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of the Second World War

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3

'GUPPY TUMMY AND SANDFLY FEVER': SOUTH AFRICAN MILITARY HOSPITALS IN THE MIDDLE EAST, 1941–1945

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INTRODUCTION

For the Italian dictator Benito Mussolini, his colonies in Africa represented a link between the ancient Roman Empire and his Fascist Empire.² During the war his hold on the East African colonies acquired a more practical use as retaining the region would give Italy a hold on the Suez Canal. The presence of British colonial territories in Africa, however, complicated matters during the Second World War. By the end of 1941 the Italian East African Empire was no more and the British hold on the Middle East had strengthened.³ South African forces played a significant role in defeating the Italians in East Africa, but their real test would come on the battlefields of North Africa.⁴ Following the disasters of the Sidi Rezegh battle and the fall of Tobruk, the Union Defence Force (UDF) showed its resolve at the Battle of El Alamein at the end of 1942. With the victory there, the South African forces were granted home leave, while the last of the Axis forces were expelled from Tunisia by May 1943.

It was also in the Middle East that the South African Medical Corps (SAMC) made its most significant contribution towards the health and wellbeing of the country's troops. During the East African campaign, and later in the Italian campaign, the SAMC had to relocate their units each time the battlefield moved, but the Middle East, and especially Cairo and the surrounding areas, became a more permanent location for SAMC military hospitals. As Allied forces were pulled out of North Africa for the campaign in Greece, the South African hospitals in the North African desert came under more pressure to meet the needs of patients.⁵ As the British forces looked towards Greece, so the British Royal Army Medical Corps (RAMC) focused their attention on the same campaign, and the role of the South African hospitals in Egypt became increasingly important.⁶ It is through an investigation into the hospitals there that one gains some insight into the daily work and challenges of the staff and patients of the South African hospitals. The central focus of this chapter, therefore, falls on the military hospitals in Egypt, with occasional references to smaller medical units and hospitals elsewhere. Furthermore, this chapter is not concerned so much with medical science as it is with human experience.

ADAPTING TO THE DESERT

When the UDF forces arrived in Egypt in April 1941, the medical services consisted of a Deputy Assistant Director of Medical Services (DADMS), Headquarters Company (HQ Coy) of the 14th South Africa Field Ambulance and one detachment of a Field Hygiene Station.⁷ Under Brigadier AJ Orenstein, the UDF medical services soon

expanded to cope with the demanding and ever-changing circumstances of the desert war. By the time that war started in 1939, Orenstein was already 60 years old; he was a veteran of the First World War and had established himself as hygiene expert with the Rand Mines Group. His reputation as a 'respected tyrant' no doubt helped to raise the standard of the medical care that UDF forces and others received during the Second World War.⁸ He was assisted by Senior Staff Officers (SSO), one Medical and one Hygiene, as well as a Senior Dental Officer and the Principal Matron. Below them in the hierarchy were the Assistant Directors Medical Service (ADMS), one for the 1st SA Division at Mersa Matruh, one for the 2nd SA Division at El Alamein, one for Helwan, and one for the Amiriya district.⁹

The SAMC had to set up hospitals in a relatively short time, but establishing military hospitals in desert conditions was not an easy task. Regular interruptions by air raid sirens, dust storms and flies made the work very challenging. While the staff of some of the hospitals arrived directly from East Africa and could bring their equipment and experience with them, others arrived fresh from the Union, and in some cases their equipment reached them only weeks later, sometimes in pieces. For all personnel, the desert conditions were vastly different from those they knew, and innovation was the order of the day. Even so, by December 1941 Orenstein would not compromise on standards and rejected an offer from the Greek community in Alexandria for the use of a small infectious diseases annexe at a Greek hospital there. The Greeks did not expect payment for the use of the annexe, but Orenstein wanted a hospital with a capacity of at least 800 beds and for this, 'considerable charges were proposed', something which the Australians had also already rejected.¹⁰

No. 4 South Africa (SA) General Hospital arrived in the Middle East from Abyssinia in August 1941, but after working near the Gazala line, it was disbanded in August 1942. No. 5 SA General Hospital, which was established in July 1941, was the first long-term hospital in the Middle East. It arrived in Helwan in July 1941, only to be moved to Helmieh soon after. Initially it was equipped with 680 beds, but by December 1941 it had expanded to 1 200 beds. The wards were mainly located in tents, and in time the hospital acquired four operating theatres, one x-ray department, a dental unit, a dispensary and stores. A neuro-psychiatric department and an ophthalmic section were also added.¹¹

In Britain and the United States alike the press played an important role in spreading propaganda and affecting morale, and if medical services were seen to be not adequate, soldiers and citizens were likely to voice their dissatisfaction during elections.¹² With the many divisions in South African society and the small majority with which the new Prime Minister, Jan Smuts, entered the war, the newspaper reassurances that the volunteers were in good hands were very important.¹³ Claiming that the medical staff

took a delight in their work, *The Star* reported on the imminent arrival of No. 5 SA General Hospital in Cairo, stating that 'as yet there are no patients apart from a few soldiers suffering from illness, but elaborate provision has been made to see that the South Africans receive every care and attention should they suffer casualties'.¹⁴ The staff were placed with British hospitals until No. 5 was ready and were 'fraternising with great cordiality with their colleagues from the other Dominions'. The nurses were singled out as creating especially positive impressions. Casualties from the November 1941 offensive and from the battles around Tobruk in June 1942 were admitted to this hospital. It remained in Egypt after the invasion of Italy and took in patients from Tripolitania, Tunisia, Sicily and Italy.¹⁵

The No. 1 Convalescent Depot arrived in the Middle East from the East African Campaign in August 1941. As was the case with most hospitals, the work of this unit was dictated by the changing circumstances of the war, but by July 1942 it began to function as a hospital dealing with less severe cases in Buseilli, where it worked alongside an Australian Casualty Clearing Station that took in wounded from the Battle of El Alamein.¹⁶

By that time the first South African hospital for 'Non-European' servicemen had also been established. An erstwhile colleague of Orenstein, Dr AO Dreosti, the Senior Medical Officer of the Central Native Mine Hospital at City Deep, Johannesburg, was appointed head of this hospital.¹⁷ The hospital Dreosti was asked to establish became known as the No. 101 Non-European (NE) SA General Hospital and its remit was to take in Non-European patients of all Allied forces serving in the Middle East.¹⁸ However, in mid-December 1941 Orenstein confirmed in the War Diary that 'Union Hospitals for Natives in the Middle East would prioritise Union men', as he estimated that patients from East Africa would take up only 5% of the available space in the hospital.¹⁹ However, No. 101 hospital was later described as a 'truly pan-African hospital [with patients including] UDF Natives, UDF Cape Coloureds, East Africans, Belgian Congo natives, West Africans, Sudanese, Palestinian Arabs and others'.²⁰ Despite the assortment of nationalities in its patient population, the hospital displayed its loyalty to the Union with a life-size statue of a Springbok at the entrance.²¹

At first the hospital was to accommodate 1 000 patients, but on the basis of a 600-bed hospital for Europeans. In October 1941 the complete contingent of 269 doctors, nurses, orderlies and other staff, together with their equipment, left ... on the *Llandovery Castle* for the Middle East.²² By 23 November, however, the hospital staff had dropped to a total of 227, and the number would continue to fluctuate as the war conditions demanded.²³ Once it was established, specialists from neighbouring hospitals visited No. 101 on a regular basis.²⁴ Before this could happen, however, the personnel had to cope with very difficult circumstances to get the hospital in working order. Upon arrival at the designated site, the staff was met with bare desert, four

huts and five water taps. Three weeks later they had managed to build toilets, erect tented wards for 400 patients and sleeping quarters for the staff. This was done while they were waiting for their equipment to arrive by train from Suez, Port Said and Alexandria. Within six weeks of arriving in the Middle East, the hospital had 1 000 beds, but the work at the hospital was made difficult by the fact that the tents had to be at least 50 feet apart from each other as a precaution against air raids. Moving from tent to tent was challenging as there were no paths between them, and staff had to traipse through dense desert sands. Concrete paths and tarred roads were added later as it was recognised that general improvements to the hospital benefitted both the staff and the patients. The hospital evolved into twelve self-contained sections each able to take in 100 patients. Sanitary facilities, equipped kitchens, bathrooms and linen rooms were purpose-built for each section. Hot water and electricity was also available to all the wards and staff buildings, as were fans and heaters. The main kitchen had its own butchery and even a separate room for bread cutting and another for a 'beer department'.²⁵ Two tents functioned as churches for the patients, who also had access to two recreation huts, each with its own 'soft' canteen.²⁶

No. 6 SA General Hospital was an amalgamation of the 5th and 6th Casualty Clearing Stations from the East African campaign. To avoid confusion with a nearby British hospital, it soon became known as No. 106. At first this hospital could not be allocated a specific site, 'owing to the unsettled conditions in the Western Desert', and as such had to make do with a partially constructed British hospital in Qassasin, more or less half way between Port Said and Cairo. The hospital began its work in January 1942, but the first weeks at this site were very trying, as the staff had to make do without electricity or hot water, as well as a sanitation system that did not work properly. To make things worse, there was no transport available and staff had to remain in the camp with very little to do.²⁷ The staff received another shock when they were informed on the last day of February 1942 that they were to open a hospital 'on the spot' with capacity for 800 patients. In their haste to carry out the order, medical equipment was damaged, something which, given the slow arrival of equipment in the Middle East, could be ill afforded. To their relief the deadline was extended to the end of March, but the bustle in the camp must have been extraordinary, especially as the most basic of materials were not available. Nevertheless, an air of optimism and innovation prevailed and by the end of March the War Diary proudly stated that 'owing to a shortage of wood, all the Dispensary shelves and counters were built of concrete, giving a very satisfactory final result.'²⁸ Other innovations included a 'stool destructor' for the sake of good hygiene in the dysentery annexe, fly-proofing for the kitchens, and 'food carriers [with] heating apparatus' that provided hot food to patients despite the long distances between the kitchens and the wards. One aspect that this hospital had difficulty dealing with in its early months was the high incidence of theft from its stores. The 'acquisitive habits of the neighbouring population' were blamed for this as it was seen that 'the long flowing outer garment of the local population

[was] very useful from an appropriating point of view!²⁹ With the end of the desert war, the hospital became the No. 106 Combined Hospital, meaning that it took in patients of all races. It arrived in Italy early in May 1944.³⁰

No. 102 NE SA General Hospital started its work in Amiriya in May 1942, and like No. 106, also became a 'Combined' hospital when the Italian campaign started. While still in North Africa, however, the hospital was constantly being relocated as the front line moved. The staff of No. 102 did not have an easy start and on 6 May 1942, the second day of the hospital's existence, a tent with equipment was destroyed by fire, prompting the formation of a fire-fighting squad under Lieutenant Fresen later on the same day. At this time equipment was still arriving from Port Said. Despite the difficulties of the first month, time was found to invite some of the staff to lunch at the Springbok Club in Cairo, in honour of 'Isie' Smuts, the president of the Gifts and Comforts Fund and wife of the Prime Minister.³¹ By the end of May 1942 the hospital managed to equip an x-ray room and an operating theatre, as well as four wards that were able to accommodate 200 patients. With only 24 nurses, most of whom were detached from No. 106 hospital, each nurse had fewer than 10 patients in her care. The hospital, although not yet functioning at full capacity, also survived a visit from the Principal Matron in its first month.³²

The Matron in Chief of the SAMC was CA Nothard, who started her full-time service in May 1940. Her duties and responsibilities were considerable and her place on the military hierarchy was one step below that of Brigadier Orenstein. She was responsible for the nursing service in the Union as well as in the theatres of battle where the SAMC had a presence, including hospital ships, aircrafts and trains that transported patients. Training and discipline, matters relating to salaries, allocation to hospitals as well as staff reinforcements and leave of absence fell within her remit and, with this heavy burden of duties, Matron Nothard set high standards for herself and for others. As such, she made it clear from the start that nurses deserved military rank, not only to bring the South African Military Nursing Service (SAMNS) in line with British and other Commonwealth medical services' practice, but also because the SAMNS was the oldest female military service. Her success in this respect, however, did not mean that she held the view that nurses deserved special treatment and when nurses asked for a 'danger allowance' after the Battle of El Alamein, Matron Nothard did not react kindly and reminded the stunned nurses that they were privileged as they were seeing the world at the government's expense.³³

The war posed a constant threat to the hospitals and precautions had to be put in place to keep staff and patients as safe as was possible in a war situation. No. 106 Hospital, for instance, made provisions for air raids and specific instructions were issued as each person needed to know exactly what was expected of them if and when the enemy struck. In the event of a raid the administrative centre of the hospital would become

the command post, and as a precautionary measure, the tent in which it was located was sunken and provided with slit trenches. The tented wards were also sunk to provide protection against a direct blast, while wards located in huts were protected by 'anti-blast wall[s]'. Trenches throughout the camp were deemed sufficient to provide protection for all the patients and staff. Not knowing if the enemy would employ poison gas, as was the case in the First World War, a 'gas cleansing centre' was placed near the command post and a 'permanent chemical warfare Sergeant' put in command. The double-canvassed tents were believed to be 'impervious to the heaviest spraying by war gases', but as an extra precaution respirators, eye-shields and capes were also available.³⁴ A prevailing image of the First World War is that of helpless soldiers unable to defend themselves against poison gas attacks. The shock of its effect on the soldiers, and the added shock of the realisation that humanity would stoop to using this weapon, led to the recognition that gas was a 'barbarous method of waging war'.³⁵ The use of gas was banned with the Geneva Protocol of 1925, yet despite universal aversion, some signatories reserved the right retaliate 'in kind to a chemical attack'.³⁶

Another legacy of the First World War was the concept of black-outs as protection against bombing raids, which meant that all lights were either switched off or made invisible from the outside. In the case of an air raid warning, a complete black-out was maintained throughout hospital camps. If an air raid warning was given during the day, the work of the hospital was expected to carry on as usual, with the exception that any parades, church services or gatherings around entertainments were to end immediately and staff and patients were to return to their barracks or wards.³⁷

HEALING IN BATTLE

Medical services on the battlefield were arranged in such a way as to get wounded away from the frontline as fast as possible to preserve medical manpower.³⁸ Wounded men from the frontline would go to a Regimental Aid Post (RAP) and from there to the Advanced Dressing Station (ADS), where they would be classified according to the triage system which would determine their next destination. Those whose lives were in danger (level 1) were sent to the Field Dressing Station (FDS), those with injuries or wounds that required surgery but whose lives were not in immediate danger (level 2) went to the Advanced Surgical Centre (ASC) and from there to a General Military Hospital. The least severe cases (level 3) went to a Casualty Clearing Station (CCS). Once treated, the men who initially went to the FDS or ASC also ended up at the CCS where everyone was again assessed.³⁹ Here the casualties were divided into four groups, depending on the severity of their wounds, for example 'dying', if death was imminent, 'desperate', if it was deemed that the man's life was in significant danger, 'serious', which meant that the man's life was in danger but death was not

imminent, and lastly 'satisfactory', in other words 'there seemed a reasonable chance of survival'. During battles that took place between 25 October and 1 November 1942, for example, 133 men were divided into these four categories, with four dying cases, 23 desperate, 25 serious and 81 satisfactory.⁴⁰ Those who were well enough were returned to the frontline, while the rest were sent to a hospital that fell within the evacuation zone.⁴¹ Getting casualties to a hospital was no easy task, as the desert sand made transport very difficult and, in response, Mobile Surgical Units were created.⁴² If it was necessary, patients were sent from the evacuation zone to hospitals outside the war area, or by hospital ship to hospitals overseas.⁴³

In the desert, however, units moved around continually, and the Medical Corps was rearranged from lightest, known as A Section, to heaviest, known as HQ Section.⁴⁴ As casualties passed from one section to the next, they were assessed and if their condition allowed it, the men were returned to their units. The more serious cases were sent onwards to the hospitals in Allied territory. The main areas in which the medical services were located in the Middle East were Mersa Matruh, 440 kilometres North East of Cairo, El Alamein, 280 kilometres from Cairo, Helwan, which fell within the Cairo city bounds, and Amiriya⁴⁵ near Alexandria.⁴⁶ In Tripoli a hospital staffed with volunteers from the hospitals in Cairo was set up to alleviate the difficulties of the long journey which patients had to make from Benghazi to Alexandria.⁴⁷

The chaos caused by the sudden surrender of the Tobruk garrison in June 1942 also meant that those Field Ambulances and CCS which had not been captured had to be evacuated with the rest of the units that were in retreat. As No. 4 and No. 102 Hospitals were near the battlefront at that time, both were evacuated and their staff and patients allocated to No. 5, 106 and 101. The wellbeing of the nurses was of specific concern, but in the end it was decided not to separate the nurses from the patients in view of the belief that the 'nurses would resent being ordered away and leaving patients without attendance.' Probationer nurses, however, were ordered to evacuate. Others, in their eagerness to return to relative safety, abandoned their duties and were severely reprimanded, as was the case with Colonel Verster, who apparently returned to Alexandria without any knowledge of the whereabouts of the CCS of which he was in charge.⁴⁸ It was not only posts of duty that were abandoned, but standards of hygiene fell as the different units retreated. Diseases spread easily in unhygienic conditions where many men are congregated, and at El Alamein the situation could easily have had a negative effect on the outcome of the battle that was to come. Writing in 1944, Lieutenant-Colonel HS Gear, Assistant Director of Hygiene in the South Africa Medical Corps, identified a number of factors that contributed to the unhygienic circumstances at El Alamein. In his view, the evacuation of troops resulted in a lessening of supervision by hygiene officers, and understandably, personal hygiene was neglected in favour of basic survival. The large number of local inhabitants who retreated alongside the Eighth Army and who settled near the El Alamein line also

created unhealthy living conditions. To protect the troops, these people were removed to an area further away. The season during which the retreat took place also added to Gear's woes, as this was the time of the year when flies and dust were most prevalent in the extreme heat. Ironically, troop reinforcements added to the hygiene problem, as these new men were 'unsalted' and especially susceptible to 'guppy tummy and sandfly fever'.⁴⁹ As the hygiene section was ultimately responsible for preventing the outbreak of disease, this situation also had an effect on morale, but the low admission rate of men suffering from diseases showed that hygiene matters were quickly rectified and the result, in Gear's proud words, was 'the excellent health of the Eight Army in the prelude [to] and in the actual battle [of El Alamein]'.⁵⁰

The battles in Libya from November 1941 to August 1943, especially those of Sidi Rezegh and Tobruk, kept medical personnel in Cairo very busy and in most cases the capacities of the hospitals all expanded. No. 5 Hospital, for instance, grew from an initial 680-bed hospital to one of 1 500 beds following the fall of Tobruk, while No. 102 expanded to 1 100 beds, at the same time also increasing its staff with 10 medical officers and 75 nurses. On the home front the press continued to champion the work of the medical corps, as this was seen as a way to motivate more medical staff to volunteer. As the men volunteered to serve in the UDF, so did trained nurses volunteer to serve in the SAMNS. Other medical volunteers included those in the Voluntary Aid Detachments (VAD), who served as untrained nurses with the Red Cross Society or St John's Ambulance. Following the Sidi Rezegh battles, *The Star* reported on the 'need for more nurses' and for those at home to collect money for the Gifts and Comforts Fund, which provided essentials to the wounded. However, it was also made clear that it was 'time that our young women of service age realised their duty to their country and joined the nursing staff'. The article also quoted Orenstein, who stressed the importance of 'the essential oneness of mankind, and to break down the fear and distrust of foreigners to which so many are prone', no doubt hoping to invoke in the citizens of the Union a sense of duty that would dispel fears of the unknown.⁵¹

The SAMC learnt many lessons from their experience in East Africa where disease caused most of the casualties. By the time the 2nd Division arrived in the Middle East, the Hygiene Section was better equipped than the 1st Division, which arrived directly from East Africa.⁵² Perhaps as a result of their experience in East Africa, where diseases were prevalent, the SAMC held a somewhat condescending view of the hygiene standards of other Allied nations in the Middle East, and it was felt that 'some of the Allied Forces were devoid of any sense of Hygiene or Sanitation and if they did have any knowledge of it, they certainly did not practice it'.⁵³ The South Africans often noted the how other Allied troops would swim in water supply tanks, destroy toilet seats and then using the seats to carve models, and 'all the propaganda, orders and appeals to their better feelings made little difference'.⁵⁴ Whenever UDF Divisions moved into an area previously occupied by another Allied force, they were confronted

with unhygienic conditions and felt compelled to spend valuable time on improving the situation. At Mersa Matruh, for example, the South Africans worked from mid-1941 to December of that year to improve hygiene conditions.⁵⁵ It was during such times that enteritis flared up amongst the men, only to decrease again once hygiene had been brought up to standard. It was commonly believed that the awareness of the importance of hygiene among UDF troops and UDF medical services kept the number of diseases among UDF troops to a minimum.⁵⁶

DAY-TO-DAY WORK OF THE SAMC HOSPITALS

With thousands of UDF volunteers arriving from the Union, and with others already active in the various battle arenas in the desert, the hospitals' preparedness to receive patients had to be arranged as fast as possible. Hospitals put measures in place to deal quickly and effectively with high admission rates, categorising patients and allocating them to specific wards. Once patients had received initial treatment, they were categorised again, this time determining their future in the UDF. Category B patients were 'fit for Garrison, Base or Special Duties abroad', in other words, they would return to their regiments, although some would be sent to a convalescent home or depot before reporting for duty again. Category C patients were deemed 'fit for sedentary or other selected employment in the Union only', and such men may have been utilised in the Union at prisoner-of-war camps. In all such cases a medical board was required to make the final decision. Category D patients were the most serious medical cases and they were evacuated to the Union as 'sitting case[s]'.⁵⁷

Once admitted to hospital, patients were still subject to military discipline, and a long list of rules constrained their behaviour. If a patient held a senior rank, he was responsible for the discipline in his ward, but medical staff were expected to report any instances of waywardness to officers. Every aspect of life was controlled to maintain order and to help the medical staff perform their work as efficiently as possible. Lights were to be turned out between 9 at night to 6 in the morning, the same period when smoking and talking were not permitted. Patients' freedom of movement was also curtailed and 'out of bounds' areas included any places that sold alcohol, living quarters of staff, and the venereal diseases (VD) and infectious diseases wards. 'Up patients' had to make their own beds and clean their eating utensils; they were also expected to shave and wash before breakfast every day. If inspections took place, these men were also instructed to 'come to attention (at the foot of the bed if up patients) except in such cases in which, for physical or other reasons, it is not possible'. Those patients who were well enough, also had to 'assist in such light duties in the hospital as the Matron or the Nursing Staff may direct'.⁵⁸

While the staff dealt with battle casualties, they also admitted patients who suffered from illnesses, some of which were common and some of which were more specific to the desert conditions. Each hospital had to complete an admission form for every 24-hour period, indicating the unit the patient belonged to, his name and number, the nature of the disease or injury, how the patient was 'disposed' of, which could include being returned to duty or being transferred to another medical unit. Other means of disposal included 'sick, died, discharged, etc.'⁵⁹ In the case of No. 101 the most prevalent diseases for the period of July to the end of September 1942 were diarrhoea and dysentery with 758 cases, 599 cases of VD and 159 patients admitted with malaria. Pneumonia, bilharzia, pulmonary tuberculosis and leprosy made up the last four places of the top seven illnesses.⁶⁰ September was the height of the malaria season in Egypt and staff were frequently reminded to be 'mosquito-minded' to prevent the spread of the disease.⁶¹ At the time medication was not seen as an ideal measure against malaria, and it was thought that prevention was better than cure, especially as quinine was believed to have many adverse side-effects. Amongst some soldiers, rumours of impotence as a result of quinine also added to the resistance against the medication.⁶² Some of the less common reasons for hospital admissions included ingrown toe nails, mumps and scabies.

Venereal disease among volunteers remained a challenge for the medical personnel and in December 1943, when No. 6 Hospital returned to its original site at Qassasin and became known as No. 106, the hospital's first 62 patients were men suffering from VD. Along with these patients came the instruction that No. 106 was to function as the VD centre for the area. A week later the hospital was equipped with more beds and the total number of patients increased to 742. During that time outbreak of influenza among the nurses also kept the staff busy, as did administering typhus vaccines to Egyptian labourers at the outpatients department.⁶³

Another aspect of desert life, and one that seemed to follow large groups of men, was lice infestations, which could lead to typhus. To control the spread of the disease, the extermination of lice and fleas was of great importance. In one instance, in an effort to rid the UDF of the pest, the Hygiene Section decided to delouse the entire Polish Independent Brigade, 'freshly captured POWs', POWs in camps and civilian refugees. Members of the Non-European Army Service (NEAS) and the Cape Corps were inspected for lice when they returned from casual leave, and if found to be 'lousy', would be disinfected immediately. In addition, the UDF used lectures, films and demonstrations to warn Non-European members about the dangers of lice and flea-borne diseases. By 1944 the Armed Forces in the Middle East had the additional protection of an anti-typhus vaccine.⁶⁴

A condition directly related to battle casualties, but which carried a stigma, was known by medical personnel as NYD. This was a less frequently listed reason for admission and was an acronym for Not Yet Diagnosed. NYD N indicated 'Nervous', while in

other cases the patient's condition was described as 'NYD Fits'.⁶⁵ The use of the term NYD Functional was decided on by the American 1st Armoured Division in June 1944 during the Italian campaign, when it became clear that tanks, previously thought of as relatively safe, resulted in their occupants suffering from severe psychiatric conditions, especially if they were survivors of burning tanks or tanks hit by explosives.⁶⁶ These men were psychiatric casualties and during the First World War the condition became known as shell shock. With no physical wounds, these men were sometimes seen as 'malingerers' during the First World War, but medical staff quickly realised that treating soldiers with this condition close to the front and as soon as possible resulted in the best outcomes. By the time the Second World War started, this lesson had to be learnt all over again and initially soldiers were sent to hospitals away from the front for treatment. The stigmatisation of the condition also extended into the Second World War and was not taken seriously by, among others, the British Prime Minister, Winston Churchill, who regarded psychiatrists and psychologists as 'gentlemen [who asked] odd questions'.⁶⁷ Treatment of soldiers suffering from combat stress presented a genuine conundrum for the medical services, as it was only after the Second World War that studies revealed that stress levels among soldiers increased as they anticipated battle, not when they participated in battle. Fear of the unknown was for many the main factor that damaged their sanity.⁶⁸

In the SAMNS there were eight probationary nurses who had completed psychology courses during their training and they were deemed proficient to deal with 'nervous' cases who had been evacuated from the Middle East to the Union hospital at Potchefstroom. Towards the end of 1942 one of these nurses joined the staff of No. 101 Hospital to start an occupational therapy unit for psychiatric patients.⁶⁹ In No. 106 Hospital, a 'large number' of patients were admitted suffering from what the medical personnel viewed as mild anxiety in April 1942. As this was not a time of much activity on the battle front, the explanation was given that the men felt aggrieved that their home leave had not materialised. Clearer communication with rank and file, as well as carpentry for the patients in the occupational therapy room, was prescribed. The personnel of No. 106 discussed the approach they would take regarding 'neurosis' and training for medical officers in this regard was also deliberated.⁷⁰ However, no further such cases were recorded in the records of No. 106 and it was only in March 1944 when the matter of psychiatric cases was mentioned again, if only in the form of Brigadier RF Barbour, a consulting psychiatrist, discussing 'minor matters' with No. 106's physician, Lieutenant Colonel Brink. The precise topic of the discussion is not mentioned in the War Diary, but at this stage the hospital received no battle casualties from Italy and dealt mainly with diseases.⁷¹

Although health threats came mainly in the form of battle wounds and disease, the UDF authorities were also very careful to warn their medical staff of the dangers posed by the local residents. Hawkers viewed the Allied troops as a source of income and

established a lively trade. Ever vigilant to the need for cleanliness, hygiene officers saw health risks in the local wares and in June 1943 Colonel AD McKenzie, Commanding Officer of No. 5 Hospital, warned that troops who bought drinks from hawkers were putting their health in danger as, according to a bacteriological report, the home made drinks were contaminated with sewage water, which could spread typhoid fever and cholera. Evidently, the hawkers were aware of the notice and used old corks from bottles which were originally sold by the Navy, Army and Air Force Institutes (NAAFI) in an effort to make their drinks look safe. McKenzie ordered that all corks were to be collected and returned to the depots, where they were done away with.⁷²

While the main purpose of military hospitals was to provide medical treatment for soldiers, medical personnel also required care from time to time. One facility for this was the *El Amiriya*, a houseboat on the Nile next to Gezira Island in Cairo for women in the UDF, including nurses, and members of the Women's Auxiliary Army Services (WAAS) and Women's Auxiliary Air Force (WAAF). Here the women received medical attention or recuperated after an illness. A medical officer from No. 5 SA General Hospital visited patients twice a week, but when there were emergencies the staff of No. 15 Scottish General Hospital attended to the cases.⁷³

REST AND RELAXATION

When the campaign in North Africa came to an end and the battle front moved to Italy, most South African hospitals remained in Egypt, receiving patients by air from the European mainland.⁷⁴ For the staff of No. 106 and No. 102, new challenges lay ahead as they were relocated to Italy. For those remaining behind in Cairo, life now became less stressful as the threat of German invasion of Egypt had dissipated. It was especially the staff who were now able to adopt a routine that would make their lives more bearable while they were away from the Union. A somewhat lighter work load, however, did not mean that less emphasis was placed on morale-boosting activities. The importance of maintaining morale went hand in hand with discipline, and with less work to do, staff morale became more important. For the military, and perhaps more so for military hospitals, the terms 'discipline' and 'morale' conveyed similar meanings. Morale was seen as the 'state of confidence and respect in which men hold their cause, their leaders, their unit and themselves'. In addition, discipline was the 'essential and acquired habit of obedience to orders [and] discipline and morale inevitably improve or deteriorate together'.⁷⁵

While the North African campaign was still in progress, maintaining high morale among the patients and the staff meant that battles could ultimately be conducted more efficiently. In short, if the medical staff performed their duties conscientiously,

soldiers received better care and were sooner able to return to active duty. It was here that hygiene and discipline intersected with morale. Medical Officers observed men's health, which in turn affected morale. Discipline was linked to high standards of hygiene, which ultimately also influenced morale and the willingness to do battle.⁷⁶ For the medical staff, however, the expectation that they needed to return the wounded to the battleground often represented a conflict. On the one the one hand, they had to mend broken bodies, but on the other hand, they had to send those bodies back to the battleground.⁷⁷ As such, the pursuit of non-medical pastimes to maintain good morale was crucial, although it was a fine balancing act, as military hospitals presented the authorities with unique challenges. Hospital populations were diverse, consisting of casualties traumatised to greater or lesser degrees, and staffed by mostly male medical doctors and mostly female nurses. Hospital personnel often also worked in close cooperation with the staff and patients of military hospitals that belonged to other Allied or Commonwealth countries, each with its own national idiosyncrasies. Added to this mix was the local population that, depending on prevailing attitudes, were seen to help or hinder the work of the hospital.

For female staff, especially the VAD nurses who were unfamiliar with the military *modus operandi*, and who were outnumbered by male colleagues and working almost exclusively with male patients, the experience must have been astonishingly enlightening. The extent to which men and women worked together during the Second World War is seen as the most important agent of the disruption of gender stereotypes, and while the war may have contributed towards gender equality, the nurses and other female staff at the time initially bore the brunt of the onslaught against age-old prejudices. Among the American personnel, for example, it was widely rumoured that nurses were there merely to 'fulfil morale purposes', and that nursing was a minor part of their work. Consequently, many men believed that the women were required to carry contraceptives whenever they left their barracks.⁷⁸ An assumption of supposed immorality among nurses was not confined to the American forces, and it would seem that South African nurses also had to deal with their fair share of roguish ideas. One serviceman noted in his diary that the men in his unit had

an argument this morning about South African women in Cairo. So many fellows say they don't want to know us and plumb for pips on Imperials. [We] discussed this with South African girls (nurses) and they indignantly denied it. We get priority, and I believe it.⁷⁹

Ironically, patients in military hospitals were instructed to regard nurses as 'officers, and must be treated as such'. Patients were also under orders not to be 'violent, insolent or disrespectful ... especially to or in the presence of members of the Nursing staff'.⁸⁰ These orders may stem from the notion that, historically, morality and the idea of wholesomeness were the sought-after characteristics when it came to nurses who

adopted a motherly or sisterly role when working with patients. Bringing comfort to wounded men was therefore regarded as more important than their medical skills, and as such the nurses were to be protected against the sometimes unscrupulous behaviour of soldiers.⁸¹

Recreation was important for morale as well as a stress release. In some instances recreational activities were the result of the authorities' efforts, while in other cases the staff took the initiative. Initially, however, it would seem that nurses were ignored or simply left out of the official records, as was the case with No. 6 Hospital when it was still at Qassasin. Its staff were confined to the camp because of lack of transport, and the 93 female staff, including the matron, nursing sisters and nurses, were left to their own devices. The hospital diary asserted that 'quite attractive pictures are shown to the men [and] regular lectures have also been given to the male personnel'.⁸² It was only towards the end of 1942 that the war diaries reflected nurses' inclusion in recreational activities. Remarkably, most nurses took this state of affairs in their stride and performed their duties, arranged social gatherings and contributed towards maintaining good morale amongst the patients. For example, in December 1943 the nurses' Christmas Cheer Fund collected £40. The nurses also helped their patients discover new hobbies, and needlework became very popular in No. 106 Hospital.⁸³

Notwithstanding the dust and the flies, the desert seemed to hold a sense of romance for a number of the staff, and in some cases relationships developed between UDF personnel which led to marriages. With efficiency and productivity in mind, the Cairo HQ issued an order in 1942 stipulating that if two members of a unit were to get married, one of them should be transferred to another unit. However, in June of the same year, the *Rand Daily Mail* published an order of the military authorities which stated that women serving in the Middle East, WAAS, WAAF and nurses of the SAMNS, were not allowed to get married while in service. This was apparently to prevent hasty marriages in foreign countries and was something which the Canadian and American authorities also proscribed.⁸⁴ One of the last weddings to take place in Egypt must have been between Captain du Toit and Ms Brink, who were both stationed at the General Headquarters. Apparently Orenstein made a 'witty' speech at the reception, perhaps because the wedding cake was decorated with a SAMC badge.⁸⁵

The ban on marriages did not deter the staff and most of them were determined to make the best of their time in Egypt. Military personnel in Cairo could attend 'concert parties' organised by Britain's Entertainments National Service Association (ENSA), but the UDF's Major Myles Bourke and Captain Sybil Gaiger decided to offer entertainment with a South African flavour to their own troops. The *Crazy Gang* was the first to arrive from the Union late in 1941, followed by the *South Easters*, *Africa Star* and *Jabulani* for Non-European personnel. The *Ballyhoos* and the *Amuseliars* followed with the *Swingboks* the last of the entertainment units to arrive in the Middle East.⁸⁶

One show performed at Tel-el-Kebir, 'George and Margaret', was so popular that it made it into the war diary of No. 106 Hospital. Staff and patients of this hospital were allowed to attend the show in a week that also experienced air raid warnings, bombings and anti-aircraft fire seen in the distance.⁸⁷

In many cases the staff of the hospital also took it upon themselves to arrange entertainments or to arrange activities to benefit the patients. At No. 101 the families of the white staff set up a fund to meet the needs of patients and staff, while the staff themselves devised a plan to raise money for the entertainment requirements of the black staff. Beer was brewed and sold to the staff, and the money was then used to buy musical instruments for a jazz band in which staff members played. For those who did not want to spend money on the hospital beer, *Marewu* was available free and on a daily basis.⁸⁸ From the outset the NAAFI provided canteens for hospitals and at No. 6 five canteens were established as early as March 1942, each carefully segregated from the other, although the nurses and the officers shared one.⁸⁹

Up patients were permitted to attend recreational activities which had been organised by the hospital administration, although their movements were strictly controlled. If a concert or lecture took place at the hospital, the patients only had 15 minutes to get back to bed after the curtain call. In cases where the entertainments were held away from the hospital, a member of the hospital personnel would accompany them, taking responsibility for the group.⁹⁰ In some cases concerts were open to personnel only, like the one held at the Helmieh Garden Theatre on 21 June 1943, where the RA Base Depot Band played.⁹¹

Sport was hugely popular among staff and patients alike, and the different hospitals would often compete against one another in cricket, rugby, tennis and soccer. On 12 June 1943, for example, No. 5 played cricket against the Ambulance Train Depot on the No. 102 Hospital grounds, and on 13 June No. 5 played cricket against No. 101 at the Kenya grounds in Cairo.⁹² Later that year No. 102 Hospital hosted a NEAS Athletic Meeting, with the programme indicating that it was held on 16 December 1943, 'Dingaan's Day', a public holiday in South Africa. Teams from No. 5 Hospital, No. 101 and an NEAS team participated in events such as a 100-yards race, cricket, long jump, high jump, shot putt and a mile race.⁹³

Each Christmas also presented an opportunity for all hospitals to boost morale with concerts, church services, special food and visits from dignitaries. In December 1943, despite an outbreak of bubonic plague in Suez, Port Tewfik and amongst British Military personnel in the Canal Area, No. 101 Hospital went to great lengths to decorate the tented wards and to distribute 'gifts and comforts' to the patients. With the hospital's Bugle Band playing and staff and patients marching and dancing along, the kitchen prepared the special Christmas lunch, which included '2 pints of *Tyvala*' for each man. In the afternoon the '101 Yellows' took on a team from the 8th CCS, with the hospital

team emerging victorious.⁹⁴ In the meantime, precautions against the plague were put in place at the hospital. Dead rats were to be reported to the Company Commander and the rodents were destroyed. Where necessary, personnel were disinfested and anti-flea measures, including the airing of clothing and bedding, were put in place.⁹⁵

Although the physical activities distracted staff and patients from the bleaker side of life in the desert, reading was also popular and, when controlled by the authorities, served a dual purpose. No. 101 Hospital published the *Sandy Times* newsletter, which although very basic in its design and layout, was able to inform and also measure morale through the contributions from staff and patients. The first edition appeared in July 1943, and the editorial placed a great focus on unity and the successful carrying out of duties. In the editor's opinion, 'here at 101 we may truly say that perfect Unit Unity has reigned from the very beginning. As South Africans we may be proud of that fact, for we happy band of brothers – and sisters! – have actually brought to life and illustrated in unmistakable fashion the power and truth of our country's motto – *eendrag maak mag* [strength in unity]'. He also asked everyone to contribute, even if those contributions were 'grim, gay, prose, verse ... even controversial provided it is not offensive'. However, it would seem that most of the contributions were from the authorities, posing either as 'Spiky', 'Sakkie' or 'Bessie', representing the English, Afrikaans and nursing contingents respectively. The articles were often thinly disguised pieces of information and subtle warnings, such as a 'letter to the editor' from 'Spink', who related the story of how he replaced a lost button with a pin so that he would not violate instructions with regard to malaria precautions.⁹⁶ For the sake of humour, jokes were also included, an example of which was one entitled 'Of Hearts and Flowers' about a military wedding: 'the groom only recently back from the Middle East, had hardly glimpsed his bride before the ceremony. Therefore, when the time came for the kiss, it was a long one, lasting on and on until a child's voice rang out in the silence of the church: "Mummy, is he spreading the pollen on her now?"'⁹⁷ For the more discerning personnel at No. 101, an amateur dramatics society and a book club were created.⁹⁸

In a similar effort, but only in 1945, No. 106 Hospital, by then in Italy for more than a year, published *The Shuftiscope*. Compared to the *Sandy Times*, it was a much more professional-looking newspaper, but most of its contributions were also conceived by the authorities in an attempt to inform and steer thoughts in a desired direction. In some cases, no effort was made to hide the fact that the writers were fake, as was the case with 'Mad Typhoid', who wrote regularly for the '*Mein Mamph*' column.⁹⁹

The most impressive example of adventurous diversion came from the officers at No. 5 Hospital, who went as far as publishing a book on their desert endeavours. The publication, *Now There's a Thing! A manual of liar dice and Taurocoprology*, must have been the result of many hours of nonsensical brainstorming which resulted in a humorous but bizarre collection of essays; all of which were obviously utterly devoid of factual information. The fictional science of 'taurocoprology' was satirically put

into practice with ‘Liar Dice’, a game on the skill of deceit and a metaphor for ‘the art of carrying conviction to sceptics by subtle mannerisms or by apparently logical processes of own self-glorification’, with the title of ‘Sacred Bull’ conferred on the master taurocoprologist.¹⁰⁰

CONCLUSION

The war came to an end in May 1945, but it was months before the hospitals returned to the Union. Patients were still arriving for treatment and others were still in the process of recovery. In most cases staff had to be evacuated systematically so as not to disrupt the normal hospital routine.¹⁰¹ No. 101, for instance, disbanded on 31 August, but the closing down of the hospital could not be completed until the end of September.¹⁰² No. 106 Hospital arrived in the Middle East from Italy in September on their way back to the Union, with all the personnel demobilised on 24 September.¹⁰³ In the Union, Brigadier Orenstein said his goodbyes to his staff at the end of August 1945 and at the farewell it was acknowledged that there had been a ‘certain amount of floundering’ as far as the Medical Services were concerned at the beginning of the war, but that Orenstein’s appointment had been a wise decision.¹⁰⁴ Smuts also wrote to his ‘old comrade’ to thank him for his work during the war.¹⁰⁵ Five years after the war the SAMNS became part of the Permanent Force and the nurses were at last eligible for pensions.¹⁰⁶ The Matron in Chief, CA Nothard, remained in her post until 1946.¹⁰⁷

The work of the medical personnel in the Middle East was a test of endurance which required huge doses of initiative and good humour. In both environments, medical and military, discipline and morale are crucial components to success, and in the case of the military hospitals in the Middle East, the staff performed remarkably well in difficult circumstances. Faced with changing circumstances, adapting to unfamiliar climates and confronted with new diseases, the staff remained committed to their duties.

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