government's decision to employ CNs to work in government hospitals is that it was simply due to the lack of any acceptable alternative being available; the authorities therefore, are likely to have consciously decided to employ CNs to work and care for local people in government hospitals.

What may well have enhanced the idea of recruiting CNs in government hospitals was the foundation of the Colonial Nursing Services (CNS) in 1940. This organisation was thought to have been established to more or less provide the Colonial Office with a way of using CNs in a way that would underpin the colonial administration's interest inside the colony (Solano and Rafferty, 2007). In addition to this, it may also have been to support the colonial office in the development of health services that the colonial administration had been trying to improve since the end of the World War II, which ultimately was thought of as an essential part of the general development of the territory.

The situation outside Aden in terms of the lack of trained and qualified nurses was probably similar if not worse than the situation in other parts of SA. This is perhaps the reason why the CNs were also asked to work not only in a setting where they would look after the others, and here I mean non-British patients, but they were also asked to live and work outside Aden the Crown Colony, for example in Mukallah where there were more British families and more security and, according to the records, a better quality of life. This time however, even though they were not working in the colony of Aden, CNs were sent there for the purpose of serving the British and European families who lived outside Aden.

Furthermore, recruiting CNs to work in SA in general seemed very challenging and this was perhaps due to the difficulty in meeting the required conditions to send those nurses out to the colonies. For example, records from the ONA archive suggests that the lack of proper housing for CNs was an obstacle towards recruiting more of them from the CNA. We are not sure if this was the case in other colonies but this seems to be one of the important conditions towards recruiting these nurses. One of these obstacles was highlighted in a

letter addressed to the ONA formerly CNA written by Principal Matron Barnes, pointing to the poor housing available as a reason for not recruiting more nurses from the ONA:

“I dare not indent for more nursing sisters until the housing situation improves, but I anticipate about three more vacancies about April”

Medical and Health Report (ONA, 1960a)

This quotation emphasises the problem of housing as a reason of not recruiting more CNs. The term “sister” opens up many other speculations. One of which is regarding the great demand of nursing management personnel at that time, as well as the apparent exceptional status of nursing sisters at that period of time. This raises the question as to whether nursing sisters worked under better conditions and received much better treatment compared to other nursing staff in the colony. Nevertheless, the nursing management in Aden represented by the Matron seemed very much in control over when to recruit more nurses and how many.

In a report, entitled *Nursing in Aden and the Protectorates*, the advantages of working in places such as Mukalla and Mekhzan in the Eastern Protectorates was clearly highlighted:

“There is a special high Commission Allowance for those prepared to serve in the Protectorate states, plus a Federal allowance if a person called upon to do so”

(ONA, 1961b)

This report hints to two possible suggestions: the first is that it was optional at that time for CNs who were already working in the Colony of Aden to work outside Aden. And the second is that there was an unwillingness of the CNs to serve outside the Colony of Aden at that time and that persuading them to work and live outside Aden was not an easy mission but challenging regardless the above mentioned advantages of working and living in those areas.

The main reason of the establishment of the CNA was practically met when it decided to send CNs to Mukalla, which was according to the *Nursing in the Federation of Aden and the Protectorates* report, to serve the 20 European families who live in Mukalla. In efforts to persuade the CNs to move to places like Mukalla, the report went on to mention other advantages that the CNs might benefit from living and working in there:

“It was thought that the swimming in Mukalla was good and there was Badminton and occasional films”.

(ONA, 1961b)

Furthermore, and in an attempt to make things sound nicer to those nurses, in relation to socialising, the report went on to note that:

“If a sister is prepared to entertain she will in turn be entertained”.

(ONA, 1961b)

Perhaps what is meant here is if the sister was prepared to socialise with other people she will in turn make new friends and will be socialised. This is unlikely to include being entertained with or by the local people due to the communication barriers and expectations.

Terminologically, it was not only nurses recruited by the CNA who could be called colonial nurses (CNs). In fact, the term “Colonial Nurse” itself, although sometimes referring specifically to the nurses who were employed by the CNA, also refers to all those nurses who were also part of the colonial administration or worked in Aden as a result of the British colonialism. As a result, in this study, all British or non- South Arabian nurses, regardless of which organisation they were part of, whether they were recruited by the CNA or by the military forces or even by private companies, in a formal or an informal way, will be all called CNs as they existed in the colony as a result of the colonial existence,

and hence may or may not have acted in accordance with the colonial policies. Colonial nursing as a concept and an expression will be discussed in more detail in a later chapter.

6.1.2 Private Nursing Services

In the 21st century, when mentioning a private nursing service, the first assumption might be that is that one is referring to a nursing service delivered by an agency that provides nursing services to individuals in their homes or to health organizations, which experience shortage of nursing staff during certain periods of time. However, in this research, we are making reference to a completely different type of nursing service. This type of nursing services which is the private nursing services delivered by agencies probably did not exist in the period under review; however, the next section will examine some of the organizations that provided private nursing services in the colonies. Here private nursing services mean a nursing service that is delivered to a particular group of people, the private sector or by a non-governmental organization.

6.1.3 The RAF Nursing Services

The records which have been accessed, have revealed that nurses who worked in the RAF hospitals worked exclusively in those hospitals and thus solely looked after the RAF Personnel and their families. According to the archived records, the Princess Mary Royal Air Force Nursing Service (PMRAFNS), also called the RAF Nursing Services, had the responsibility of providing nursing care only within this health care setting and thus operated mainly in the two RAF hospitals in Aden (ONA, 1958:42). It could be that these nurses had a military rank beside their professional grade and that they had some privileges over other nurses who were not employed by the RAF. Although the accessed records made no mention of this, Mackie (2001) and Martin, Brayley and Bujeiro (2002) in their books *A History of Princess Mary's Royal Air Force Nursing Services* and *World War II; Allied Nursing* retrospectively emphasise that nurses

worked for the RAF had a military rank and thus were regarded as military nurses.

The records accessed from the archives tell us very little about the PMRAFNS or the RAF nursing services. The only records that made a mention of them were records from TNA and the ONA archive and the references made to these services were very brief. This may be due to the fact that documents related to the RAF operations, services and personnel are currently kept in a special archive of the RAF. RAF nursing staff perceived themselves as part of a military service (but it is unclear whether the two RAF hospitals can justifiably be called 'military hospitals') and whether there was any difference between the way they worked and carried out nursing in a military establishment are questions that remain worthy of investigation. Neither do we know whether there were any disagreements or clashes between the nurses' military ranks and their professional grades, duties and performance. Finally, considering the fact that the two parties were part of the colonial government or more accurately existed as a result of the colonial presence, it is not clear whether one of the two parties had a special status which would inevitably have been reflected in how both groups of nurses perceived themselves.

6.1.4 British Petroleum Nursing Services (BP)

BP hospital was a private hospital and provided medical and nursing care for personnel who worked for BP Company. The accessed records show very little about the PB nursing services. All we have been able to establish is that nurses who worked in the BP hospital were British, and expatriate nurses from other British colonies or Commonwealth countries possibly from India (ONA, 1959)

6.1.5 Independent Nursing Services

What we mean here by independent nursing services is the type of nursing services that were delivered by an independent bodies or personnel who had little support but maybe some sort of ties and collaboration with the colonial authorities. Nevertheless, they also existed largely due to the colonial presence.

According to the *British Red Cross Society Overseas Branches Reports* accessed from the BRC archive, The British Red Cross, had its own trained nursing personnel. Thus, in addition to the ordinary humanitarian services, the BRC provided nursing care when needed. According to the accessed BRC reports, the BRC supported the health authority in Aden when a need arose, for example:

“One member who is a trained nurse, worked for a while in the casualty department when the hospital was experiencing staffing difficulties, and another nurse helped regularly with clerical work for the Matron”

(BRC, 1958: 4)

In another *British Red Cross Society Overseas Branch Report* for the years 1965-1966, mention is made of a two-day strike in the hospitals of Aden, when the BRC society had to send number of their nurses to help in the wards, in the QEH and in the Maternity Hospital (BRC:1966).

The records also reveal that in 1966, the BRC society contributed to the appointment of a health visitor to work in the colony, though mainly in the child welfare clinics in Aden. It subsequently handed over this service to the government and the BRC Health Visitor went to Hadramout (Eastern Protectorate) to establish a similar service there. However, the records reveal no evidence of other BRC operations within SA outside the colony of Aden other than Hadramout (BRC: 1966).

The accessed records from the BRC Archive place considerable emphasis on the BRC society's role in training staff on nursing and first aid practice, and gave rather less attention to explaining where these staff worked. The same reports tell us that the BRC had a role to play in government hospitals especially in organizing relief, distributing food and helping to place the sick. It is not clear

from the data where these nurses did their nursing training and how these nurses, and we mean here the BRC nurses, join the BRC society?

Another form of an independent nursing service was provided by nurses who worked in SA as nurses but who worked autonomously and with little help or support. The researcher in this study was fortunate to be able to interview two British nurses who worked in SA during the period 1950-1967. In fact, the two interviews opened up a new perspective of how nursing was looked at and delivered at that time in the colony. From the two interviews we learn a great deal about the two nurses who worked in completely different not only settings but also, under different conditions from the previously mentioned nursing groups.

The reason this section is entitled independent nursing services is because those nurses worked independently and had little support from the colonial administration in recognition for their contribution to the health and wellbeing of the population. Here it is worth mentioning that the two nurses looked solely after the indigenous people of the colony. Yet, there are some similarities and dissimilarities between the two nurses in terms of where they worked and the amount of support they were able to call upon.

In the next part of this chapter, we will learn more about these two nurses, as the present section is more concerned with identifying the different sources and organizations that provided nursing services. However, at this point it is relevant to point out that the two British nurses came to SA for the same reason. This was because their spouses worked for the colonial administration. This suggests that the two nurses were also, although indirectly, a product of the colonial presence. Both nurses stayed in SA for a considerable period of time. Interestingly, in both cases, it was because their husbands spoke good Arabic and thus were needed to stay longer in the colony. The two wives or nurses had to travel very often with husbands who in turn had to be in certain places.

“My husband was in the Army so we travelled, I travelled with him after that, first we went we were in Dorset he was at

the school of technology and then to Germany and then because he had been in Arabia before we got married and because he had quite a lot of good Arabic he was asked to go back by the Army to do a job in Aden”.

(GG, Interview)

“My husband was a political officer working for the British government we both went to Arabia where he had already been there for 7 years in the deserts and Mukalla”.

(FF, Interview)

Finding more about those nurses, who they were and what their background was, is what a later part in this chapter will attempt to answer. The next section explores the role of those nurses or nurses who worked in SA. What they actually did and what was the type of nursing work that they have undertaken.

6.2 Part 2: What was the role of those nurses within the overall provision of health services?

The previous part of this chapter revealed that the nurses who worked in SA worked in different settings and were members of various organisations. This section will give an account of the specific roles of those nurses and the precise nature of their work.

In the interviews, the nurses whether the Adeni or the British, talked a great deal about what their work actually involved while they were working as nurses. Their experience differed depending on where they worked, who they worked with and in what capacity.

I have asked the interviewees about their roles as nurses. One of the questions that was asked was “what was your role as a nurse, what did you actually do

on a daily basis? Some of the responses to this question from the Adeni nurses are given below:

“they (Adeni nurses) will do, the bath, the patient they serve the patient, they give they give the injections, medicines even they clean the floor, the walls, the windows, everything, because the cleaning is the important point the surrounding, they cleaning the surrounding of the patient is very important, if the surrounding of the patient is dirty no health no health at all”.

(MM, Interview)

“To give the injection and to do the enema how to, and in which way you can do the enema not in the right the left side, not aaaaa, the injections intramuscular, intravenous, we have to do everything”.

(CK, Interview)

“We did everything, whatever nurses do these days but in better way, for example we did bed making but nowadays nurses don’t do it in a good way, and bathing a patient is very important. And so on”.

(AU, Interview)

“Nursing in past was everything, if you are a nurse, you do for example, washing the patient, give medicine, bed making everything nurse do, was good and yes we did everything”

(PB, Interview)

“our role was too much and lots of thing, like giving medicine, washing patients, cleaning lockers and patients, was very hard but very sweet”.

(AS, Interview)

From the above, one is able to establish that those nurses had worked in hospitals in ward settings rather than clinics or outpatients departments. This

is because bed making and washing patients are duties that are normally performed for in-patients in ward settings. From this data, one can also deduce that nurses at that time were often expected to multi task, as they used to do things that are not part of a nurse's responsibility nowadays like cleaning the walls and windows. This in fact opens up lots of questions with regards to whether there was anything in place similar to a job description that the health authority who managed the hospital nursing staff used. Assuming that some kind of a job description was in place in the coloniser's homeland (Britain) to determine nurse's responsibilities, it is likely that it would be used in the colonies as well. The data here suggests that, in addition to giving medications including injections, nurses had to clean the patient's environment, including the furniture and the walls.

At the same time, the nurses interviewed seem to suggest that they enjoyed it and they did not mind the very varied range of duties at that time.

"The nursing is very hard work, and also and very sweetable work".

(PR, Interview)

"We did all practically the nursing is more practically more than theory".

(MM, interview)

The latter quotation suggests that in the past nursing in Aden, involved less paperwork than now. However, that this is true in many different nursing contexts, as well as in the UK itself. It also suggests that the nurses were more directly involved in handling their patients than nowadays (washing, making beds).

Furthermore, in the present time, duties such as bed making and washing patients tend to be handled mainly by what used to be known as orderlies and now by the term clinical support workers. Nurses in the present time are asked to focus more on record keeping and sophisticated nursing skills that often

involve medical devices, in addition to bed management and quality assurance. It is important to bear in mind that these changes and the advancement of the nursing profession are evident in the case of nursing in the UK but not necessarily in the SA context. Nursing in SA at present is rather a complicated topic and thus requires a separate research project. Here the researcher has no intention to discuss the current nursing profession in SA; our intention here is to explore nursing in SA in the past and more specifically when SA was under the British control only during the period 1950-1967.

Interestingly, with respect to an emphasis on cleanliness and a healthy environment there are echoes of Florence Nightingale's era from over a century ago.

"The cleaning is the important point the surrounding, they cleaning the surrounding of the patient is very important, if the surrounding of the patient is dirty no health no health at all".

(MM, interview)

Another interviewee has actually went further to explain that:

"We were having three wards one ward the clean ward, one ward dirty ward, one ward is accident ward, all wards should be clean and the clean ward more but dirty ward should also be clean and cleaner than other wards, if wards are clean patients feel better and become better faster".

(AU, Interview)

In the literature review chapter, Nightingale's international influence was examined, but it is crucial here to remember that if there is some sort of influence of Nightingale in nursing in SA or specifically in Aden, it is largely due to the colonial element and the importation of the Western nursing to the colonies by the coloniser.

In addition, one of the Adeni nurses who was interviewed provided us with personal collections of two manuscripts that according to him go back to 1958.

The two manuscripts illustrate morning lists of duties for a medical ward and for a surgical ward (see following figures pages 141 and 142). It is very important here to ask who the author of the two documents was. The answer to this question remains fairly open, ranging from a head nurse to a ward sister to a matron, or someone who puts rules, names and allocates duties to nurses, and orderlies who work in a ward setting. The content of the two documents is very important, however, it is not possible to establish if the list of duties are for nurses only or for nurses and orderlies. In fact, the lists contain tasks that can be done by nurses as well as orderlies. Tasks such as cleaning the dressing room, serving meals, helping to bath very sick patients, cleaning the medicine cupboard and injections trays, helping with meals, feeding very sick patients, collecting food plates, cleaning the ward, collecting all the urinals before each meal. All these tasks can be done by both nurses and orderlies. Duties or tasks such as giving injections, completing intake and output charts, including entering information on temperature, pulse, respiration (TPR), administering medicines every four hours, all are tasks normally assigned only to nurses. A question which interests us here is whether the tasks listed in the two documents were allocated to Adeni nurses as well as British nurses and orderlies, this question inevitably reminds us of the setting in which the two documents were produced. The two documents are similar; the only difference is the absence of the intake and output charts and the four hourly TPR. It is not clear if the nonexistence of these two vital tasks from the surgical ward's morning duty list was intentional or an error as most patients would need a close observation of their vital signs and their intake and output pre-surgery and post-surgery.

In a manuscript written by one of our Adeni nurses who was interviewed for this study entitled *Aden Colony and Protectorate (Eastern and Western) Nursing Administration*, the author begins by stating that:

“The standard of nursing was excellent, the reason was as follows”.

(AU, Interview)

He then goes on to declare these reasons stating by:

“The Female senior nurses from UK were responsible for the wards and units”

(AU, Interview)

This declaration is very interesting, for two significant reasons: the first is that this declaration was made by one of the Adeni nurses who worked as a nurse when Aden was under the British control. One might expect a more critical attitude towards those in authority by one of the ‘colonised’ lower ranking nurses. And second this declaration was made by an Adeni male nurse who worked under the supervision of female senior nurses, who clearly had no problems working under female senior nurses. From the interviews we cannot tell whether this nurse would have felt differently if the female senior nurses were Adeni rather than British female senior nurses. However, this topic is indeed open for speculation especially when it comes to issues regarding gender, culture and nursing these topics will be discussed in more detail in a later chapter.

Another interesting aspect which transpired from the interviews was the subject of the administration of the bedpan by the nurses.

‘Before, when the hospital was in Aden (Civil Hospital) the nurse did not serve the bedpan for the patient or the urinal’, but when they transferred to here (QEH) they started this practice”.

(AU, Interview)

“The British told us you have to give the bedpan to the patient”.

(MM, Interview)

This topic is also relevant to a later discussion in relation to the cultural aspect of the idea of giving the bedpan to the patients; here we will discuss it merely from the point of view of performing this important task. But the idea of providing bedpans to patients has never been far from a nurse's mentality anyway. 'Whether now or in the past, slogans such as 'nursing is not about changing bedpans' or 'nursing beyond bedpans' are still very common and this is despite the fact that providing bedpans to patients is an important part of nursing care and an aspect of good observation.

"British nurses insisted that we should do that, it is nurses who should give bedpans and the urinals to the patient and not the cleaners".

(PR, Interview)

The later quote suggests that the British nurses were in a position to give commands and instructions to the Adeni nurses, and maybe to each other depending on the level of their responsibility. What matters here is the role of the British nurses in the hospitals in SA, particularly the exact nature of their management role.

MORNING DUTY LIST

Check Oxygen Cylinders
Clean Dressing Room
Injections
Serve Meals
Responsible for all Instruments

Medical Unit

Intake & Output Charts Pulses 4 Hourly TPR
Medicines
Help Bath ill Patients
Egg Flip
Clean Medicine Cupboard & Injection Trays

Baths No:--
Help with Meals
Feed ill Patient No:--

Collect Food Plates
Clean Ward Beds Ledges Lights Lockers Screens
Wash Walls
Clean all Lockers Inside & Out

Collect all Urinals Before Each Meal
Suice
Office
Ward Sinks

MORNING DUTY LIST

Check Oxygen Cylinders
Clean Dressing Room
Dressing
Serve Meals
Responsible for all Instruments

*Subject list
list*

Injections
Medicines
Help with Dressings
Egg Flip
Clean Medicine Cupboard & Injection Trays

Baths No:--
Help with Meals
Feed ill Patient No:--

Collect Food Plates
Clean Ward Beds Ledges Lights Lockers Screens
Wash Walls
Clean all Lockers Inside

Collect all Urinals Before Each Meal
Stirce
Office
Ward Sinks

The records which were accessed from the ONA suggest that British nurses worked proportionately more in Aden than the rest of SA and they worked mainly in hospitals of which there were several.

I have created the table below using information provided from the *Health and Medical* reports of the years 1955-1959 accessed from the ONA (ONA, 1955-

1959). The table shows the number of nursing posts established and filled in the mentioned years.

Table2: *Nursing post established and filled for the period 1955-1959*

Designations	Established Posts					Filled posts by end of year				
	1955	1956	1957	1958	1959	1955	1956	1957	1958	1959
Matron	1	1	1	1	1	1	1	1	1	1
Assistant	1	1	2	2	2	1	1	1	2	2
Nursing	19	25	29	38	42	15	13	16	26	30
Male Nurses	6	6	6	6	9	5	5	5	5	8

Whilst I cannot be absolutely sure it is, unlikely that Adeni nurses were recruited for the position of matron, matron assistant or nursing sisters and this is supported by both interviews and documentary evidence. At the same time, it is probable that a number of those who were recruited were male nurses. The *Health and Medical Reports (1955-1959)*, which were examined in this research, did not make clear the nationality of the individuals who occupied these posts, but it is most probable that the role of Matron, Assistant Matron and Nursing Sister were occupied mainly by British nurses. As far as I know, the nature of these posts is managerial, supervisory and instructional. Thus, it is unlikely that these posts would have been given to Adeni nurses.

Here is lack of detailed information about what the British nurses' clinical roles in hospital ward settings were. There is also evidence from the archival sources and from the interviews that the British nurses were involved in training the local nurses and supervising them, nursing training and the role of the British nurses will be considered in more detail in the next chapter, which will deal with nursing training in SA during the period under study.

Although the interview questions asked to the British nurses and to the Adeni nurses were not always the same, the same questions were asked with respect to nursing roles and the type of nursing care that was undertaken by the

interviewees. The responses of the two British nurses on the question of the nature of their work gives us an idea of the range of their responsibilities:

“Everything, we had a lot of infections of all description, because there was no doctor, I was very busy, morning, evening and night, as you can imagine”.

(GG, Interview)

“I would be called to see a very dreadful cases especially women with childbirths, the Arabs had a lot of bilharzia and TB”.

(FF, interview)

These two British nurses worked in a community setting and one of them changed to work in a clinic. Both felt they needed to do something to help the poor health situation in the place where they lived. But to conclude from both quotations above is that both nurses perceived themselves as taking on the role of doctors and that they had to deal with the situation and to take full control. And perhaps this was what they had to do as there were no doctors where they were and therefore, working autonomously, they did whatever they felt was necessary to assist with the poor health situation around them. The expression ‘autonomous practice’ is a term that is increasingly used within the nursing profession but is mainly practiced nowadays by advanced or experienced specialists nurses.

However, certain kinds of settings may force nursing professionals to work autonomously. For example, these two British nurses found that they had to expand their clinical practice and make some complex clinical decisions and this was perhaps due to the lack of doctors where they lived and worked. The first question here is about the kind of professional areas where such assistance was lacking. Secondly, it is important to ask how they coped and dealt with the health situations that they found. In fact, this brings us to a very controversial topic, which is the practice of traditional medicine and the introduction of western medicine. In chapter three a brief mention was made of the introduction

and the imposition of western medicine in the colonies. Nursing is considered an integral part of this and thus had a role to play through nurses who came to the colonies and worked in hospitals or in the community.

Within this context, it is crucial to mention that the two nurses had what may be called a political role to play which was to enhance the sustainability of a good relationship with the allies of the colonial power. This was achieved through giving favors and returning favors for and with the Amirs, Sheikhs or the Ashraf²⁶ of SA.

According to the British nurse who worked in Baihan which is about 200 miles away from the city of Aden, she was brought to Baihan:

“My husband knew the Amir quite well who said if your wife is a nurse, she can come and be our doctor. So he gave me permission or gave my husband permission for me to go and join my husband”.

(GG, Interview)

And thus:

“Ashraf of Baihan became very close friends to ourselves”

(GG, Interview)

And therefore:

“The Amir of Baihan as I said because there was no doctor in Baihan, he gave me a land rover for my work which was absolutely wonderful, and we had guards that were provided by the Amir as well so I was always looked after very well looked after and they took it very seriously. So I had a very advantageous position but I was very busy, morning, evening and night as you can imagine”.

(GG, Interview)

As a nurse, GG helped in seeing the ill patients in Baihan and probably she was asked to do more than what she was able to do as a nurse but she needed to

²⁶ **Ashraf** is an Arabic name meaning "most honorable one." (Cited from Wikipedia)

somehow please the Amir. The Amir in turn, as a result of this nurse's services, may well have been better able to keep his people content to avoid any uprising which would ultimately keep the situation in the colony quiet and all this should be for the interest of the colonial power.

A similar scenario existed in Lehej in the Eastern Protectorate where the other British nurse worked:

*"We lived in Lehej; we lived in one of the Sultans
palaces gardens, peacocks lots of rooms just for the
two of us"*

(FF, Interview)

She states:

*"There I mostly saw the Sultan's wives whose main
problems were related to child birth"*

(FF, Interview)

With regards to the BRC staff or to other trained staff, in addition to their role within the normal humanitarian duties of the BRC, they also helped to establish the Maternal and Child Welfare Services. Likewise, the BRC health visitor in the Eastern Protectorate pioneered a similar service in Mukalla.

Furthermore, their contribution and role within the health services in the colony of Aden went further to support hospital emergencies. An example of this was during a two- day strike in the colony of Aden when the BRC nurses were called in to help in the wards. There is no mention of the nature of the work of those BRC members, but if they were to cover and help on the wards, one could only think that they were either nurses or orderlies. The document which was accessed from the BRC archive, reported this by calling these staff the "Women's Detachment", they volunteered to help in the QEH and in the Maternity Hospital, doing as many as eight hours duty both days (BRC, 1965:5).

Whether British nurses, Colonial, BRC nurses, or private nurses, or even SA nurses, males or females, what the next section will attempt to explore is the individual nurses who work in SA during the British Colonial period only in the period 1950-1967.

6.3 Part 3: What do we know about the people who worked as nurses in SA in the period under study?

Chapter Five explored the kinds of illness and diseases that the population of SA suffered from in the period under study; it also gave an account of the health care institutions and services in SA at that time. We also learnt about the different bodies that sponsored the health services and the health institutions that were available. What was also important for us to know was who provided the nursing services in SA and where these services were mainly operated. We were also able to explore the kind of work that nurses who worked in SA undertook, and what their role within the health care services at that time was. Thus from all what we have learnt and explored so far, we have been able to capture some significant and rather interesting facts about those nurses. The part of the chapter that follows is dedicated finding out more about the specific characteristics of those nurses who worked in SA during the period under study. It will focus on such topics as gender, age, and nationality. By doing this, we should be able to have a much more complete picture, not only about nursing services and nursing roles, but also about the individual nurses who worked in Aden and in the rest of the SA protectorate.

6.3.1 Gender

One of the documents that were accessed at the ONA was a register book that contained the names, dates of birth, the home addresses and the places of work

of all ONA nurses. In the visit to the archive, information was collected from this register. At that time of the visit, this was mainly undertaken to search for nurses who worked in SA, the intention being to focus on finding nurses who had worked in SA in order to interview them for this study. The researcher at that time was not looking for specific information such as those nurses' gender, age. Nevertheless, it was noted that most of the names of the ONA nurses were women's; no men's names were identified in the sample examined. Thus there remains the small possibility that there may be some men's names that were not seen by the researcher. Having said that, although the accessed records from the ONA give no hint or detailed information as to the gender of the nursing staff who worked in SA, according to the table illustrated in page (144) there were male nurses amongst the staff recruited by the ONA to work in the colony. We are not sure if those male nurses were part of the ONA or just British male nurses who wanted to work in SA and were able to do this through the ONA. Table 3 illustrates the number of nurses recruited in the years 1950-1959 in general, irrespective of whether they were ONA nurses or other British nurses, as it is unlikely that there were male nurses amongst the ONA nursing members.

It is also important here to remember that during the period under study, in the 1950s and 1960s, female nurses were predominantly occupying nursing posts in the UK. If there were some British male nurses who were sent out to work in the colonies, their number would be far fewer than their female counterparts. Some male nurses may indeed have been sent to work in SA as they may have been greatly needed to look after the male patients. This in fact is very likely in a culture such as that in South Arabia culture.

British male nurses were perhaps more common in private hospitals; here we mean hospitals such as the RAF hospitals. In a website entitled *British units serving in Aden 1955-1967*²⁷, a list of the British forces that served in Aden is available to view. Under the RAF heading, a mention is made of the RAF

²⁷ <http://britains-smallwars.com/Aden/units.html#raf> accessed on 20th October 2014

Hospital, at Steamer Point. The website also quotes a statement given by a Mr. Caroe

“I was there from April 1955 to Nov 1955 working as orderly on the wards”.

(Caroe, 2010)

Mr. Caroe sadly passed away just prior to the interviews for this research project being conducted.

In addition to the Princess Mary's RAF nursing officers who ran the wards and theatres as mentioned previously in Chapter Five, the above mentioned website, under the *RAF Khormaksar Medical Centre* heading, contains a quotation by Sargent Colin M Banks who was a Registered General Nurse (RGN) and later Chief Tech- Nurse Tutor:

“Served as a Male Trained Nurse on Surgical and Intensive Care Ward during the time with the Argyll Southern Highlanders under Col Mitchell took Crater”.

(Banks, 2009)

Unfortunately, we were not able to find more information regarding British male nurses who worked in SA during the period under study and the ones we have been able to find out about were mainly based in Aden, the Crown Colony.

Now in relation to the male and female SA nurses and orderlies, from our collected data, it has not been possible to establish the specific number of this group of people, but some data indicate that the number of male SA nurses at that time could be higher than for their female counterparts. The following quotation suggests that this may have been the case.

“The duties of the profession are more arduous than those of teachers and clerical staff, the hours of work are longer and irregular and the discipline is firmer”.

(ONA, 1958)

Moreover:

“A large proportion of those recruited have failed to continue with their instruction either because of inability to absorb the training offered, because of temperamental unsuitability for nursing or because of social reasons. The latter cause is particularly noticeable among female many of whom resign because of family pressure or on occasion of their marriage”.

(ONA, 1958)

Both quotations reveal factors that may hinder SA females, more than males, from undertaking this work certainly in a culture like that of SA, where women are attached to their families more than men. This will be discussed in more detail in a later chapter, but it is important to mention it here because it could lead to having more males in the profession of nursing than females in SA. From the two quotes above, one could suppose that during the period of this study, there was a greater number of SA male nurses compared to female nurses.

6.3.2 Age

At the time of the study, with the intention of being unobtrusive and in order to try to protect the identity of the participants, it was decided not to ask the participants their exact ages. We were therefore not able to establish the average age of the British males and females' nurses who worked in SA in the period under study. Although knowing the nurses' typical age is not a central concern of this research, it would have helped us to obtain an idea of their level of experience. Experienced nurses who worked as nurses for a considerable period of time would be preferable as working in such a complex setting as SA requires this. Older nurses would probably be in a better position to train and supervise staff. Sisters are expected to be more experienced and older and this is likely to be true for associate matrons and matrons.

There were some regulations in terms of who could apply to work abroad, and certainly in the colonies, the age limit could be of these regulations. In any

case, working in the colonies would perhaps not have been so attractive to younger individuals who would have lacked experience, and broader thinking.

Nevertheless, unfortunately such data is not available and thus we cannot establish the average age of the British nurses who worked in SA in the period under study.

6.3.3 Nationality

In addition to the British and the SA nurses, other nationalities worked in SA in the health services whether as doctors, nurses or even as orderlies. In fact, nationalities from places such as India and Somalia are represented in the archives.

This was not surprising at all, as the researcher herself studied nursing in Aden and knows that most of Aden's old nursing generation were of Indian origin. At the same time, Somalis worked mainly as orderlies. Amongst the people the researcher had interviewed for this study a considerable number of the interviewees were of Indian and Somali origin. What the motive for these nationals to work in SA is not clear but it is important here to remember that Northern Somalia and India were both under British control during the period under study. Interviewees stated that:

“Nursing in the past was Somalis, Hindus and some of British people, here in the hospital when I start my job it was sisters from British and Somali staff nurse, charge nurse, and some of Hindus from India”.

(MM, Interview)

“The students were from India, they, moreover, were ordinary nursing assistants, trained specifically to assist the nurse for three years, after which they would graduate.”

(AU, Interview)

The above quotations raise a number of questions as to what extent SA nationals contributed to the early stages of nursing profession in their own country.

6.4 Summary

This chapter has reported and discussed three main themes. It first considered the different parties that provided nursing services in SA in the period 1950-1967 and how this provision was organised. Secondly, it went on to discuss the role of the nurses who were part of the existing nursing services within the general health services. Lastly, it revealed the more specific characteristics of the individual nurses who worked in SA in the period under review.

In SA in the period 1950-1967 nursing services were provided by different organisations. In addition to the trained and registered nursing, patient care was also delivered by other groups of individuals who varied in terms of their service provider, their level of training and their role.

The collaboration of the British colonial authority in Aden with CNA during the studied period of time resulted in sending CNs to the colony. The CNs worked mainly in Aden the Crown Colony and mainly in government hospitals but not exclusively as they were also sent to other parts of the protectorates for important and special missions connected to colonial authority demands. It was important for the colonial power in SA to have British nurses working in the colonies' hospitals since their presence was vital to fill the lack of trained nurses amongst the locals. The mission of the nurses of the CNA in SA was planned and supported by the colonial power, inevitably any services including nursing services delivered by these nurses appeared to be delivered by and for the interests of the colonial power. As a result, these nurses may be considered to be as agents to the colonial power, at the same time, they also appear to have been exploited and used by the colonial government' political agenda in the colonies. There were important conditions that needed to be met when recruiting CNs; the lack of proper housing for CNs for instance was an obstacle

towards recruiting more CNA's nurses. Furthermore, there was unwillingness amongst the CNA's nurses to work outside Aden the Crown Colony; hence promotions were introduced to encourage them to do this.

In addition to the CNA nurses that were sent to SA, there was a private nursing service which aimed to serve mainly in the non-government hospitals. The RAF for example, had its own nursing staff, which were part of the PMRAFNS who operated in the two RAF hospitals inside Aden. Nurses who worked for the RAF as part of its nursing services are thought to have had a military rank in addition to their nursing rank. As part of the RAF nursing staff there were also, some male nurses who worked either as trained nurses? or orderlies.

BP nursing staff were also considered to be part of the nurses resources and delivered private nursing services. They served only in BP hospitals and, similarly to the RAF nursing services, delivered their service only within their medical care organisations.

Unlike the private nursing services, the independent nursing services provided a nursing service. The BRC in SA provided this type of service and have supported areas in crisis as well as providing community services as well as extending their services to areas outside Aden.

The colonial presence has also meant that some women accompanied their husbands to the colony and they coincidentally were nurses. Such nurses had also provided an independent type of nursing services which was directed mainly to the community of the natives. They worked independently using their own initiatives and their own professional judgement. However, their presence contributed to the colonial presence, as they had connections to the colonial power and strong ties with the allies from the natives.

The role of nurses who worked in SA in the period of time under study differed depending mainly on where they worked and what their role was. The role of the Adeni nurses who worked in a hospital setting consisted of more than basic nursing care, as they seem to have been required to undertake certain cleaning duties. The actual roles of the British nurses have not been easy to establish

from our collected data; however, it is clear that in most situations they had the overall managerial and supervisory in addition to training duties. This was particularly the case in government hospitals where CNA's nurses mainly worked. The British nurses who were interviewed in this study are considered as an independent source of nursing services, and served mainly in the community. Those nurses perceived themselves more or less as doctors as they had to treat people themselves. It seemed that they were minimally involved in nursing care or managerial or supervisory duties like their co-nationals who worked in a hospital setting. The two British nurses who worked in SA provided their services wherever they lived, they sometimes had to return favours and play politics when needed.

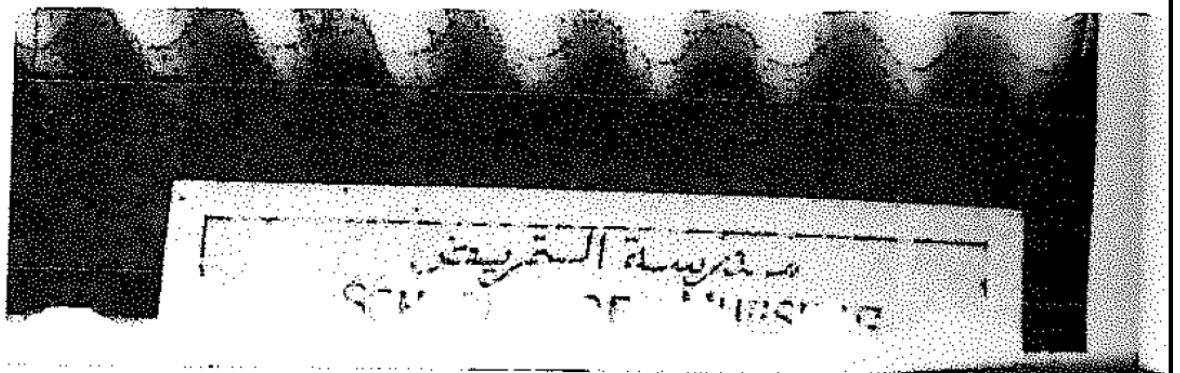
With respect to specific characteristics, CNA's nurses were mainly females rather than males, unlike the RAF nursing services where there tended to be some male nurses amongst its nursing staff. The actual proportions of female and male nurses including British and Adeni nurses in SA in the period under review remains unknown.

The age of the nurses who worked in SA was something we were not able to establish the average age of the British nurses who worked in SA in the period of time under study.

In addition to the British nurses who came to SA as a result of the colonial presence, due to colonialism nurses of other nationals also formed a part of the nursing services. SA nurses existed but occupied mainly low status within the nursing services.

The demand for more nurses and perhaps the difficulties of bringing more British nurses continued to increase, increasing the need for more SA nurses. This in turn increased the need to employ more SA nurses and before doing so the need to train them in a way that satisfied the coloniser. Therefore, the next chapter will consider the story of nursing training in SA in the period 1950-1967.

Chapter Seven: Nursing Training in South Arabia in 1950-1967



Chapter Five: Health Care
Services in SA 1950-1967

Chapter Six: Nursing Services in
SA 1950-1967

**Chapter Seven: Nursing Training
in SA 1950-1967**

Chapter Eight: Nursing, Culture,
and Colonial Nursing

Introduction

Chapter Five emphasised the need for nursing services as part of the overall delivery of health services within SA, the British colony and the protectorates, and this same chapter illustrated the numerous health problems such as the spread of diseases and the ill health of its people. Chapter Six, on the other hand, gives an account of the nursing services available in SA in the period under study and how and who delivered this service. We also learnt that in the period under study the colonial authority in SA had started to focus more on health and the delivery of better health services, which included nursing services, even though its main focus was Aden the crown colony and not the rest of SA in the protectorates. The introduction or the presence of colonial nursing in SA was important but as we know from the previous chapters, there were some obstacles. This is perhaps what made the colonial authority in the form of the health authority feel the need to have native nurses amongst the nursing staff. Another reason perhaps behind considering training local nurses is that according to Solano and Rafferty (2007) during the World War II there was a shortage of nurses in the UK. Solano and Rafferty believe that due to this,

“The number of British nurses recruited to work in the colonies fell to just over half its pre-war rate”.

(Solano and Rafferty, 2007:1057)

One important consequence of this decision made by the CO involved establishing a school of nursing, providing nursing trainers and supervisors, and ultimately recruiting the graduated staff which meant allocating funding for this. Inevitably, this means that the decision to establish or initiate nursing training in the colony was a political decision.

Against this background, this chapter is therefore dedicated to answering three main questions, the answers to which should give us an overview and enable us to make sense of nursing training in SA the crown colony and the protectorates in the period 1950-1967. The questions are as follows:

- When did nursing training start in SA, and where did it take place?
- What was the nature of the nursing training in SA in 1950-1967?
- Who provided nursing training?

7.1 When did nursing training start in SA, and where?

This part of this chapter will report and discuss data in relation to when and where nursing training in SA commenced. Our collected data show that nursing training started in the period under study; in other words, the formation of nursing training institutions only genuinely took off as from the mid-50s, when nurses started to be trained for the local nursing profession (ONA, 1955). This is somewhat surprising given that the British colonial period in SA extended from 1837-1967; it was only in the late 1940s when the British colonial power in SA started to consider health services and shortly after this period of time started to acknowledge the importance of considering nursing services as part of the delivery of health services. The need for more nurses and the difficulties of bringing more CNs has perhaps stressed the need to train the local people to work as nurses. Here we are referring to two systems of nursing training:

training local student nurses in the colony and training local student nurses in the UK.

Furthermore, the data accessed from TNA suggest that in the period under study, there were different levels of local nursing training in existence in the colony. These were: professional nursing training and practical nursing training. It is important to point out that during this period a small number of student nurses from SA were able to train in the UK in order to obtain the State Registered Nursing (S.R.N) Certificate or professional nursing as the two terms can be used interchangeably. Nevertheless, this research is mainly concerned with nursing training inside SA and in the section that follows, I will give a detailed account of each type of training, which are the professional and the practical nursing, separately since both had different starting point and were delivered differently.

7.1.1 Professional nursing training

7.1.1.1 Local Nurses training in the UK

Before the local nursing training for the professional nursing qualification began in the colony, some form of nursing training was provided to very small numbers of local nursing students in the UK, the *Medical and Health Report* (ONA, 1951:2) reports that:

“Three Adenites were in training at a hospital in England for the S.R.N certificate”.

The above statement suggests that the colonial authority started sending local students to study for the S.R.N course in the UK from 1950 or perhaps from even before then. No specific data exists that informs us exactly when the three students from Aden were sent to the UK, but it is clear that at the time of writing the above mentioned annual report which is in 1951, those students were already in the UK. This in turn suggests that if those students were not the first batch of students to be sent to the UK, there were probably some local

professional nurses had already returned from the UK after completing their courses and that they were already part of the nursing staff in the colony. Now there is no data to support this argument. but it could be that the plans to train local nurses inside the UK were prepared for before the period currently under review. This question opens up more room for future research on the nature and extent of nursing training during an earlier period of time.

The three nursing students, who were mentioned in the above report, were also referred to as "*The three local Arabs*" in the same annual report but for the year 1952. These students returned to SA in 1952 and according to the report they proved to be very successful. The same individuals were referred to differently in the same series of reports, but it is possible, that the reports of 1951 and 1952 were written by different authors and that each had a slightly different perception of the local population. It is even possible that the phrase 'three local Arabs' was intended to have negative connotations, yet we cannot prove this.

Significantly, the *Medical and Health Report* (ONA, 1954:17) reports the following:

"One male S.R.N took up his duties during the year. The training of Arab Male staff as state registered nurses has proved of considerable benefit to the hospital".

The above quote is useful as it implies that the three local nursing students who were sent to the UK were males. This in turns suggests that the colonial authority in Aden was perhaps biased in sending male local nursing students to the UK for their S.R.N certificate rather than females. The quote has also pointed to the benefit of training those Arab male nurses without mentioning what the benefit was and raises the question of why Arab female nurses would not be as beneficial as their male counterparts?

Records indicate that the colonial government continued sending local nursing students to the UK for their nursing training. According to the *Medical and Health Report* (ONA, 1955), seven scholarships, including one female, were

awarded by the colonial government during the year 1955 for the study of professional nursing training in the UK. The same report advises that of these mentioned scholarships awarded, two students one male and one female did not complete the nursing course in the UK in the allotted time, but there is no mention of why this was the case. Other potential questions relate to the proportion of males and females sent to study in the UK and the reasons for this. In addition, we have no data regarding the selection criteria for the eligibility to study nursing training in the UK by the SA students at that period of time. It is quite possible that the colonial authority had allocated seven scholarships without specifying the gender of the applicants. However, based on the above mentioned quote in relation to the hospital benefit of sending male students to the UK for their nursing training, there is a strong likelihood that the colonial authority allocated six scholarships for male student nurses and only one for females. If this is indeed true, one of the question arises as to why would the Colonial authority prefer to have more local male nurses than local female nurses, contradicting the norm in their motherland (UK) where nursing at that period of time was predominantly a female profession. SA is a completely different cultural and political setting than the colonial power's homeland. Under the colonial administration, laws and norms could completely and easily altered if this ultimately served the interest of the coloniser. This in fact takes us back to the criteria determining the selection of students for study in the UK. Here I am not referring only to gender but to other criteria such as the local students' standards or level of education for instance.

The reason why the issue of standards of education of local student nurses is mentioned is because at that time this was a source of concern towards training local nurses inside the colony, and one may assume the same concern existed when it comes to sending local nursing students to the UK, especially in regards to these students' comprehension of the English language. The unsatisfactory standards of education were mentioned on at least two occasions in the *Annual Medical and Health Reports* when reference is made to local nursing training or in other words when talking about nursing training in the colony.

“The local scheme for full time training of nurses is making very

slow progress. The lack of applicants of suitable educational qualifications to enable them to benefit from such training is very disappointing”.

Medical and Health Report (ONA, 1958:19)

Moreover,

“The scheme of the local training of nurses is labouring, clearly due to a lack of sufficient numbers of applicants of suitable educational qualifications”.

Medical and Health Report (ONA, 1959:17)

No mention is made, however, to the standards of education of the students who were sent to the UK. Instead, the report comments that:

“The students undergoing formal nurse training for state registration in the UK are making satisfactory progress”.

Medical and Health Report (ONA, 1958:19)

Besides, the same report for the year 1957 reported that all the six nursing students who studied in the UK were successful in passing the first examination for S.R.N and their further progress was also reported to be satisfactory. Amongst these nursing students, two returned to Aden during the same year,

“One having gained his State Registered Nursing and the other her S. R.N. and S.C.M”.

Medical and Health report (ONA, 1957: 2)

The subsequent *Annual Medical and Health reports* of the years (1958-1964) made no mention of any more local student nurses studying in the UK for their S.R.N certificates or to any students who had been sent or who were going to be sent to the UK. The reason for this could be that the colonial authority decided not to send any more local nursing students to the UK since the local nursing training in the colony had begun.

7.1.1.2 Local Nurses' training in the Colony

In regards to the local training of nurses or training local nurses in the colony, according to the records accessed from TNA, there were two types of this training: the professional and the practical nursing training. Nevertheless, it is important to point out that our data show no evidence that local nursing professional training existed elsewhere in SA apart from the colony of Aden. In fact, this information is not surprising as the reason behind training local nurses in general was considered to be less relevant to the rest of SA, one of the reasons to relieve and support the CNs as well as shortage of nursing in general and the difficulties of recruiting more CNs. And as the majority of the CNs, if not all, worked mainly in Aden and that only a small number of CNs worked elsewhere in SA for a short period of time, the need to train local nurses in the rest of SA was not central.

7.1.2 The establishment of the school of nursing

According to one of the interviewees, the British colonial authority in Aden established the first nursing school in 1956 in the compound of the Civil Hospital (CH) in Crater in Aden.

“The first school of nursing was inside the Civil Hospital. they built it in 1956”.

(JD, Interview)

The interviewee went on to explain that this school of nursing:

“Started with professional nursing course and short courses in practical nursing”.

(JD, Interview)

This was also supported by the *Medical and Health Report* of the year 1956:

“A start was made in October in the full time training of nurses and midwives. The plan is to provide a three year training course in general nursing for both men and women”.

Medical and Health Report (ONA, 1956:20)

In relation to the term “practical nursing” which was used by at least two of our interviewees, who were local Adeni nurses, and the term “subordinate nursing staff”, which is used in the annual medical reports of the colonial power. The records are not clear if there was a difference between the two terms.

In 1957, the professional nursing course was moved to the Girl’s College at Khormaksar, and a classroom was prepared for this reason (JD, *Interview*). This suggests that there was only one single classroom and seemingly a small number of students. There is lack of data about why the professional nursing course was moved out from the Civil Hospital and how many classes were available when they were still at the Civil Hospital for both the practical and the professional courses.

One probable reason for transferring the professional nursing course out of the CH to the Girl’s College may be connected or is probably the same reason behind the discontinuation of the practical nursing course. It is crucial here to remind ourselves of what was previously mentioned in Chapter Five regarding the official launch of the QEH in 1958. The QEH replaced the CH, and this may be the reason behind the discontinuation of the professional course in the CH. However, according to our data, the professional nursing course was recommenced and ran from the QEH in 1958 after the launch of the latter, but we have little information which indicates for how long. We will endeavour to explore this further.

As mentioned in the previous part of this chapter, student nurses started to be trained for the nursing profession in 1956, when the British set up the first school of nursing in the Civil Hospital premises in Crater in Aden.

“The first batch of nurse students who joined nursing training was in 1956, and we were the second batch. We started in 1957”.

(AU, Interview)

The later quotation was provided by one of our interviewees who reported that he was one of the student nurses of the second batch of the professional nursing training. According to him, they started their training in the 1957 and the first cohort started their training in 1956 (AU, *Interview*). As the school of nursing was moved to QEH in the year 1958, this means that the first professional nursing course commenced in CH in 1956 and the second training course ran in the Girl’s school in 1957.

Another interviewee who was also one of the student nurses of the second batch supports the later quotation and added information about the number of the students in the first and second batches of the professional nursing training during the years 1956 and 1957.

“They were over 17 nurses, and we were over 13 second batch in 1957”.

(VC, Interview)

This later quotation indicates that the number of the students in the first cohort was greater than the number in the second batch. No data suggests the reason behind the decrease in the number of students in the second batch, but it could be that fewer candidates applied for the second batch of professional nursing training or possibly that the number of nursing students in the second batch was deliberately reduced. The later suggestion, if true, could be due to many other reasons, one of them is connected to the problem of the students’ lack of

adequate or insufficient educational background as mentioned previously in the colonial power's reports. This raises the question of what was the acceptable educational background from the colonised point of view.

We have no more data with regards to the professional nursing training after the year 1958, which suggests that there were merely two cohorts of students who undertook professional nursing training during the years 1956 and 1957 and that the courses must have stopped in 1958 or shortly after then. This suggests that the colonial authority for some reasons decided to stop this course. The issue regarding the insufficient educational requirements of students was an obstacle towards continuing the professional nursing course and this could be the reason in this case as well.

Moreover, the first school of nursing was established in the CH in 1956 and that this school started with the course of professional or general nursing and short courses without mentioning who the short courses were for. However, according to the *Annual Health and Medical Report* of the years 1955:

“A start was made in the training of subordinate nursing staff at the CH. The course is one of three months duration and is in the nature of a revision and theoretical class for existing staff”.

Medical and Health Report (ONA, 1955:21)

This quote suggests the following: First, that the course for the subordinate nursing staff had started shortly before the commencement of the professional nursing training in the colony. Second, it suggests that staff who already worked as orderlies had to go for this short revision-oriented course. It also suggests that perhaps what the students would gain from this course were certain skills enabling them to support the nursing staff which were predominantly CNs. Unfortunately, what we don't know is whether the subordinate nursing staff were the same as practical nursing staff; in other words, whether the two terms might have been used interchangeably. It may be that the Adeni nurses interviewed in this study, who completed their professional nursing diplomas, used the term

'practical nursing' to refer to those who did not do or complete their professional nursing course. The next section will help us to understand and make sense of the difference between the two, and if they were not the same what was the difference?

7.1.2.1 Practical Nursing Training

A letter of significance dated 6th April 1959 was accessed from TNA. It was written by Mrs. Catharine McNeil to the General Nursing Council for England and Wales (UKCC). Mrs. McNeil, according to the letter, worked in QEH in Khormaksar in Aden, However, it is not clear from the letter what occupation she had. Nevertheless, in the letter Mrs. McNeil requests a copy of the syllabus for the assistant nurses' training. She states that:

"I have tried to run a class based on the general nursing syllabus, but are unable to get students with sufficient educational background and feel that a more practical course would be the answer".

(TNA, 1959)

The above quote establishes three main points. First, the nature of the request indicates that Mrs. McNeil worked either as a Matron or as a Chief Nurse in the QEH or as the person who was responsible for nursing training. Second, Mrs. McNeil who did not introduce herself or noted her role in the above mentioned letter seems to be well known to the UKCC maybe from previous correspondence. A third point that this quotation indicates that Mrs. McNeil had faced difficulties in training local nurses for the general nursing course or in other words for the professional nursing qualification, for the same reasons mentioned before which was the insufficient educational background of the local students. Mrs. McNeil believed that a more practical nursing course would be the best for this group of students. However, the above mentioned quotation makes things appear slightly clearer to the researcher, although other

interpretations cannot be ruled out as history can be interpreted differently by different people.

As mentioned previously, the practical nursing training was mentioned on so many occasions by the Adeni nurses who were interviewed in this study. While this is the first time in this report that the practical nursing is mentioned by someone who is part of the colonial administration, in this case: Mrs. McNeil. This in fact suggests that the Adeni nurses who studied for their professional nursing at that time used the term practical nursing training to describe what from the colonial perspective, is merely a role played by individuals who got involved working alongside the nursing staff and had some sort of training of “revision nature” and not the actual practical nursing training that Mrs. McNeil is referring to in her quotation above. This could mean two things, first that the practical nursing course started shortly in or after the year 1959 and after commencing the professional nursing course in 1957. Second that the practical nursing course must have replaced the professional nursing course from or shortly after the year 1959 due to the lack of student nurses with proper educational qualifications to study for their professional nursing course. This perhaps explains the reduction of the number of students studying for their Professional nursing course from 17 in the year 1956 to only 13 in the year 1957. The practical nursing course, however, according to another letter sent by M. Houghton in 22nd April 1959 acknowledging the receipt of Mrs. McNeil’s above letter, had no prerequisites:

“This training requires no minimum educational requirements at the present time”.

(ONA, 1959:1)

Here M. Houghton, is not clear from the letter whether it was a he or a she was referring to the practical nursing course. Here the quotation suggests that the practical nursing course did not require higher educational qualifications at the time of writing the letter; it also implies that this might change in the future and students who need to do the practical nursing course might need to have the

proper educational background to do so. This would be difficult in the view of the educational attainment of the natives, as what minimum educational requirements from the colonial administration perspective are may not exist in the first place.

Unlike the local professional nursing training in the colony, the practical and maybe the subordinate nursing training in the colony took place not only in Aden but also in other parts of SA. In Mukalla in the Eastern Protectorate for instance, school-aged Beduin girls were trained for the practical nursing training and in addition to this it was intended:

“That these girls will do a one year course of midwifery and health visiting”.

(ONA, 1958:42)

The same happened to the Fadhli in the Western Protectorate: young girls were trained for the practical nursing training course (ONA, 1958:42).

Here it seems that the colonial authority saw girls or women in SA playing better role as practical nurses. This could be for the many reasons, but one of which is likely to be the standards of education of girls and women in SA at the period of study; however, it is worth pointing out that this problem was also applicable to SA men as well. Alternatively, it may have been due to the nature of the work of professional nurses in terms of out of hours services. This is because SA women might have found it difficult to commit themselves to out of hours services for social reasons. However, out of hours services were also applicable to both practical and professional nurses' duties. The real reasons of why SA girls and women are encouraged to go for the practical nursing training and not the professional nursing may well lie within the colonial mind-set. Yet we can only try to interpret what had happen and why.

Furthermore, and as far as our data are concerned no local student nurses were sent to the UK for the practical nursing certificate. This is likely to be for two

reasons: the first is that the CNs can train local practical nurses in the colony, as the nature of this job in the past did not require a sophisticated nursing training and the CNs should have been more than capable of providing this type of training. It would also be of course more expensive to send practical nursing students to the UK in order to obtain their practical nursing certificate. Second, as the practical nursing course at that time did not require the individual to be of high standards of education similar to the ones needed for the professional nursing, students who were former orderlies could easily be absorbed to do the practical nursing course (ONA, 1955).

The next part of this chapter will focus on nursing training in SA in the period under review; what it consisted of and how it was delivered.

7.2 What was the nature of the nursing training in SA in 1950-1967?

The last part of this chapter established that nursing training in SA took place mainly in hospital settings, first in the Civil Hospital and then in the Girl's College but only for a short period of time before it moved back to the campus of the QEH where a school of nursing was established. Our data also show that local students were trained for their practical and professional nursing certificates inside the colony, and that a small number of local students were sent to the UK only for their S. R. N Certificate or the professional nursing certificate. What is crucial to explore at this stage and what this part of this chapter is aiming to shed more light on is the nature of this training. In other words, we will attempt to reveal how nursing was taught, and what the syllabus and methods of training were employed for the purpose of this nursing training in SA. Our focus here will be on any nursing training, which existed inside SA only during the period under study.

It has been believed that from the mid-50s there were three system programmes of nursing training in SA: the subordinate nursing training, the practical nursing training and the professional nursing training. The later training which is the professional nursing training was for the qualification of

S.R.N and was of three years; the practical nursing was a two-year training course and the subordinate nursing training was of a three months duration.

7.2.1 Subordinate nursing training

In relation to the subordinate nursing training, we learnt earlier that this course was a three-month course of a revision nature. And as such, it was mainly a practical course with a brief theoretical element, to ensure staff are a) equipped with the necessarily skills needed for this job and b) that this group of staff are updated with the new changes in practice. This is merely a course which was designed to get people working in a health care setting, gaining very minimal skills perhaps caring skills rather than nursing skills and to enable them to do the things that nursing staff were too busy to do or maybe somehow reluctant to do. It would be very helpful if we had an idea about the contents of this course, yet, unfortunately, no data is available in regards to the content of this short training course.

7.2.2 Professional nursing course

In regards to the professional nursing course and as we learnt, it has been believed that there were only two batches of professional nurses who did the professional nursing course and trained as staff nurses. Some of the interviewees who were interviewed for this study had trained on the second set of the professional nursing course. According to one of them:

“The duration of the course was three years, each year, the Student have to do specific tests in nursing and to complete the schedule given to him during his/her training, theoretical and practical”.

(AU, Interview)

The same interviewee of the above quotation provided us with manuscripts that, according to him, belonged to him when he was a professional student nurse in 1958. The three manuscripts consist of a schedule, and each schedule consists of a list of interventions or procedures that needed to be performed by the student nurse and signed by the ward sister who witnessed the nurse performing these interventions satisfactorily, as part of the degree of professional student nursing course. The first manuscript contains the name of the student and the year which is 1958 in this case and it is entitled the “1st year schedule”. The second manuscript is entitled the “2nd year schedule” and the third manuscript is entitled the “3rd year schedule”. However, we have no indication of the actual years to which the “2nd year schedule” and the “3rd schedule” refer (See copies of manuscripts in the following pages).

The procedures listed in the schedules are numbers of tasks that nurses performed in a ward setting. Apparently, student nurses were expected to be able to perform all these tasks independently as part of their course assessment. In front of each procedure, there is a room for the signature of the ward sister who supervised the student performing the procedure or task successfully but the date of when the task was performed or when it was signed off by the ward sister is missing. What is also missing is a space where the student needs to sign to agree as to whether he/she had performed the listed tasks satisfactorily or unsatisfactorily.

The absence of this information makes one think of the person who created these schedules. It is very likely that the sisters or the matron who were responsible for nursing training were the ones who created these schedules and that these schedules were not standard forms that were used for professional nursing training more widely, whether inside the UK or in the colonies. On the other hand, there is also a possibility that they were standard forms and were in use in the UK for the purpose of training professional nurses, considering the fact that in the year 1958 nursing training in the UK was not as complex or sophisticated as it is nowadays. There is no intention here to embark into a comparison between nursing training in SA in the past and present, although this could be an interesting topic for further research in the future. However, this

comparison was mentioned here merely for illustration purposes. It is most likely that the three schedules were created by the ward sisters or whoever was responsible for the training of student nurses at the time.

The Sister to sign below when she has seen the student perform the following satisfactorily.

Procedure	Sister's Signature
1. Bathing a patient in bed	G. Bainbridge
2. Treating pressure parts	G. Bainbridge
3. Treating a mouth	G. Bainbridge
4. Washing hair in bed	
5. Taking a temperature, pulse and respiration and charting same	G. Bainbridge
6. Giving an enema saponis	G. Bainbridge
7. Giving a rectal saline by: (a) Drip method ✓ (b) Tube and funnel method	G. Bainbridge NSLWJ
8. Preparing patient and tray for a rectal examination	G. Bainbridge
9. Preparing patient and tray for a vaginal examination	
10. Preparing a dressing trolley	G. Bainbridge
11. Doing a simple dressing	G. Bainbridge
12. Preparing and applying a surgical fomentation	G. Bainbridge
13. Preparing and applying an antiphlogistine poultice	G. Bainbridge
14. Preparing a post-anaesthetic tray	G. Bainbridge
15. Feeding a helpless patient	G. Bainbridge
16. Admitting a patient	G. Bainbridge
17. Discharging a patient	G. Bainbridge
18. Removing flatus by a flatus tube	G. Bainbridge
19. Preparing patient and tray for examination of throat	NSLWJ
20. Preparing and giving a hypodermic injection	G. Bainbridge
21. Preparing and giving an intramuscular injection	G. Bainbridge
22. Filling an ice-bag	
23. Laying out the dead	
24. Doing a rectal w/o	G. Bainbridge
25. Giving medicines	G. Bainbridge
26. Giving an inhalation	G. Bainbridge
27. Administering oxygen	G. Bainbridge

1. Preparing a tray for intravenous injection
2. Preparing and giving:
 - (a) Glycerine enema.
 - (b) Olive oil enema. ✓
 - (c) Turpentine enema.
 - (d) Starch and opium enema.
3. Preparing a trolley for an intravenous infusion
4. Preparing and giving a subcutaneous infusion.
5. Catheterizing a patient.
6. Taking a blood slide.
7. Testing urine.
8. Taking a throat swab.
9. Doing a stomach wash-out.
10. Irrigating an eye
11. Instilling drops into an eye.
12. Syringing an ear.
13. Preparing a trolley for a tracheotomy.
14. Management of a patient with a tracheotomy.
15. Doing a tepid sponging.
16. Giving cold wet pack.
17. Managing an "iron-lung".
18. Preparing patient and trolley for aspiration of chest.
19. Strapping a chest.
20. Making and applying a starch poultice
21. Preparing a trolley for a neurological examination.
22. Preparing a trolley for paracentesis abdominis.
23. Preparing a trolley for a lumbar puncture.
24. Doing a F.T.M.
25. Doing a urea concentration test.
26. Bathing a Baby.
27. Painting a throat.
28. Taking blood.
29. Hot bathing an eye.

L. Bainbridge.

L. Bainbridge.

L. Bainbridge.

R. S. Lloyd

J. D. Blake

L. Bainbridge.

L. Bainbridge.

J. D. Blake

R. S. Lloyd

R. S. Lloyd

L. Bainbridge.

R. S. Lloyd

R. S. Lloyd

L. Bainbridge.

L. Bainbridge.

L. Bainbridge.

L. S. Lloyd

L. S. Lloyd

L. S. Lloyd

L. Bainbridge.

L. Bainbridge.

J. D. Blake

Almooney

Almooney

3rd YEAR SCHEDULE

Sister's Signature

- | | |
|---|----------------------|
| 1. Preparing for an Artificial Pneumothorax. | <i>L. Bainbridge</i> |
| 2. Preparing for suturing a wound. | <i>L. Bainbridge</i> |
| 3. Preparing and applying a Scott's dressing. | <i>L. Bainbridge</i> |
| 4. Preparing for application of a Plaster of Paris. | <i>L. Bainbridge</i> |
| 5. Feeding a patient with hare-lip. | <i>L. Bainbridge</i> |
| 6. Feeding a patient with a cleft palate. | <i>L. Bainbridge</i> |
| 7. Preparing for putting up an extension. | <i>L. Bainbridge</i> |
| 8. Feeding a patient with a gastrostomy. | <i>L. Bainbridge</i> |
| 9. Aspirating a stomach. | <i>L. Bainbridge</i> |
| 10. Feeding a patient nasally. | <i>L. Bainbridge</i> |
| 11. Doing a bladder wash-out. | <i>L. Bainbridge</i> |
| 12. Preparing for an antrum puncture. | <i>L. Bainbridge</i> |
| 13. Doing a vaginal douche. | <i>L. Bainbridge</i> |
| 14. Doing swabbing. | <i>L. Bainbridge</i> |
| 15. Preparing infant feeds. | <i>L. Bainbridge</i> |
| 16. Feeding a baby. | <i>L. Bainbridge</i> |
| 17. Doing a skin preparation. | <i>L. Bainbridge</i> |
| 18. Removing stitches. | <i>L. Bainbridge</i> |

The three schedules contain tasks that need to be performed in a ward setting, and that almost all of them represent basic skills a nurse may perform in either a medical or surgical ward. It is also interesting to note that from the three manuscripts, tasks that are directed to female patients or babies such as "preparing patient and tray for vaginal examination", "Bathing a baby", "doing a vaginal douche" and "feeding a baby" all are deleted from the list this which could be interpreted in a number of ways. For example, this could be due to the

fact that the tasks were not applicable to the setting, such as a male patient ward. One would expect that student nurses whether male or female are expected to look after both sexes, but this was probably not the case at that time, and we must remind ourselves that the manuscripts belonged to a male student nurse.

Another point of interest that emerges from these documents is that they suggest that this student nurse worked and trained with the same ward sister, who observed and signed most of the procedures performed by this nurse, during a three year nursing training career. This suggests that there was some form of continuity on supervising the student nurse in the clinical area as this was done by the specific individual ward sister. This in turn suggests that this student was probably trained mainly in one ward, even though one can note that the listed procedures in the schedules varied in terms of the nature of each skill.

In relation to the female professional student nurses, we have found evidence that those nurses were to have additional training classes:

“They will receive additional instructions in paediatric nursing”.

(ONA, 1956:20)

On the completion of their professional nursing course, those female student nurses:

“Will do one-year training in midwifery”.

(ONA, 1956:20)

The above quotations suggest that only female student nurses were to have the above courses in addition to their professional nursing qualification. The report from which the two quotations were taken, gives no hint that male student nurses had to have any of the above additional courses similar to their female counterparts of at least the instructions in paediatric nursing. This exactly what

was hinted at on the previous page, which represents a second piece of evidence that male student nurses did not deal with paediatrics and were not trained to look after sick children. The *Medical and Health Report* of the year 1957 also show that after the end of their professional nursing course and after a period of ward services and shortly after gaining the qualification of staff nurse, a number of nurses, both male and female would be selected to attend courses in the UK to train as health visitors, or tuberculosis nurses but not ward sisters for instance (ONA, 1957). After their professional nursing course local staff nurses were equipped with other skills that enabled them to deal with different groups of illnesses. The data show no attempts to train those nurses on management skills.

The accessed data lacked information in regards to the theoretical courses that student nurses used to take as part of their nursing training in SA or more precisely in Aden during the studied period of time.

7.2.3 The practical nursing training

In regards to the practical nursing training and in the same letter sent by Mrs. Catharine McNeil to the General Nursing Council for England and Wales, Mrs. McNeil requested a copy of the syllabus for the assistant nurses' training.

“I should be grateful if you would send me the syllabus for the assistant nurses' training, with any helpful hints you may have with conducting such a course (Male Nurses)”.

(TNA, 1959)

This above quotation is very important, and shows us that nurses who studied the practical nursing course were called assistant nurses and that male nurses are again the main focus. The quotation also reveals that Mrs. McNeil was not an expert in conducting such a course since she asked in her letter for some suggestions for conducting the practical nursing course. Mrs. McNeil may have asked this question on behalf of the trainers who were delegated to train those

nurses. But, if a more in depth general nursing training, which is a more sophisticated type of nursing training, was available at that time, the practical nursing training course would be much easier to conduct. In other words, it certainly would be easier for the trainers to carry out the practical nursing course, since they were able to manage the more sophisticated professional nursing course.

Asking for some “hints” or suggestions with regards to how to conduct a practical nursing course, leaves the following questions open: a) how confident were these CN trainers about training student nurses and b) what was the actual reason behind the inability to continue with the general or the professional nursing course for the qualification of the S. R.N. With respect to b), it can be argued that the discontinuation of the general nursing course was probably not only due to the student nurses’ poor standards of education, as has been hinted at several times, but it might also have been due to other challenges and difficulties that the trainers themselves face. For example, they may have simply lacked the skills to run such a course themselves rather than the inadequacy of the student’s standards of education.

As Mrs. McNeil requested:

“a copy of the syllabus of training for assistant nurses, curriculum of training, The schedule of practical ward work and a copy of the conditions under which hospitals are approved as training schools for admission to the role of assistant nurses”.

(TNA, 1959)

The above quotation lists the documents sent to Mrs. McNeil of the QEH in Aden by M. Houghton of the UKCC. It suggests that this course is applicable for staff who work in a ward setting in a hospital. In addition, it reveals that at that time hospitals had to have particular possessions to be recognized as being suitable for training assistant nurses or training nursing students in general. However, if this hospital (QEH) was suitable for training general nurses, it should also have been suitable to train nurses who were of a lower rank of

nursing status as well. But this also suggests that since nursing training was carried out in QEH and before then the Civil Hospital, these two hospitals were at that time considered as teaching hospitals and thus suitable for training purposes.

However, M Houghton goes on to explain that:

“The syllabus of training for the pupil assistant nurse is less theoretical in content than that for the general nurses and is designed for those whose educational attainments are not sufficient to enable them to pursue successfully the full course of training for admission to the register of nurses”.

(TNA, 1959)

Furthermore, she emphasizes that:

“This training is essentially practical in its approach and would appear to be Suitable for nurses whom you are hoping to train in Aden”.

(TNA, 1959)

The training was clearly very practical in orientation; however, it has not been possible to establish a clearer picture of the contents of this course. Having said this, we do have information that suggest the course was more suitable to the local students in SA at least from the trainers' point of view.

From the interviews, we learn that many members of the nursing staff attended the practical nursing course somewhat late in their nursing career. For example, one interviewee stated:

“I worked as a nurse orderly since 1960, then I did a course in practical nursing for one year here in the hospital school or nursing school”.

(MM, Interview)

From the quote above we also learn that the practical nursing course was also undertaken over the course of one year. The quotation might also indicate that taking the course was normal for people were already working in a hospital and who were familiar with the hospital environment by working with nurses, and patients.

The subordinate nursing staff that we have mentioned previously are likely to have been those who are named orderlies and who were able to do a one-year practical nursing course to become assistant nurses. It could be suggested that there was not much difference between the two jobs of the subordinate nursing staff and the assistant nurses as the two groups are working as subordinates to the staff nurses or in other words under the CNs. However, in relation to practical training course one question that could be raised here is that; if the subordinate nursing staff were allowed to do a one year course instead of a two year course to become assistant nurses, and if this was truly the case, it is not clear if it is appropriate for the practical nursing course to be reduced to one-year course, instead of two years without consulting the UKCC. It could be that those who were responsible for staff training in Aden were permitted to do so if needed, taking into consideration the type of students they are training as well as the setting as a whole. However, one of the main objectives of this part of this chapter is to reveal how the practical nursing course was taught in SA in the period under study and it is also concerned with the contents of this course. This data are unfortunately unavailable. Yet, things seem to be very confusing and muddled when it comes to the practical nursing and the subordinate course.

7.3 Who provided nursing training?

The archival data, as well as the interviews, show that British nurses were involved in training the South Arabian student nurses whether in the UK or in the colonies.

We have seen on many occasions mention of CNs working with the local nurses before they receive proper professional training. According to the *Annual*

Health and Medical Report of the year 1956, an Arabic speaking nursing sister was engaged in connection with the training scheme. It is unclear if this Arabic speaking nursing sister was from SA or whether she was a British sister or of any other nationalities who learnt Arabic and was recruited to work in SA. We have two explanations here. This sister is South Arabian, for it seems that at least one native nurse was promoted to a sister level and in this case we are mistaken in saying that all the managerial and supervision jobs were taken by the CNs. It is not clear if there are any other native sisters working alongside the CNs. Bearing in mind that this sister was recruited for her/his ability to speak Arabic and thus make it easy for the training process. The second statement which I am inclining to believe is that the Arabic speaking sister is likely to be of any other nationality, including being British, and can fluently speak Arabic and is used to facilitate the training process.

Furthermore, according to the *Medical and Health Report* (ONA, 1958) doctors of different specialities, such as surgeons, ophthalmologist gave lectures to student nurses. What is crucial to mention here is that, most of the doctors in SA at that time were British, and if surgeons and ophthalmologists taught student nurses at that time, professionals of other disciplines may have also taught student nurses, and this probably depended on the level of nursing training. Doctors may have been involved in training professional nurse students and not the practical for instance, they are most likely involved in the theoretical aspect of their training and not the practical.

7.4 Summary

This chapter is concerned with the nursing training in SA in the period 1950-1967. It set out to answer questions with regards to: when and where the training of nurses started, and who provided this training.

The initiation of nursing training in SA was connected to the establishment of health provision and health services by the colonial administration in SA in the mid-50s. The initiation of training local nurses may have been found to be a

necessity arising from the difficulties that the colonial power faced when trying to recruit CNs, against the background of the shortage of nurses in the UK around that period of time.

In SA there were two systems of nursing training for the local students in the mid- late 50s. Nursing training in SA and nursing training in the UK. The latter was training for the professional nursing course and we have no data about when it was started or discontinued. However, the nursing training inside SA is thought to have commenced in 1956.

The first school of nursing is thought to have been established in the Civil Hospital 1956. It was then moved to the QEH in 1958. Since then at least two professional nursing students' groups had graduated from the 1956 intake. The professional nursing course, according to the accessed data, was initiated prior to the commencement of the practical nursing course, but there was a course of a revision nature conducted for staff who were already part of the hospital staff at that time and who were working as orderlies.

The professional nursing course was replaced by those who were responsible of nursing training, by the practical nursing course. This is likely to have been due to a number of challenges; nevertheless, we know that at least one of these according to records from the colonial hospital administration at the time was the insufficient educational background of the local students. The data obtained in this study hints at another possible reason, which is the lack of the training and teaching skills by the CNs. However, the practical nursing course unlike the professional nursing course was also provided outside Aden, and young women were also encouraged to do this course. We have no data about the contents of this course.

The tasks performed by a professional student nurse in 1958 in SA have been illustrated in this study. Student nurses were expected to perform nursing care under supervision by their individual tutor and this tutor would accompany them through the 3 years of their course. Male student nurses were not expected to undertake tasks related to mothers and babies. Further classes related to

mothers and babies would be taken by the female professional nursing students after the completion of their professional nursing course. No data were found in relation to any leadership or management classes being provided to the local professional nursing students.

The study has also revealed that nursing training was mainly provided by the CNs although some doctors were involved in the theoretical aspect of training.

Chapter Eight: Nursing, Culture, and Colonial Nursing

Chapter Five: Health Care Services in SA 1950-1967

Chapter Six: Nursing Services in SA 1950-1967

Chapter Seven: Nursing Training in SA 1950-1967

Chapter Eight: Nursing, Culture, and Colonial Nursing

Introduction

The last three chapters have retrospectively provided and discussed data with regards to the health services, the nursing services available, and nursing training in SA during the period 1950-1967. This chapter will discuss the issues that have emerged from my perspective as a researcher. Among these issues are the cultural dimensions of the phenomenon I have been researching. In particular, how cultural factors impinged on the delivery of nursing services in SA in the studied period of time. Then, there are the assumptions and notions that we bring to terms such as colonial nursing/nurse and how uncritical use of this term could potentially jeopardise the writing on the history of nursing in the colonies.

8.1 The influences of the Colonised Culture

In chapter three we examined the South Arabian culture and in the last three chapters, evidence of what I may call cultural factors have strongly emerged.

At this point, it is important to mention that culture, here, is referring to traditions, norms and customs of the region. I am not referring to religious attitudes and practices as some might expect since these can be varied and, in any case, may also be influenced by the culture of the region.

The culture of SA is very different from the cultures that we often come across when we read about the history of nursing in the British colonies. This distinctive culture I think has contributed to the existence of two apparent scenarios in relation to nursing in SA in the period under review. The first scenario is to do with how nursing was seen and perceived by the individual South Arabian nurse and society and where the cultural values stand against the acceptance of this profession in this society. The second scenario is in relation to the apparent tension that occurred in number of situations, especially where the cultural values of the colonised stand against the coloniser's goals, plans and actions in relation to the provision of nursing services, and nursing training in SA. This part of this chapter however, will attempt to discuss these two dimensions of cultural influence within the provision and training of nursing in SA in the period of time under study. We will attempt to do this with respect to the following broad areas:

- South Arabian nurses - personal and cultural perceptions
- The culture of the colonised and the coloniser's projects

8.1.1 South Arabia Nurses Personal and Cultural Perceptions

In this section, I explore the South Arabian or more accurately the Adeni nurses as a colonised group and how they perceived themselves as nurses and how their cultural views may have influenced these perceptions. The reason we are considering Adeni nurses here rather than the all South Arabian nurses is because the nurses we interviewed were all from Aden, and quotations from their interviews will be used for this discussion. In addition to this, we will attempt to explore the community views of the nursing profession and the potential reasons behind this view.

In regards to the Adeni nurses interviewed in this study and how they perceive themselves as nurses, the interviews we have conducted with those nurses show that they had almost no problems seeing themselves as nurses. According to them they enjoyed being nurses, loved it and felt that they were good at it:

“I did nursing it was good and enjoyed it, nursing it was very important for the peoples for the future, if there is no health, no life”.

(MM, Interview)

MM also stated that:

“No, no, no never regret being a nurse”

(MM, Interview)

“Before nursing was nice, from everything, education, ethics, etiquette”.

(VC, Interview)

“I did nursing; I was very successful in nursing”

(ML, Interview)

While AU believes that:

“Nursing was good, we enjoyed it, I enjoyed nursing and loved it but it was hard”.

(AU, Interview)

“Nursing was very rewarding; I wanted to be a nurse”

(PB, Interview)

Therefore, and from the quotes above these Adeni nurses' personal views towards being nurses seem to be very positive. On the other hand, many of those who were interviewed went on to talk about how the nursing profession was perceived negatively by other parts of the community.

MM, for instance, although he stated above that he enjoyed nursing and that he never regretted being a nurse stated that:

"It was a very shameful job but it was excellent job for the people".

(MM, Interview)

MM previously mentioned that nursing is good for people because it provides excellent services for them, and I think the second part of his above quotation which is *"excellent job for people"* is what he personally thinks about nursing. And when I asked him why nursing was shameful job, he said:

"When someone wants to get married, he will be asked: what is your job? If I am a driver, if I am a clerk, yes, but if I am a nurse, oh no no no".

(MM, Interview)

PB in the same vein agrees by saying:

"If you are a nurse and you want to get married, they will not agree to give you their daughter".

(PB, Interview)

The above quotations were given by male nurses, who previously stated that they have enjoyed nursing but they also believed that nursing was not liked by the society, especially when it comes to getting married. It is possible, of course, that they themselves personally experienced being rejected as a result of being a nurse.

A similar view was given but from a female nurse who emphasised that:

“It was difficult for girls to get married if they did nursing, if they are wives and mothers they can’t do shifts”.

(CK, Interview)

ML who is a male nurse also believes that:

“Difficult for girls to become nurses”

(ML, Interview)

What the above quotations are telling us is that in the period under study, nursing as a job was not generally considered to be acceptable in the wider community. There is evidence that families seemed to oppose the marriage of their daughters to men who were nurses. If this was the case, in regards to female nurses were marriage proposals negatively affected by their job? This issue is something to bear in mind as it may lead to two things: a) the lack of local nurses, opening the room for recruiting more CNs or nurses from the other British colonies such as India and Somalia, which as far as our data tell us, there were some Indian and Somali nurses worked in SA or more precisely in Aden during the studied period of time. b) The rejection of the community to nursing and to those who work as nurses may affect women more than men and this is one reason which is due to the well-known nature of nursing profession, requiring women or girls to work unsocial hours, especially nights is probably what made this profession unpopular for girls and women. I do not think this was too bad for male nurses as from nursing as a job even though not very popular in the community it is a job from which males could earn a good amount of money to support their families. Women in a culture such as SA culture are not expected to work and earn money to support their families. Therefore, I think local male nurses would have a better chance to become

nurses and stay in the profession, which may explain the fact that there are more male nurse in SA and in Aden in particular than female nurses.

Furthermore, the situation of girls or women working unsocial hours worried people in the community. If this was true, their worry was driven by the fact that in a situation in which girls and women are required to work out of hours, there arises the possibility of interaction between female nurses and males, whether these are male nurses, patients or males of other professions. This interaction is likely to have been viewed as unacceptable by most members of the very conservative South Arabian society since, to many, it might lead to indecent situations and even illicit relationships. However, I think we need to emphasise here that this kind of unacceptable behaviour could in fact occur in any setting not only in a hospital setting, by other professionals from different fields, for example teachers, and not merely nurses. The occurrence of such situations would also depend on the maturity level of the nurses as well as their sense of responsibility.

On the other hand, we need to understand the point of view of people of this society, who could argue that many nurses actually begin their nursing career when they are quite young, after the completion of the secondary school or maybe even earlier than that and perhaps at this age when they are most vulnerable. It may be that this point of view with regard to male and female relations cannot be easily understood by people who are from other societies or cultures; and it may be that to many over protection of the females in Middle Eastern societies, such as that of SA, is quite strange. However, people from the same community, or maybe the Arab community more generally, would understand the norms and concerns of SA or the Adeni society. In traditional South Arabian society, restricting the free mixing of men and women was, and still is, seen as a way to safeguard their own daughters from being in a situation where they would be vulnerable and could be exploited sexually, emotionally and in other ways, especially when they are very young and naive. To them nursing was possibly not for them.

Another point of view, which was raised by one of the interviewees and which perhaps further explains attitudes of SA society towards the nursing profession and those who work in it, concerns the fact that people felt they had to protect their own culture and identity, by rejecting foreign values:

“The Adeni culture especially in the past has been affected by the British, some Adeneis were very free, they took too much from the British”.

(ML, *Interview*)

In the above quotation, the interviewee is implying that people in SA were becoming too liberal and too open in their attitudes and values, since they were imitating the values of the colonisers. Here I am referring to the western culture in the form of the British culture as it was during the period under study. Certainly being liberal is something positive, but according to the interviewee, it may become negative if it meant changing an individual's manners and attitudes, and that such openness should be rejected by the wider South Arabian society. The interviewee states that:

“It could affect the tradition and custom”.

(ML, *Interview*)

It is important to point out here that during the period of time under study, Aden was a cultural melting pot and that, in addition to the locals of Arab descent, there were many in the colony from Somalia and from India. This was also the case with the nursing staff. However, those people who came to Aden as a result of British colonialism may well have been influenced themselves by the dominant British culture.

One might also suggest that amongst the factors that may have also contributed to the negative attitude of many in SA, or more specifically in Aden, towards nursing during the period under study was that nursing was thought of as something new to this society and therefore it was not recognised, trusted or

accepted. However, I disagree with this suggestion as nursing as we mentioned in the second chapter of the literature review was not new to the Arab World, and that the nature of nursing as a caring profession was already known in this society. What was perhaps the main reason for this rejection was that nursing was probably seen by the wider society as a job that was supported and enhanced by the British colonial administration. Engaging in nursing job may have been seen as encouragement to work with the coloniser, even though the people of this society needed such service.

Another factor or reason behind the society's negative view toward nursing was the nature of some of the duties that nurses performed as basic nursing care.

“People do not know when you say I will join nursing, they think you are providing service and also an unclean service, it is a dirty service”.

(JD, *Interview*)

One of these duties or tasks is what we have already mentioned previously in chapter six which is the giving and receiving the bedpan in addition to bathing a patient for instance. In chapter six, I then discussed in more detail about the bedpan issue, we considered this from the perspective that it was one of the tasks that nurses did as part of their nursing care at that time. Although we could not at that time establish who was to be doing this task, from the interviews we were able to deduce that these kind of tasks were left for the subordinate nurses or the assistant nurses, and that these nurses were mainly South Arabian nurses. The interviewees did not explicitly show their dissatisfaction in performing such tasks but as an interviewer I was able to sense that a couple of the interviewees were uncomfortable performing the task of giving and receiving the bedpan to patients. However, they had to do it as they were told to do so.

It is important here to make the reader aware that if there were cultural biases against nursing as a profession, their biases were possibly stemming from traditional attitudes towards the nature of the work undertaken.

“Nobody accepts this service, especially the high families”.

(VC, Interview)

'High families' in the last quotation refers to families of a good tribal origin, and strong descent. Even within the tribal nature of an Arab society like the South Arabian society, there is no doubt of the importance of nursing as a profession. Yet, because of this society's tribal nature, and the great self-esteem and pride of its people, they find working in a profession that requires washing, cleaning and maybe wiping other's wastes a very offensive type of work and not suitable for them. At this point, I am reminded of Lawler's *'Behind the Screens'* in which he explored attitudes towards the performance of care work or more specifically 'dirt work'. Twigg (2000) believes that performing tasks such as bed bathing and giving and receiving bedpans behind the screen is not merely to preserve the patient's privacy, and confidentiality, but also to preserve the public respect towards the care worker or the nurse. This is probably how the South Arabian society perceived nursing duties. However, South Arabian people provided all type of encouragement and support to those who carry out such work, but they may remain conservative towards performing it, they would not mind others doing it, but not their own daughters or sons.

8.2.2 The culture of the colonised and the coloniser's projects

In the literature review chapter, we reviewed the term colonialism; however, we did not explain the term 'coloniser'. The term 'coloniser' describes individuals who came to be as part of the colonial power, which not only includes soldiers or military forces or the colonial administration, but may also describe individuals who were sent to the colony by the colonial power: civilians such as nurses, doctors, and administrative staff and so on. However, it has been noticed in several occasions, about the discomfort or the irritation that the

differences between the colonised and the coloniser were causing to the coloniser and perhaps to the colonised at the same time.

Relevant to this theme of cultural factors is the fact that this study has revealed some evidence of the coloniser's frustration with regards to South Arabian culture, especially in relation to how people act and do things. For example, from the *Medical and Health Report* for the year 1955, the following two quotations were used in chapter five but in relation to the obstacles towards caring for mothers and babies (ONA, 1955). Here we are discussing these two quotations from another point of view which is the echoes of resentment and dissatisfaction of the report's writer of the way mothers and babies are looked after in the community and by grandmothers.

“Apathy, mismanagement and ignorance, rather than poverty and overcrowding, are the main factors”.

Medical and Health Report (ONA, 1955: 26)

“Early marriage, frequent child bearing and interference by ignorant grandmothers all play their part”.

Medical and Health Report (ONA, 1955: 26)

The writer of this report accuses the individuals who were looking after this group of patients of being “apathy”, which is in other words a form of carelessness, and with “ignorance” which could mean unawareness. The two adjectival terms are in this particular case contradicting each other, since the mother or grandmother individual can be either careless or negligent in looking after the babies and mothers in their families. A person can be both careless and ignorant, which could be true but not in this particular case. While the term ignorant means that the individual is unaware of his/her own mistakes as a result of lack of information, knowledge or education, and in this particular case this could be the most applicable reason for why mothers and babies were cared for in this dissatisfactory way as the writer suggests. But who is it to blame for ignorance or illiteracy, should we blame the people or maybe the

regimen? Education and literacy in general and health education in particular in SA are very important areas that need further research.

In the first quotations above, the writer of this report has also used the terms poverty and overcrowding. He/she is implicitly rejecting the idea that the ill-health of mothers and babies are due to poverty and overcrowding and that they are due to ignorance and carelessness. We know from Chapter Five in particular that the people in SA were poor and had poor health during the period of this study. Indeed, blaming poverty and overcrowding for the ill health of this group of people is like blaming the colonial administration for not providing a proper standard of life and proper accommodation for the people of the colony and thus for the ill health of the people of SA. It is therefore easier to blame early marriages and grandmothers' interference, as in the second quote for example, which are significant traits in the South Arabian culture for the ill health of mothers and babies. The discussion of early marriages and grandmothers' role in the health or ill health of mothers and babies in SA during the British control, "who to blame", could be another project for further research. What matters here is that the evidence suggests that certain cultural norms in SA were probably not good enough for the colonised, as they were perceived as obstacles towards health of the colonised from the coloniser's perspective.

The accessed data from the archives also suggest another source of infuriation to the coloniser. This seems to be the issue of *purdah*, or the "*purdah system*" as it is called in the *Medical and Health report* (1954: 16).

In chapter five, we briefly defined what *purdah* is. This simple definition was given for the sake of making sense of the discussed topic at that time. However, *purdah* has been defined and understood differently by different writers coming from different perspectives. Papanek (Papanek, 1973:289), for instance, who is interested in the health of South Asian women, believes that:

"Purdah, meaning curtain, is the word most commonly used for the system of secluding women and enforcing high standards of female modesty".

In her article "*pardah: Separate world and symbolic shelter*" Papanek gives an overview of the *pardah* as a practice in South Asia by both Moslem and Hindu women in order to establish clear boundaries between women and men. In her book, Papanek differentiates between the practice of *pardah* by Moslem and Hindu women, providing a much deeper concept of it. According to her,

"Muslim pardah restrictions do not apply within the immediate kin unit, but only outside it, while Hindu pardah is based on a set of avoidance rules between a woman and her male affines. Muslim seclusion begins at puberty, Hindu seclusion strictly speaking begins with marriage".

(Papanek, 1973:289)

Papanek's (Papanek, 1973) article brings to people's mind that *pardah* is not merely a practice that can be seen in Muslim societies but it also exists in other societies such as the Hindu society. Interestingly Papanek in this article pointed out to the interest amongst writers, the "*foreign diarists*" in their contemporary accounts on *pardah* issues. The use of the word "*foreign*" by Papanek implies that the practice of *pardah* is irrelevant to those writers' societies. Papanek believes that some of those writers have considered *pardah* issue differently in their writings, some have treated this issue with respect and they were inquisitive in why *pardah* is practiced, while the other writers who probably were looking for a debatable issue in their journal wrote about it in "*a strange way*" according to her (Papanek, 1973:289). What Papanek perhaps means here that some writers addressed the subject of *pardah* with criticism to the practice and those who practiced it.

Ahmed (Ahmed, 1992) on the other hand examines how Middle Eastern women including Arab women survive in *pardah* condition. Ahmed, in her book, *Women and gender in Islam: Historical Roots of a Modern Debate* (Ahmed, 1992) explains why Middle Eastern women practice *pardah*. Ahmed also criticises the western view of this cultural practice. However, the issue of *pardah* and women's life in *pardah* is very controversial especially since the increase in the Feminist's movement. How the practice of *pardah* might have affected the

practice of nursing and the training of nurses in SA would make it a very interesting topic for further research. Further research needs to be undertaken into ways in which South Arabian society has been successful in abolishing the practice of *pardah*, or at the very least how people have been able to work around the system. I would now like to return to the question of how the practice of *pardah* was affecting the provision of health services in SA and particularly nursing services.

According to the writer of the *Medical and Health report* year 1954, *pardah* was an obstacle towards training South Arabian girls to do midwifery.

“With the present pardah system it would be difficult to get trained Arab girls to go out into the houses and deliver babies”.

Medical and Health Report (ONA, 1954:17)

It seems that the writer of the above statement, by saying “*it would be difficult*”, had already made up his/her mind in regards to the difficulty of training Arab girls to do midwifery. It is not clear here if training was provided to some Arab girls and then found it to be difficult to do so or this was just an assumption made by the writer? Also, if *Purdah* was proved to be as an obstacle to training Arab girls to do midwifery, what measures were in place to overcome this obstacle?

Thinking of the *pardah* practice itself, which is the separating rather than isolating women from men, and limiting their contact with men to only men from the family; it is important to ask how *pardah* might have been an obstacle to train these girls. In fact, *pardah* is unlikely to have been an obstacle unless the girls were trained by male midwives. Once trained to do midwifery the Arab girls would only need to be in contact with pregnant women, or with those with very young babies. There is also, of course, the possibility that the girls would have come into contact with husbands at certain times; indeed, in certain situations this may even have been necessary. It can even be argued that midwifery in particular is something families would encourage their daughters

to choose a career in, rather than nursing, since nursing would have required them to work side by side with male nurses and doctors. It is for this reason that I am not entirely convinced that *purdah* was an obstacle towards the recruitment and training of midwives in the same way that it might have been for nursing.

Moreover, we have previously mentioned that the Maternity hospital was situated in Aden, and our data show no evidence of the existence of other Maternity units in the rest of SA. This means that probably people have to travel long distances from other areas to reach the Maternity hospital in Aden.

“It may be possible in the future years to institute smaller Maternity units in these outlying parts where a doctor is available and trained Arab staff could live under strict purdah”.

Medical and Health Report (ONA, 1954:17)

However, the quotation above implies that there was an intention or at least a trend by the colonial administration to establish units outside Aden where *purdah* can possibly be practised by the trained Arab staff. This forces me to ask the following question: was it common or more acceptable for the *purdah* system to be practised outside Aden’s hospitals in rural areas for instance and not in the modern Maternity hospital of Aden the Crown colony which could be predominately run by British nurse? *purdah* perhaps is something looked at as backward and uncivilised phenomena that could potentially harm the appearance of the Crown colony. In other words, if it is not possible to train Arab girls who live in Aden and practice *purdah* to do midwifery, what makes it possible and easier to practice their counterparts from other areas outside Aden to be trained to do Midwifery?

purdah was clearly seen by the coloniser as an obstacle towards training women or girls to do nursing or midwifery in SA in the studied period of time as claimed by the writer of the above mentioned annual report. Yet, if there was a sincere intention to overcome this obstacle, and more efforts were put in place to encourage the Arab girls to join nursing, we would not be in this position now

discussing the issue of *purdah* as an obstacle, we would probably be discussing how this phenomenon was managed and what was implemented to overcome it.

8.2 Rethinking Colonial Nursing and Colonial Nurse

In chapter six, mention was made of the CNA, and the fact that colonial nurses who were part of this association were sent to SA in order to provide the British settlers in the colonies with standards of nursing care similar to what is provided to them in their homeland. In this part of this chapter, we will revisit the terms 'colonial nursing' and 'colonial nurse' and discuss their contextual, ideological and connotational dimensions.

To begin with, I think that connecting the term 'colonial' with the word 'nursing' or 'nurse' is rather problematic and counter-intuitive. Linking nursing, which is considered to be a noble, caring and humanistic profession with the word colonial by some nurse historians, might not only relate to nursing services provided by the colonial administration in the colonies, but it has the potential to raise doubts about the integrity of those engaged in nursing, either at the organisational or hands-on levels. The term 'colonial nurses' might not only refer to nurses who worked during the colonial era in the colonies, but it may also suggest that, since those nurses were part of the colonial administration, they had a part to play in the colonial process. So in fact, the term can be understood on two levels: on a simple descriptive level and also on a more ideological level.

It is worth pointing out that it is likely that that scholars who used the term 'colonial nurses' in their writings about the roles played by the nurses who were sent to work in the colonies by the colonial governments, were not the first to use this term. In fact, the term was probably first used by the CNA when referring to the members of their own organisation.

Nevertheless, it is clear that certain scholars such as Nestel (Nestel, 1998), Solano and Rafferty (Solano and Rafferty, 2007) and Howell (Howell, 2015) have used this term to refer to individuals working in colonies as agents of the colonial power, and by calling them so, they distinguish them from the 'other' nurses who worked in the colonies but were not part of the colonial system. The other nurses could be either the native nurses of SA or the non- British nurses who came from the other British colonies such as Somalia and India in this case.

In light of the above, one of the problems with the term 'colonial nurses' is that it colours the view that we may have of the many professionals who were sent to work in the colonies during colonial periods. It suggests that these people were merely agents to the colonial power, and as a result raises doubts about their motives and thoughts, and ultimately about the roles they played as, and about how the profession was used in colonial settings. In fact, this concern may have been one of the unannounced reasons behind changing the name of the CNA to Overseas Nursing Association in 1919.

The term 'colonial nursing' is still used by many scholars such as Jones (Jones, 2004), Solano and Rafferty (Solano and Rafferty, 2007), Howell et al. (Howell et al., 2013), and Sweet (Sweet and Hawkins, 2015) to refer to a growing and rather well established branch within the historiography of nursing. Here I suggest that the use of the term 'colonial nursing' needs to be reconsidered; I believe that if this term continues to be used, there is likelihood that this branch of the history of nursing will become a sub-discipline for scholars who are only interested in analysing the history of nursing in the colonies from a colonial perspective. It could thus potentially exclude scholars or accounts which are attempting to consider the history of nursing in the colonies in a more neutral or balanced way.

From the point of view of this researcher, the term 'colonial nursing' is a loaded term which encourages the reader to view the role of nurses during the colonial period as having a role in reinforcing the colonial status quo. Finding an alternative to the term colonial nursing, which is more balanced and inclusive, could potentially bring more and encourage more people to take interest in the

history of nursing during this period., In particular, it has the potential to make the 'colonised' feel part of this inquest into the history of nursing.

It is also crucial to mention that most of the accounts on history of nursing in the colonies or what is well known by history of colonial nursing such as Howell (Howell et al., 2011); Rafferty (Rafferty, 2005); Rafferty (Rafferty and Solano, 2007); Roberts (Roberts, 1996) considered mainly the life history of the colonial nurses and their experience in the colonies during the colonial area.

One of the other problems with the term 'colonial nurses' is that it would appear to reinforce the domination of the history of nursing by the Anglo- Europeans, as hinted to by Mortimer (Mortimer and McGann, 2005). This current study, in contrast, has considered the history of nursing in SA, and in doing this it has included the experiences of both South Arabian nurses and their British counterparts' experiences in relation to this history. This is because, in writing on the history of nurses in the colonies, it is imperative to include all nurses who worked in the colonies. This indeed has the potential to provide us with a more balanced and accurate view of what has happened in the past.

The term Colonial nursing somehow reminds me of the term Western Medicine. We have previously in chapter two mentioned Western medicine. The two terms have two different meanings, but there are numbers of similarities between them. Colonial nursing was made for the sake of introducing the western way of nursing in the colonies. Colonial nursing and Western medicine both were introduced to the colonies aiming to primarily provide the required standard of medical and nursing services for the European living in the colonies. The topic of Western Medicine vs Colonial Nursing is rather very interesting theme and requires a dedicated research project.

8.3 Summary

While reviewing the history of nursing services and training in SA in the period 1950-1967 some very interesting topics emerged.

One of these topics concerns the extent to which cultural factor as well as the nature of nursing as a practice affected how South Arabian society saw nurses, and how the individual South Arabian nurse perceived nursing as a career and a profession.

Nursing as a career in SA and in Aden, particularly during the studied period of time, was thought to be an obstacle towards gaining respect from the society, especially when it comes to getting marriage. In fact, when it comes to marriage and family life, nursing as a career affected not only the female SA nurses, due to the nature of the nursing careers out of hours service, but also the male nurse who could be rejected as potential husbands as a result of their choice of career.

Another cultural issue arose in this study, perhaps of a more political nature, was the colonizer's frustration with regards to some of the native's actions and behaviours. The colonial administration denied the responsibility for the ill health of mothers and babies in SA. Instead, it blamed this on the ignorance and mismanagement of the South Arabian mothers and grandmothers'. In fact, the coloniser blamed the colonised for this situation, whether it was s poverty, illiteracy, or poor accommodation.

Purdah as a practice which connected with South Arabian culture was not only a source of frustration to the coloniser; it was also a practical hindrance to many health related projects, in relation to introducing midwifery and maybe nursing training in SA and in Aden in particular in the studied period of time. According to the colonial administration; the *purdah* system was an obstacle towards training the Adeni native girls to do midwifery. However, it is not clear how the practice of *purdah* was an obstruction to women training for a career in midwifery in SA since this career is to do with women and babies and is likely to be trained by a female midwife.

The *purdah* issues appear to have been less of a problem when native staff midwifery trained or practised in rural areas or outside Aden in the rest of SA. It is not clear however, how the *purdah* issue would somehow be easier to

overcome in the rural areas, hinting at the colonial administration's rejection of such cultural practice inside the health institutions of Aden the Crown Colony.

Another interesting topic that also emerged in this study is the use of the terms Colonial nursing and Colonial nurse. Colonial nursing is a term used to describe the nursing services delivered by the colonisers in the colonies although this is from the coloniser's point of view. Similarly, the term 'colonial nurse' has been used to describe not only the CNA nurses but also all those who worked in SA in the studied period of time. In fact, this term has also been largely used in accounts of the history of nursing in the colonies but mainly from the colonizer's perspective. Connecting the term colonial to the terms nursing and nurse reinforces the two terms as colonial legacies although there is a degree of truth on this. In addition, when it comes to the writings on history of nursing in the colonies the use of the two terms implies that this history is written from the coloniser's perspective and thus more biased towards colonialism and put the interpretation of the history of nursing in the colonies in doubt.

Chapter Nine: The Conclusion

9.1 Conclusion

This study set out to explore the health care and nursing services and training in SA during the British colonial period, specifically during the period 1950-1967.

In my journey to explore this history, some significant and valuable data have emerged with regards to the health conditions of the people of SA and the health services available at that time. The study has shown that for the British administration, ill health or the poor health of the South Arabians was a problem

and a hurdle, but this seems to be mainly because it threatened the colony's sustained economic development and the stability of the colonised population.

The study has also shown that, in the period under study, SA experienced many health problems and challenges. These took the form of the numerous number of diseases that needed proper planning and resourcing for prevention and treatment by means of a well-managed health care service. The study has also found that most of the diseases presented in SA at that period of time were preventable diseases and that some were transmitted and brought to the country as a result of immigration and colonial troop movements. However, this research has shown that the colonial administration in fact did very little to stop the spread of the epidemic diseases, and that the enhancement of curative medicine was favoured by the colonial authorities over preventive measures. Indeed, the research found no evidence of any preventive actions being put in place, even though such measures could potentially be much cheaper and more effective.

Looking at the nature of the most common diseases in SA and in Aden in particular during the period under study, the colonial administration's efforts to tackle these diseases was heavily reliant on providing health care for patients in hospital settings. On the other hand, the colonial administration remained reluctant to deal with the underlying causes of these disease. For example, the study has established that TB was one of the most common diseases in Aden the crown colony. The government made no effort to deal with the main causes of TB which were the poor housing, sanitation and the lack of public health education. The reluctance of the colonial authority in this regard meant that eradicating this disease remained difficult and challenging.

Furthermore, this study has also found that, maternity and child care issues was considered another main health concern in SA during the period under study. The health condition of the babies and children of SA was poor, mainly due to malnutrition. Although this was a major problem for the colonial authority, the children's care unit was inadequately founded, hence no real efforts were made to tackle this problem. The annual reports from the 1951-1956 which were

reviewed in this research show no evidence of any efforts or measures taken by the colonial state to overcome the ill health and high levels of mortality amongst babies and children.

Women's health was another area of concern at that time. Most of the problems were related to childbearing and giving birth. Women's ill health, along with children's ill health, appears to be connected to malnutrition which is a disease associated mostly with poverty. Yet, the study has shown that there was no clear plan or defined objectives put in place by the colonial authority with regards to how to overcome these health concerns.

The evidence from this study suggests that some of the health problems that the people of SA suffered from were connected with colonialism, through the transfer of new diseases into the colony, and through the economic exploitation, which led to diseases associated with poverty. In addition, the colonial authority did not feel that it was a priority to invest in preventative measures which could have protected the colonised population.

The existence of diseases and ill-health in SA during the period of time of interest to this study meant that the establishment of health institutions was inevitable, something that the colonial health authority would eventually attach some importance to. In fact, the British colonial administration at the time established a number of health institutions though many of these were established in Aden or in the nearby areas.

Moreover, most of these hospitals were not accessible to the native people in the colony as they were private and/or were only accessible to the British settlers, such as soldiers, colonial personnel, their families and colonial power allies. Furthermore, the evidence obtained by this study suggests that other parts of SA were secondary to Aden in terms of the establishment of health institutions and thus in terms of the provision of health care. It is quite clear therefore that nursing services in SA were not equally accessible to all of the population. On this issue, the study found that the available hospitals at that time belonged to different organisations with different priorities and with different

groups of people as a focus for concern. Even though the people of Aden formed the vast majority of Aden's population at that time, there were only two hospitals that were set up to address the health needs of the natives and these were called government hospitals. There were also a number of smaller government health centres scattered randomly in some big cities of SA, about which we have very little data. This study has found that there was actually very little government funding to provide health services in SA. As a result, a substantial amount of health provision was funded by other parties in support of the colonial administration, yet, this remains largely limited to Aden. The provision of health services in SA by different parties in the period under study meant that there was quite limited coordination between the funders and the government. It also seems that each health services provider managed their own health institutions and potentially adopted their own policies that were not the same as those of the colonial government. This research found no evidence of a scheme to properly coordinate and manage the health services provided in the colony, whether provided by the government or by other organisations. The research goes further and hints at the lack of government and institutional planning in relation to the provision of health services.

Similarly, to the health services, nursing services in SA in the period under study were also provided by different parties. The study reveals that nursing services in SA were provided mainly in Aden and in the nearby area. Nursing services were also provided in certain areas where there were British nationals or when and where these were demanded by the colonial authority's allies. The study also found that nursing services tended to be associated with or concentrated in hospital settings and this represents another aspect of biased and unequal provision.

With respect to nursing staff, the study found that the CNA operated in SA during the period under study, through sending their nursing staff to work in government hospitals which mainly served the natives. CNs worked mainly in Aden but they were sent to other parts of SA in certain circumstances; this was mostly under the requests of either the colonial authority or their allies from the natives.

The RAF, BP, BRC, on the other hand, had their own nurses who were not part of the CNA, and who worked only in their designated health organisations, excluding the BRC nurses who are known to have supported the government hospitals during crisis one of which was the two days strike that took place in the hospitals of Aden.

This study has also shown that in SA and during the studied period of time, there were nurses who worked independently, as they were not part of any organisation. However, in the same way as the other British or foreign nurses, they came to SA as a result of colonialism, accompanying their husbands who worked for the colonial office in Aden. Those nurses had their own way of delivering nursing services. This delivery of nursing care was largely determined by the surroundings they lived in, and some had acted very often as doctors. In certain situations, these nurses did work to please the colonial authority's allies and delivered nursing services in return for certain services provided to them by the colonial power allies, and not necessarily where the needs for nursing care were greatest. In such cases, nursing could be seen as being utilised in order to enhance relationships built on mutual interests.

Furthermore, the study demonstrates that there was a form of inequality in relation to the distribution of duties between nurses in a hospital setting. The nature of nurses' role in SA in the studied period of time depended on who they were and where they worked. In other words, there is evidence that the native nurses were asked, in addition to basic nursing care, to undertake some cleaning duties. Moreover, there is no evidence to suggest that CNs were undertaking the same tasks that the native nurse were performing. In fact, our data show that almost all CNs were in supervisory and managerial positions, which in one way or another enforces the colonial dominance, hinting to their role within the colonial administration. In the same vein, there is no evidence suggesting that any native nurses, during the studied period of time, had occupied a managerial or supervisory position. The only position a native nurse had occupied other than the usual nursing position is a teaching position as a tutor. However, this position was given to this particular native nurse for his

fluency in speaking Arabic as it was thought by the management that an Arabic speaking tutor would be beneficial to train the Arab staff.

The study has provided little data with regards to the specific characteristics of the nurses who worked in SA in the studied period of time. However, the study suggests that female dominance of nursing profession was relevant in SA during the studied period only when it came to government hospitals where CNA nurses worked. This was different in private hospitals, where the nursing service was linked to a military role, although it does not mean that there were fewer female nurses in private and military hospitals such as the RAF hospitals, the number of male nurses could be more or equal to the number of female nurses. I here mean the British male and female nurses.

Generally, the study could not determine the actual proportions of female and male nurses, including British and native nurses. One of the major findings that this study has also shown was that nursing in SA during the studied period of time had a foreign past. In addition to the British nurses, whether CNA or others British nurses, there were other nurses of other nationalities who were also part of the colonial enterprise. As previously discussed, we were not able to identify the number of native nurses who worked in SA in the study period of time but it was clear that there were a considerable number of foreign nurses who worked in SA at that time. The study has also highlighted that the recruitment of CNA during the studied period of time was challenging. This underlies the importance of training local student nurses.

The story of nursing training in SA in the studied period of time was somehow similar to the story of nursing services: they were unsystematic and hard to grasp, and a comprehensive record of all the activity is very difficult to find. The study has shown that in SA and during the period 1950-1967 there were two systems of nursing training for the local students; a nursing training organised and conducted inside the colony and nursing training where local student nurses were sent to study in the UK. Local student nurses who were sent to the UK for their nursing training went there to do the professional nursing course. In contrast, the nursing courses that were organised and conducted

inside SA were for the professional as well as the practical nursing and were provided only in and for government hospitals.

Another major finding that this study has shown was that the first nursing school in SA was established in 1956 in the compound of the Civil Hospital in Crater in Aden. It was then moved to newly built which is the QEH in 1958

The study found that the professional nursing training course had commenced in SA before the practical nursing course in 1956 and that there were at least two cohorts of students for the professional nursing course conducted at that time. Prior to this, there was a short nursing course which was designed for the staff who were already part of the nursing staff as orderlies, but they were named by the colonial authority as subordinate staff and it seems that this course was not a practical course for nurses. The practical nursing course, however, was considered by the QEH administration in 1959 when a letter was sent to the UKCC, which suggests that the professional nursing course was replaced by the practical nursing course in 1959 or shortly after then. It has also been thought that the insufficient educational background of the local students was behind the replacement of the professional nursing course with the practical nursing course in Aden. However, requesting information on how to conduct the practical nursing course which much less complex than the professional course can be seen as evidence hinting at the failure of the authorities to continue to conduct the professional nursing course. It may be therefore that one of the reasons or may be the primary reason why the professional course was discontinued was that the CNs had very little training student nurses skills.

Furthermore, unlike the professional nursing course, when the practical nursing course commenced the data from this study suggests that this course was conducted not only in Aden but in some areas in the Eastern and Western protectorates, and that girls were encouraged to do their practical nursing.

In relation to the nature of nursing training in SA during the period under study, this study has revealed more about the tasks performed by student nurses

undertaking a three year professional nursing course. Student nurses were expected to perform tasks under supervision; they worked and trained with the same ward sister for most of the time, and that, there were some tasks in relation to female patients or babies that could not be undertaken by male students.

There is also evidence that, after the completion of their course, the female professional student nurses, had to attend additional training classes on paediatrics and also a one-year training on midwifery. The study has shown no evidence that those professional nurses undertook any management or leadership courses, in contrast, we have lack of data on the theoretical courses that student nurses used to take as part of their nursing training. Unfortunately, the study could not provide any data in relation to the nature of the practical nurse course training.

The study has also revealed that it was mainly the coloniser, in the form of CNs, who provided nursing training to the local student nurses and that the Arabic language was beneficial to use in this training. The training of the local nurses was not only undertaken by the CNs, sometimes doctors also helped to provide the theoretical classes to the student nurse. However, unfortunately, we have no data on the contents of these classes.

Cultural factors have strongly emerged in relation to perceptions towards nursing as a profession. The individual South Arabian nurse accepted nursing as a profession. However, the views of the wider society were not as positive, in some cases there was suspicion, and this may have prevented many nurses from feeling fully satisfied with their choice of career. For cultural reasons, this negative social pressure probably affected the female nurses more than the male nurses. One of the reasons why nursing was not a popular career choice for young women in SA society has much to do with marriage prospects. This is because many of the tasks that nurses were expected to do in their work, were not compatible with the idea of a good South Arabian wife. In fact, many male and female South Arabian nurses would have to choose between nursing as a profession and marriage or family life. This clearly affected the number of female nurses in SA in general.

The study has found that the colonial administration did not see itself as being responsible for the poor health of mothers and babies in the colony. The authorities rejected the accusation that the ill health and poverty were due to colonialism, in the form of economic exploitation.

The study has also shown that the cultural practice of *purdah* was a source of frustration to the colonial authorities since it stood against its plans and projects in relation to the provision of nursing services as well as nursing training and more precisely midwifery training. However, the study hints at the lack of any efforts to tackle this issue or at least attempts to work around it.

The existence of CNs in SA during the studied period of time forced a close scrutiny of the terms Colonial Nursing/Nurse. The two terms seem to have been used to represent the colonizer's identity. Indeed, this study tells us more about how the nursing profession was from the colonizer's perspective. In the same vein, the term Colonial Nurse not only symbolizes the individual nurse who worked in a colony but also emphasizes his/her role within colonialism. When it comes to the writing on history of nursing in the colonies the Colonial nursing as a term seems to be inappropriate to use.

In fact, this study tells us that historiography of nursing during colonial eras have been so far more biased towards how the colonizer perceived history of nursing during this very exceptional setting. Despite this, there are some outstanding accounts of this branch of the history of nursing. I think we are in need of a rethinking historiography of nursing in the colonies in a similar way to the rewriting nursing history of Celia Davies (Davies, 1980) and revisiting, and rethinking, the rewriting of nursing history of Patricia D Antonio (D'Antonio, 1999) Then we will probably be able to produce balanced accounts on history of nursing in the colonies.

9.2 Limitation of the study

The study has a number of limitations.

This study is on writing on history of nursing services and training in SA in the period 1950-1967. I think one of the most important limitations of this study is that this history is written for the first time, lack of previous studied make it very challenging to have a brief idea about this history.

Another major limitation is that, although reference is made to areas outside Aden, most of the research and the data gathered pertains to people living and working near to or within the Aden area. The reason for having more data on Aden is because the people interviewed in this study were all from Aden, interviewing people from outside Aden was not possible as none were identified. Another reason is related to the data obtained from the Archives were referencing mostly to Aden than the rest of SA. However, it would have been useful to have had a more comprehensive view of nursing in the whole of SA.

Moreover, one of the most obvious limitations is the low number of nurses of British background who were interviewed. In fact, it was only possible to interview two British nurses. Clearly, more first-hand accounts of the experiences British nurses who worked for the colonial authorities would most likely have given more reliable data.

One last limitation is the fact that this study did not provide any information on the current status of nursing in SA for the reader to comprehend the full picture of this profession in this particular country. However, talking about the current situation of nursing in SA might open the door to many other interesting issues. Therefore, I have decided to just focus on the past and history of this phenomenon.

9.3 Significance of the study

What made this study unique is that this thesis answers for the first time the following questions in relation to nursing services and training in SA during the period 1950-1967 when SA was under the British colonialism.

- i) Where the nursing services were provided and who were able to access them?
- ii) Who provided these services and how was the provision organised?
- iii) What was the role of nursing within the overall provision of health services?
- iv) What did the training of nurses consist of and who provided this training?

This research was conducted through the gathering of first-hand accounts. These were carried out in the form of oral history interviews with both South Arabian nurses and British nurses who worked as nurses in SA during the studied period of time. The interview data was complemented by data obtained from the archives. Both methods of data collection provided a semi integrated image of the history of nursing in SA during the studied period of time.

This study is also considered the first account on history of nursing in SA taking the colonial period in account and probably one of the first accounts of history of nursing in the region of the Arab World. This study is also suggesting important areas for future research of special interest for the research and they are as follows:

9.3 Future research

Future research could be carried out in the following areas:

- The Arab/Moslem world had a great history in medicine; great hospitals were established in the biggest cities in the Arab world, such as al-Qirawan in Tunisia, Cairo, Damascus, and Bagdad. A proper review of this history would probably give us a good history of nursing in those hospitals around that period of time.

- TB was considered to be one of the major health challenges for the colonial administration in SA in the 1950s. It would be interesting to find out more about how the administration responded to this problem, and whether preventive or curative measures were implemented. A worthwhile future study, therefore, would focus on TB in SA during the colonial period.
- This study has shown that in 1951 there were local nursing students in the UK to do their professional nursing course. Another worthwhile study would focus on the training of South Arabian student nurses in the UK during this period. What obstacles did they face and what options were open to them? How did the experience change them as professionals and as individuals?
- It would be fascinating to find out more about how early marriages affected the health or ill health of mothers and babies in SA during the British control, who to blame? Related to this is the question of the grandmothers' role in raising young families and helping the young mothers.
- Intriguing questions remain about the views of members of the Arab culture, of both sexes, towards nursing, in the past, present and the future.
- The *purdah* is a common practice in most of the Arab countries. It is important to ask how this practice has affected and affects the delivery of nursing care in these countries and ways of working around it.

- Questions remain about the extent to which SA society has been successful in abolishing the practice of *purdah*, or at the very least how people have been able to work around the system.
- Studies have yet to be carried out on the impact of the introduction of Western Medicine in Arab countries and in particular SA.
- A systematic study to determine the extent, to which the current accounts of history of nursing in the colonies are biased, either towards the colonisers or towards the colonised is recommended.
- Finally, a systematic review of accounts on the history of nursing in the British colonies still needs to be undertaken.

9.4 Personal reflexivity

As this current research is concerned with the history of nursing services and training in SA, in the beginning of writing this research I found myself in the middle of nowhere, as there was no previous research and little data on nursing in SA. It was also very challenging, as I was not quite sure as a researcher whether this research would produce enough data or whether what it did find would be valuable.

I commenced the journey of my research with very little knowledge on the colonial era in SA in general and on history of nursing in SA in particular. But then I found myself starting to know more about the topic and I became much more involved in the research questions.

As a South Arabian nurse, I have a great emotional and intellectual interest in relation to nursing in SA in general. This to me has been one of the strengths

of the current project. However, I should therefore confess that, at times, I was torn between being a South Arabian and being a researcher. What was of most importance to me was to know what has happened in the past and to provide an unbiased account on this history. Foucault (Foucault, 2005) asserts that researchers who write on history always write “from within themselves”. What he means here is that the researchers cannot change who they are; indeed, the research itself maybe a product of who they are since it is their interest and intellectual and emotional energy which drives the work. Yet, at the same time it is important to acknowledge who we are and it is important to have the ability to control our biases and focus on accurate, objective historical research. This is certainly an important skill that historian should have.

I continued the journey of conducting this research and I feel privileged. However, one last thing to confess, I sometimes wished I was there to be able to tell the real story of nursing services and training in SA in the period 1950-1967, but I knew that this could never happen.

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Questions asked by the Ethics Committee and the answers were supplied by the researcher.

Appendix 1: Ethics Committee Question

Q1 It will be helpful to state whether the researcher has the experience of conducting in-depth structured interview. If not explain the type of training intend to pursue.

The researcher recognises her limitations as a novice researcher, so to allow knowledge and skills to be improved she intends to attend available conferences, workshops related to the writing of history of nursing, and most importantly oral history interviewing. She will keep good link with the History of Health and Social Care Group, who organises a regular workshops and seminars for researchers who are working on mainly a research on history of nursing.

Q2 How is the data going to be analysed?

All the oral history data will be transcribed onto computer Word documents; it will then be converted into Rich Text files for importing into NVivo (Nvivo is a qualitative data analysis (QDA) computer software.

Q3 Is there funding available costs for instruments and data transcription etc.?

There is no funding available for instruments and data transcription. The researcher has been granted full funding in order to conduct this research but this including only the course fees.

Q4 How do you deal subjects with memory problems?

Memory loss can be a natural side effect of aging, or it can be caused by disease or injury to young individuals. Therefore, subjects with memory problems will not be excluded from the study, they will be interviewed and will use only information or data that they can well remember and are sure of.

Re other unsatisfactory comments such as:

I wonder the duration of the experience and time for the participants to recall over forty years ago. Explain in more detail why this study was needed.

The initial phone call that the researcher intends to make with the participants in preparation for the interview should help the participants to start recalling what happened in the past. The researcher limited the interview time to 1 hour to 1 and a half in order to avoid exhausting the participants giving their age.

How many in each country?

The researcher is aiming for 10-12 Yemeni/ SA nurses and at least 6 British nurses this is for the following reasons:

- The need for at least 6 British nurses reflects the anticipated difficulty in tracing and establishing contacts with these people as many of them have settled in different parts of the world.
- This also represents the fact that there were fewer British nurses who worked in Aden during the late colonial period.

Have you identified institutions that you intend to approach? If there are any – you need to write them a letter to get their permission etc. It is not specific at the moment.

No, at the moment there are no institutions that I intend to approach.

If there are any upsetting memories – How do you intend to deal with it?

Should the interview or the topic brought any upsetting memories, the researcher will give the participants the option to stop the interview and restart when feeling better and wish to continue or to withdraw from the interview if they wish to do so.

Appendix 2: Faculty Ethical Approval

MANCHESTER METROPOLITAN UNIVERSITY
FACULTY OF HEALTH, PSYCHOLOGY AND SOCIAL CARE

M E M O R A N D U M

FACULTY ACADEMIC ETHICS COMMITTEE



To: Mona Fareh

From: Prof Carol Haigh cc Emma Reilly

Date: 27 April 2012

Subject: Ethics Application 1147

Title: Nursing educational institutions and Services established in Aden in the period
1950-1976: A History of Nursing, of a Colonial Perspective

Thank you for your application for ethical approval.

The Faculty Academic Ethics Committee review process has recommended approval of your ethics application.

We wish you every success with your project.

Prof Carol Haigh and Prof Jois Stansfield
Chair and Deputy Chair
Faculty Academic Ethics Committee

Appendix 3: Participants information sheet

PARTICIPANTS INFORMATION SHEET

Title of the study: *The nursing educational institutions and services established in Aden in the period 1950-1967: a history of nursing.*

You are being asked to participate in an oral history interview in connection with the history of nursing in Aden as part of an MPhil/PhD program at the Manchester Metropolitan University. You are being asked to participate because you lived and worked as a nurse in Aden or within its geographical and political boundaries and surroundings during the period 1950-1967.

The purpose of this study is to explore and make sense of the history of nursing in Aden. Nothing or at least very little has been written about nursing in Aden the period 1950-1967. The study will focus on the provision of health and nursing services while Aden was under the British control. It will also give an account of the establishment of the nursing institutions around the above-mentioned period.

During the interview, you will be asked about your life and work as a nurse in Aden or its surroundings, and about health and nursing services in general during that period.

The interview will take approximately 1 to 1 ½ hour. During the interview you may request to stop the recording at any time to discuss and clarify how you wish to respond to a question or topic before proceeding.

The interview will be audio-taped, transcribed and used for the purpose of this study only. All recordings and transcripts will remain with the researcher (Mona Fareh) and will be destroyed five years after the end of the study; your words may also be quoted and used for future dissemination, but they will be presented anonymously.

Appendix 4: Participants Consent Form

Participant Consent Form

Title of the study: *The nursing educational institutions and services established in Aden in the period 1950-1967: a history of nursing.*

Please initial boxes

1. I confirm that I have read and understand the participant information sheet dated 27th Feb 2012 for the above study and I understand that I have the opportunity to ask questions.
2. I confirm that I am freely giving my informed consent to participate in the study described in this form.
3. I understand that my participation is voluntary and that I am free to withdraw at any time during the interview without giving reasons.
4. I understand that the interview will be audio-taped, transcribed and used for the purpose of this study, and that all recordings and transcripts will remain with the researcher (Mona Fareh) and that my words may be quoted and used for future dissemination.
5. I agree to be contacted in the future if needed
6. I agree to take part in the above study.

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Name of participant	Date	Signature
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Name of Researcher	Date	Signature

Appendix 5: Creating nodes and sub-nodes in Nvivo

The screenshot displays the Nvivo software interface with a list of nodes and sub-nodes. The interface includes a menu bar at the top, a toolbar, and a sidebar on the left with navigation options like Nodes, Relationships, and Node Matrices. The main area shows a table of nodes with the following columns: Name, Sources, Preferences, Created On, Created By, Modified On, and Modified By.

Name	Sources	Preferences	Created On	Created By	Modified On	Modified By
health conditions	1	5	05/11/2013 13:54	MF	11/02/2014 23:15	MF
aden /vs proctocate	0	0	11/02/2014 23:12	MF	11/02/2014 23:12	MF
diseases and outbreaks	0	0	11/02/2014 23:16	MF	11/02/2014 23:16	MF
life condition	0	0	11/02/2014 23:15	MF	11/02/2014 23:15	MF
public health	0	0	11/02/2014 23:13	MF	11/02/2014 23:13	MF
re sanitation	0	0	11/02/2014 23:14	MF	11/02/2014 23:14	MF
health institutions	0	0	11/02/2014 22:49	MF	11/02/2014 23:15	MF
conditions of health institutions	0	0	11/02/2014 22:54	MF	11/02/2014 22:54	MF
what health institution	0	0	11/02/2014 22:57	MF	11/02/2014 22:57	MF
non governmental medical institutions	0	0	11/02/2014 22:59	MF	11/02/2014 22:59	MF
who access what	0	0	11/02/2014 23:17	MF	11/02/2014 23:17	MF
health services in Aden	3	6	05/11/2013 14:26	MF	11/02/2014 23:15	MF
available health services	0	0	11/02/2014 23:18	MF	11/02/2014 23:18	MF
what health services	0	0	11/02/2014 22:58	MF	11/02/2014 22:58	MF
who provides health services	0	0	11/02/2014 22:55	MF	11/02/2014 22:55	MF
non governmental organisations	0	0	11/02/2014 22:55	MF	11/02/2014 22:55	MF
health staff training	1	5	05/11/2013 13:57	MF	11/02/2014 23:15	MF
health staff	0	0	11/02/2014 23:18	MF	11/02/2014 23:18	MF
helping the neighbouring country	1	2	05/11/2013 14:11	MF	11/02/2014 23:15	MF
how was nursing	2	3	16/01/2014 12:14	MF	11/02/2014 23:08	MF
medical staff recruitment	0	0	11/02/2014 22:48	MF	11/02/2014 23:15	MF
nurses	1	1	05/11/2013 14:21	MF	11/02/2014 23:15	MF
nursing today /vs and yesterday (colonial time)	4	22	16/01/2014 12:18	MF	11/02/2014 23:15	MF
nursing training	3	16	16/01/2014 12:02	MF	11/02/2014 23:08	MF
obstacles in training health visitors and medivies	0	0	11/02/2014 23:05	MF	11/02/2014 23:06	MF
qualifications	0	0	11/02/2014 23:04	MF	11/02/2014 23:04	MF
training nurses in UK	0	0	11/02/2014 23:01	MF	11/02/2014 23:01	MF
training nursing orderlies	0	0	11/02/2014 23:02	MF	11/02/2014 23:02	MF
who did nursing in Aden	0	0	11/02/2014 23:05	MF	11/02/2014 23:05	MF
population accepting health and treatment	0	0	11/02/2014 22:53	MF	11/02/2014 23:15	MF
reason for going to Aden	1	1	05/11/2013 13:53	MF	11/02/2014 23:15	MF
role of nurses	4	11	16/01/2014 12:22	MF	11/02/2014 23:15	MF
colonial nurse role	0	0	11/02/2014 23:09	MF	11/02/2014 23:09	MF
job within nursing	0	0	11/02/2014 23:15	MF	11/02/2014 23:15	MF
nursing grade	0	0	11/02/2014 23:07	MF	11/02/2014 23:07	MF
nursing today /vs and yesterday (colonial time)	0	0	11/02/2014 23:07	MF	11/02/2014 23:07	MF
pis	0	0	11/02/2014 23:08	MF	11/02/2014 23:08	MF