THE TOMLINSON REPORT

EXTRACT FROM THE SUMMARY OF THE REPORT OF THE COMMISSION FOR THE SOCIO-ECONOMIC DEVELOPMENT OF THE BANTU AREAS WITHIN THE UNION OF SOUTH AFRICA

PARAGRAPHS DEALING WITH VITAL STATISTICS AND HEALTH

The Commission, which consisted of Prof. F. R. Tomlinson (Chairman), Mr. M. D. C. de Wet Nel, M.P., Mr. C. W. Prinsloo, Mr. J. H. J. van Rensburg, Mr. G. J. Badenhorst, Mr. C. B. Young, Prof. C. H. Badenhorst, Prof. F. X. Laubscher (resigned and succeeded by Prof. J. H. R. Bisschop), Dr. J. H. Moolman, and Mr. F. H. Botha (Secretary), presented its report in typed form on 1 October 1954. The printed abridged report (the Summary), prepared by the Commission itself, was published in 1956.

The following extract is a copy of paragraphs dealing with vital statistics and health, which constitute little more than one-twentieth part of the text of the Summary.

IN PART I: A BROAD PERSPECTIVE

IN CHAPTER 7: THE POPULATION PROBLEM IN SOUTH AFRICA

I. GROWTH OF POPULATION

1. According to the census of 1951, the population of the Union of South Africa consists of 2,643,000 Europeans, 8,535,000 Bantu, 367,000 Asiatics, and 1,103,000 Coloured persons. The total population increased by 144 per cent, namely from 5,176,000 to 12,646,000, between 1904 and 1951. In consequence of their greater absolute numbers, the Bantu have contributed most to this increase, to wit, 5,044,000 in comparison with 1,526,000 in the case of Europeans, and 657,000 and 243,000 in the case of Coloured persons and Asiatics repectively. Of the four groups, only the Asiatics have increased in relative importance to any considerable degree. The numbers of Bantu and Coloured persons today represent more or less the same percentage of the total population as at the beginning of the century, 67·5 per cent and 8·7 per cent respectively. The European section has diminished slightly in numerical importance and forms 20·9 per cent of the total today in comparison with 21·6 per cent in 1904. There are about 3,229 Bantu, or taken as a whole 3,785 non-Europeans, for every 1,000 Europeans.

III. MORTALITY

6. On a comparison of mortality conditions among theur fo population groups, the Europeans appear to be in the most favourable position, with a crude death-rate of less than 9 per 1,000 in 1952. This compares with 10·9 for Asiatics and 19·9 for Coloured persons. In the case of the Bantu for whom vital statistics are not available, it is estimated at between 27 and 32 per 1,000. The death-rates for the three first-named population groups all show a long term decline, while those for the Bantu probably only began to decrease in the most recent period.

7. The decline in mortality must be attributed mainly to a decline in deaths among children during their first year of life. Thus, the European infant mortality rate declined from 52·9 on an average during 1936-1941, to 34·6 in 1952, and that of Asiatics and Coloured persons from 93·1 to 71·3 and from 164·9 to 140·6 per 1,000 live births respectively. Among the Bantu, nearly one-fifth of the children born alive die before they reach their first birthday, as a result of the unhygienic customs and conditions under which they are born and grow up. Socio-economic progress thus reveals itself particularly in the saving of children lives, a process which aggravates the burden of dependency in an underdeveloped community.

8. The average expectation of life at birth, obtained from life-tables, affords a more accurate indication of health conditions than the ordinary death-rate, which is influenced by the particular age and sex composition of a population. Such life-tables, based on the experience of the period 1945 to 1947, indicate that at birth the average European child has a probable duration of life of 66 years and an Asiatic, Coloured and Bantu child 50·3, 42·8 and 36·4 years respectively.

9. In comparison with the urban areas, living in the rural areas appears to be a cause of longer life, in the light of the lower mortality rates prevailing among rural Europeans, Asiatics and Coloured persons. This urban-rural differential is, however, diminishing. It is not impossible that the process of urbanization could have caused increased mortality—among Bantu at the beginning, but that the increasing utilization of medical facilities and improved living conditions, may have altered the differential in favour of the city.

IV. FERTILITY

10. The Coloured community, with an ordinary birth-rate o 45·5 per 1,000 on the average, for the period 1936 to 1952, is the most fertile. Among the Bantu, for whom vital statistics are not available, it has been determined indirectly that the rate, with a lower and upper limit of 43 and 47 per 1,000 respectively, probably does not differ much from that of the Coloured people. Then follow the Asiatics (Indians) with an average rate of 38·6 births per 1,000 during the period 1936 to 1952, while the Europeans reveal the lowest fertility rate; their birth-rate is lower than that of Asiatics by more than 12 per 1,000. Of all the ethnic groups, only the Europeans have experienced a secular decline in their birth-rate.

11. Because the Asiatics have a relatively low deathrate, their net natural increase over the entire period 1936-1952, at a rate of 25 per 1,000 on the average, was the highest. Then follow the Coloured people with a rate of 23·2 per 1,000 and the Europeans with 16·9. Since 1951, however, the Coloureds surpass all other groups. In spite of their high fertility, the rate of natural increase of the Bantu is only 15 per 1,000 as a result of the high mortality among them. The Net Reproduction Rate, which allows of a more accurate comparison of potential population growth, amounts to approximately 1·45 for Bantu, 1·54 for Europeans, 2·03 for Coloured persons and 2·12 for Asiatics.

12. An analysis of the age distribution of married women, indicates that the Asiatic population includes the largest relative number of potential mothers at the most fertile phase of life. In this respect, the Europeans are the worst off, while the Bantu and the Coloured people occupy an intermediate position. Moreover, marriage does not play so important a part in the process of propagation among the two last-named groups as among Europeans and Asiatics. Illegitimate births seldom constitute less than one-third of the total Coloured births, and it may be expected that the relative figure will also be comparatively high among urban Bantu.

13. Fertility differentials are found in respect of urban and rural communities and socio-economic classes. The European rural community is more fertile than the urban dwellers, while the

opposite tendency has been found among Coloured people and Asiatics. Although, in consequence of the excess of males, the birth-rate of the Bantu will be lower in the cities than in the rural areas, it may be doubted whether the fertility of urban women is lower. The contrary appears to be more probable.

14. While the size of the European family is negatively correlated with the social status of the father, measured, *inter alia*, by income and occupation, we find that Bantu and Asiatic families are larger in proportion to income. In contrast with the Europeans, the size of families in the last-mentioned cases is not necessarily a consequence of the economic status, but may also be a cause thereof.

V. AGE AND SEX COMPOSITION

15. In South Africa, as in the rest of the world, more boys than girls are born. While, however, an average of 105·7 European boys are born for every 100 girls, the ratio is much lower among non-Europeans, namely less than 103 : 100 in the case of Coloured people and Asiatics. It appears to be still lower among the Bantu. However, boys are subject to a higher mortality with the result that the excess of males disappears at about the age of 45 to 50, so that at the higher age levels there is an excess of females. The Asiatic population represents an exception to this, inasmuch as the expectation of life of their girls at birth is lower than that of their boys, a phenomenon which must be mainly attributed to the early marriages and high fertility of the females.

16. The masculinity ratio of the total population in 1946, was 101·4, 104·2, 109·7 and 100·7 for Europeans, Bantu, Asiatics and Coloured persons respectively. This represents a diminution since the beginning of Union, save in the case of the Bantu. The causes of the decline are the decrease, after 1904, in European immigration—the majority of whom were males, the sex-selective emigration of Indians and the greater decline in mortality among female Coloured persons than among males. The masculinity ratio of the Bantu, on the contrary, has been raised by increasing immigration of Foreign Natives, among whom males predominate numerically. The exclusion of the latter lowers the masculinity ratio from 104·2 to 95·5.

17. Among the four ethnic groups, only the Europeans have 'aged' as a result of the lowering of the birth-rate and decreased immigration, that is to say, the relative number of children has diminished while older persons have increased in numerical importance. The small measure of 'aging' apparently experienced by the Bantu group has been artificially induced by the reinforcement of those at the productive period of life, by temporary migrant labourers. When these alien-born elements are eliminated, it appears that the age distribution of the Bantu has remained almost stationary. The Coloured and Asiatic populations have even become 'younger'; that is to say, the number of children has increased relatively. This is a consequence of the maintenance of a high birth-rate, while mortality has diminished, and as already mentioned, the saving of lives is largely concentrated at the first year of life. An accessory factor in the case of Asiatics is the age-selective effect of emigration, in so far as it was especially men in the middle age groups who emigrated to India.

18. As in the case of any other under-developed population which has a high birth-rate and whose death-rate has not yet reached the low level of Western countries, our non-European population is weighed down by the burden of a high dependency ratio, that is to say, there is a large number of children under 15, who may be regarded as non-productive. Although the number of old persons of 65 and older, who do not normally perform productive work, is small, this does not compensate for the large percentage of dependent children. The total number of persons in these two age groups expressed as a percentage of those in the ages 15 to 64, amounts to only 58 in the case of Europeans, but to 74 among the Bantu and to 85 and 95 among Coloured presons and Asiatics respectively. When only the indigenous Bantu population is taken into account, their dependency ratio amounts to 82 instead of 74 as stated above.

In simpler terms this burden of dependency implies a greater number of dependent children per family; a factor which renders the attainment of a higher level of material welfare more difficult.

VI. URBANIZATION

19. The urbanization of the South African population is a consequence of economic development, especially of the secondary industries which for the most part are established in urban areas. The rural areas do not offer sufficient opportunities for work or opportunities which are sufficiently remunerative. The Bantu Areas are an outstanding example of such rural areas.

20. While at the time of the census of 1904, fewer than one-quarter of the total population of the Union lived in the urban areas, the proportion in 1951 was 42·6 per cent. The absolute numbers rose from 1,222,000 in 1904 to 5,374,000 in 1951. To this increase the Bantu contributed 1,954,000 in comparison with 1,469,000 by the Europeans. The latter are the most urbanized group with 78·4 per cent of its members resident in towns, as compared with 77·5 per cent and 64·4 per cent in the case of Asiatics and Coloured persons respectively. Although the 1951 census only registered 27·1 per cent of the Bantu population, or 2,312,000, as living in the urban areas, this, compared to an initial percentage of 10·4 per cent in 1904, represents a much more rapid increase during the past half century than is found among any of the other groups. In 1904, they constituted less than 30 per cent of the urban inhabitants. Today their share is 43 per cent. Notwithstanding this, the increase of the rural population of the Union must be largely ascribed to the growth of the Bantu population, in view of the fact that the Asiatic and Coloured inhabitants of the rural areas have not increased to any significant extent and that the number of European rural dwellers has remained practically unchanged.

21. In order to determine the intensity of the urbanization process, the increase in urban inhabitants may be expressed as a percentage of the increase of the total population. In the case of Coloured persons and Asiatics, the proportion in question was sometimes considerably higher than 100 per cent in earlier years, but in recent times it appears to have declined to 90 per cent and lower. The intensity of European urbanization has increased with the years, to reach 115 per cent. during the decade 1936 to 1946, after which it declined slightly. Among the Bantu, there was a secular rise in the rate of urbanization, until during the years 1946 to 1951 the Bantu urban dwellers were increasing at a rate of 60 per cent of their total population increase, or by 85,000 persons per year on the average. However, the position of the Bantu differs from that of the other groups inasmuch as a large number of the former who are counted in the urban areas at the time of census, are not permanent inhabitants, but temporary migrant labourers from the Bantu Areas or from outside the Union. There are probably not more than 2,000,000 indigenous Bantu resident in urban areas, instead of the 2,312,000 mentioned above.

22. A large measure of concentration of urban inhabitants has been taking place in the four industrial areas of the Western Cape, Southern Transvaal, Durban-Pinetown, and Port Elizabeth. Out of a total of 5,374,000 urban dwellers, 3,451,000 were living in these four areas in 1951. Almost two-thirds of the urban Bantu were concentrated here in 1951, after a numerical increase in the course of three decades at a much faster tempo than in the case of the other three groups. Striking evidence of this movement is the influx into the Western Cape Region where the Bantu was almost an unknown figure in earlier years.

23. The age distribution of the urban population groups, reveals the usual pattern of a concentration of large numbers in the middle ages, a consequence of the fact that it is more especially persons of working age who migrate to the cities. Among Europeans there are 1·9 persons of working age for every 1 person in the 'unproductive' ages. Among Bantu the ratio is 3·3 persons, and while there is an excess of women in the case of Europeans and Coloured persons, we find a numerical preponderance of Bantu males in the towns. This is associated with the custom among the Bantu males of periodically seeking work outside their reserves, and with the large-scale temporary immigration from our neighbouring territories in which, in the nature of things, women cannot participate so easily. Nevertheless, it is a characteristic of this urbanisation that Bantu women are taking part in it to an increasing extent.

VII. HOW MANY BANTU ARE PERMANENTLY SETTLED IN THE URBAN AREAS?

24. When it is desired to determine how many of the Bantu are already 'permanently' settled in the towns and cities, we are confronted with the problem that the interpretation of the term 'permanent' presents many difficulties in itself, and that probably a number of degrees of 'permanency' can be distinguished. Various methods have been applied to determine the extent of the

established Bantu urban population. The conclusion has been drawn that there may have been a minimum of 1,036,000 and a maximum of 1,618,000 of such Bantu in 1951, and that the actual number cannot differ much from 1,500,000. On the basis of data relating to family dwellings for the Bantu, it may be assumed that 314,000 families have already accepted the urban areas as their abode. Migration of Bantu women to the towns is usually of a permanent nature. At the end of 1951, there was a shortage of 167,000 family dwellings, and provision for this need will require the expenditure of approximately £35,000,000.

VIII. GEOGRAPHICAL DISTRIBUTION

25. As regards the geographical distribution of the population among the four provinces, the 1951 census disclosed that the largest number of persons, namely 38 per cent, and also the largest number of Europeans and Bantu, 45·6 per cent and 40·7 per cent of the two groups respectively, were living in the Transvaal. The large majority of Coloured persons and Asiatics is concentrated in the Cape Province and Natal respectively. Until 1936, the Cape was the most populous province. The fact that the Transvaal has now assumed this position, must be attributed particularly to the industrial development on the Witwatersrand, to which not only Europeans but also Bantu from the Cape and Natal reserves have migrated either temporarily or permanently.

26. The distribution of the Bantu between the Bantu Areas and the rest of the country is of importance. According to the data of 1951, 27·1 per cent of them were resident in urban areas, 42·6 per cent in the Bantu Areas and 30·3 per cent on European farms and in the remaining rural areas. The last-named portion, the remaining rural areas, did not contain more than about 6 per cent of the total. These figures include persons of foreign birth, of whom most are only temporary inhabitants. If they are excluded, the share of the urban areas in the distribution of the settled population decreases to less than 25 per cent, and that of the Bantu Areas rises to more than 45 per cent.

Viewing the matter historically, the urban areas have increased in importance as temporary or permanent dwelling-places for the Bantu, and the Bantu Areas, European farms and other rural areas have diminished in importance. To the increase in the number of Bantu urban residents since 1936, the European farms and other rural areas contributed 40 per cent, the Bantu Areas 8 per cent, foreign countries 23 per cent and the natural increase of the towns themselves 29 per cent.

27. It should be emphasised that these conclusions are based on census data which indicate the *de facto* distribution at a given period. In Chapter 13, for instance, it is shown that the *de jure* population of the Bantu Areas—that is to say, those who regard these areas as their home, and some of whom were only temporarily absent when the census was taken—amount to more than half of the total.

IN PART II: THE BANTU AREAS

IN CHAPTER 13: THE POPULATION OF THE BANTU AREAS

I. SIZE OF POPULATION

1. On the basis of census data and estimates furnished by Native Commissioners, the Commission ascertained that the *de facto* population of the Bantu Areas during the census taken in May, 1951, amounted to approximately 3,633,000. This figure has reference to the number actually present in these Areas and, therefore, differs from the *de jure* population which also includes the number of temporary absentees. The 3,633,000 Bantu are distributed among the five main administrative regions of the Bantu Areas as follows: Ciskei 264,000, Transkei 1,202,000, Natal (including Zululand) 926,000, Northern Areas 927,000, Western Areas 314,000.

2. Until 1946, the *de facto* population of the Bantu Areas increased at a slower rate than the total Bantu population and also slower than the indigenous (or South African-born) population. Between 1946 and 1951, however, the increase took place at a higher tempo than that of the latter. This must be attributed chiefly to the extension of the area of land exclusively reserved for the use of the Bantu, a conclusion which is confirmed when the distribution of the population increase among the five main regions, is compared with the geographical distribution of this territorial expansion. The numbers of the inhabitants of the Bantu Areas in the Transkei, Ciskei and Natal, which have received the smallest increase of land since 1936, have also increased least, and have, in fact even decreased since 1946. These tendencies may be regarded as an indication that the three regions named, have reached saturation point at their present level of development.

3. During the census of 1951, 42·6 per cent. of the total Bantu population, and 46·3 per cent. of the indigenous Bantu, were present in the Bantu Areas. This represents a slight decline in comparison with 1946.

II. HOW MANY OF THE BANTU REGARD THE BANTU AREAS AS THEIR HOME

4. At the time of the census in 1951, according to the calculations of the Commission, there were about 569,000 persons temporarily absent from the Bantu Areas. If this number is added to the *de facto* population of 3,633,000, we get a *de jure* population of 4,202,000. That is to say, more than 4,200,000 Bantu still had their homes in the Bantu Areas. This represents an increase of more than 800,000 over the figure of 1936, when the total was 3,410,000 and the number of absentees 447,000. It follows from this, that more than half the indigenous Bantu of the Union regard the Bantu Areas as their home.

IV. MORTALITY

9. The results of various sample studies undertaken in connection with mortality among the Bantu, do not coincide. Evidence points to the fact, however, that about one-fifth to one-quarter of the children born, die within the first year of life. Among all populations, the infant mortality rate is higher than that for older persons, and this tendency is found in an intensified form in undeveloped communities. Nearly 55 per cent. of those born, attain the working age of 16 years. The causes of the high mortality rate may be briefly listed as follows: The low material standard of living, the high birth-rate, the unhygienic conditions, the exposure of children, the primitive custom of compelling the suckling to take substantial nourishment, damage to the rectum; etc. It is difficult to determine how far the Bantu abandon their customs and to what extent their ignorance diminishes when they come into contact with European customs and morals. Bantu women are, however, making use on an increasing scale of maternity facilities and medical advice.

10. In Chapter 7 of the Report, the average mortality rate for the total Bantu population of the Union, was stated as being between 27 and 32 per 1,000. It is possible that large-scale urbanization may have raised the death-rate for urban areas above that of the Bantu Areas in the beginning, but that the position has been changing in recent times.

V. FERTILITY

11. To obtain information in connection with fertility, the Commission undertook sample studies in the following regions: Zululand, Transkei (Umzimkulu and locations), Northern Transvaal (planned and unplanned locations), Olifantsrivier, Njelele and Bochem. On this basis it was ascertained that the average Bantu family in the Bantu Areas, which functions as an economic unit and may consist of a father, one or more mothers, their own children and dependents, consists of 6·27 members.

12. Moreover, it was found that the average number of living children per *family* (excluding dependents), based on the arithmetical average, amounted to 3·7, and the number per *wife* to 3·17. The difference between the two figures is due to the fact that in some families there is more than one mother. The data collected reflect, however, a very great variation in the net fertility of marriages. For example, in 5·2 per cent of the families there were no children, while in 6·8 per cent there were 8 and more children. The greatest number, however, namely 65·6 per cent disclosed between 2 and 5 children. The large variation is a function, *inter alia*, of the composition of the families, some of which include 2 or 3 mothers, and the variety of ages among parents.

13. If the infant mortality is taken into account, it can be determined that the average number of live births per woman included in the sample surveys, amounted to 5·16, and the average number per family to 6. If the mortality among women during their fertile period, is also taken into account, the number of

children to whom a married woman will give birth before she reaches her 46th year, may be put at between 6·5 and 7.

14. The Commission found a reasonably high degree of positive correlation between the incidence of monogamous marriages and the number of children per wife. That is to say, polygamy tends to lead to a smaller number of births per woman than in the case of monogamous unions. Consequently, the promotion of monogamy by the Christian religion and contact with Europeans, may lead to an increase in fertility.

15. In the Bantu Areas, in accordance with the custom that the infant must first attain a measure of independence from constant maternal care before a subsequent child is procreated, about three years usually elapse between the birth of one child and that of the next. Viewed in this light, the absence of males as a result of the system of migratory labour, should not have much influence on fertility, except in cases where they remain away longer than say, two years. It may also happen that men in the Bantu Areas act as substitutes, in the spirit of the Bantu tradition that the reproductive faculties should not be left unutilised. The custom with regard to the spacing of births may also result in the fertility of women in the tribal territories being lower than that of women in the urban areas where the decline of family life, and the disappearance or diminution of the influence of public sanctions, encourage illegitimacy.

CHAPTER 15: HEALTH

I. HEALTH CONDITIONS IN THE BANTU AREAS

1. As the Bantu Areas lie scattered among the European areas in all four provinces of the Union, diseases occurring in a particular part of the Union are liable to affect the Bantu and European areas in that region to the same extent.

2. Vital statistics reflect the health of a community. Much of the information required in respect of the Bantu Areas is, however, unreliable. The notification of births and deaths became compulsory for the rural Bantu only in July, 1953, while, as many such Bantu either do not seek assistance or consult witch doctors, the incidence of disease is not accurately known. An indication of health conditions in the Bantu Areas can, however, be obtained from reports submitted by district surgeons and others and from surveys. Ill-health can be considered under two general headings, viz. non-infectious and infectious conditions:—

3. *Non-infectious Conditions.*—There is a fair amount of nutritional disorder among the Bantu. There is also a high incidence of eye disease and of blindness. Primary carcinoma of the liver is relatively more common in the Bantu than in the European. Acute appendicitis, formerly a condition seldom found amongst Bantu, is now occurring more frequently in the reserves. Umbilical hernia is commonly seen especially in the younger age groups. Diabetes mellitus is rare. Pneumonia is common, as are also scabies and impetigo.

Figures reflecting the incidence of dental caries amongst the Bantu vary considerably. It appears that the incidence is lowest in the primitive Bantu and highest in those who have been in contact with our European civilisation for a long period,

4. *Infectious and Communicable Conditions.*—As a result of unhygienic conditions and the abundance of flies, gastro-intestinal troubles including typhoid fever, as well as helminthic infestations are relatively common.

Venereal diseases. All the five venereal diseases occur in the Union. Syphilis and gonorrhoea are the diseases most commonly encountered; chancroid occurs less frequently and is mainly confined to the coastal areas; lymphogranuloma venereum and granuloma inguinale are seen only occasionally. As venereal disease is not notifiable in the Union, no reliable statistics are available. Results of surveys which have been carried out from time to time show a positivity rate for syphilis which as indicated by a positive Wassermann, varies considerably. Two of the more recent surveys gave the following results: 35·27 per cent in the Polela area in Natal (1941/46) and 7·4 per cent in random batches of Bantu from the Eastern Cape Bantu Areas (1947). The State provides a nation-wide free anti-venereal disease service available to all racial groups, and with modern methods of treatment this is proving very effective.

Tuberculosis. Surveys conducted with the minjature mass X-ray mobile units in the Bantu Areas, suggest that pulmonary tuberculosis occurs as frequently in the rural as in the urban areas and that the incidence rate is probably not lower than 0·8 per cent. A survey of 7,569 rural Bantu in the Northern and Eastern Transvaal in 1953, showed active disease in 0·7 per cent of those X-rayed. A survey of 2,653 Bantu in the Port Sheptone district in 1950, revealed 1·5 per cent with active disease. The problem is being dealt with actively by means of an increase in hospital accommodation, generous subsidies to local authorities for the care and treatment of cases, the provision of mobile X-ray units for the detection of cases and the provision of the most modern medical and surgical treatment.

Bilharzia. Some of the areas most heavily infested with bilharzia are in the Transvaal—especially the lowveld. Surveys conducted recently showed a high incidence rate of the urinary as well as the intestinal form—as high as 60-90 per cent of the Bantu examined in certain areas, having one or other of these infestations. The disease occurs also in Natal and to a much lesser extent in the Eastern Cape.

Malaria. Malaria is most liable to occur mainly in the Northern Transvaal and Natal. The intensive preventive measures applied have now brought this desease well under control so that the Bantu as well as the Europeans in these areas where it was formerly rife, are now free from the ravages of this disease.

Leprosy. As a result of the policy of compulsory segregation, which has been strictly applied over many years, the incidence of leprosy in the Union is comparatively low and has been estimated recently at 0·77 per 1,000. The prognosis in this disease is improving rapidly as a result of the new sulphone therapy. There are at present only some 2,000 Bantu patients under treatment at the various institutions. Because many are now discharged after a relatively short period of treatment, with the disease arrested, more and more Bantu sufferers now voluntarily seek treatment.

Trachoma. Although less than 100 cases of trachoma in all races are usually notified each year, surveys conducted recently suggest that the disease may occur more frequently than was formerly supposed in the Bantu areas.

Epidemic Typhus Fever. Epidemic typhus fever occurs mostly amongst the non-Europeans and generally runs a mild course in the Bantu. At least 90 per cent of cases occur in the Ciskei-Transkei areas. Since 1944, this disease has been brought under control, especially in these Bantu Areas, by field units employing D.D.T.

Smallpox. Smallpox usually but not always runs a mild course in the Bantu among whom it was very prevalent until 1944. Since that year, teams of lay vaccinators have virtually eliminated this disease from the Bantu Areas.

Plague. Plague which is spread by certain veld rodents occurs sporadically over a wide area of the Union particularly the Orange Free State, parts of the Northren Cape and of the South Western Transvaal. The Ciskei-Transkei area is relatively free except for the Quamata basin in the St. Marks District. A few human cases occur each year, mostly amongst Bantu who are more likely to come in contact with infected rodents in the veld. The mortality rate is high for both Europeans and non-Europeans, especially when the disease occurs in the pneumonic or septicaemic forms. Systematic antirodent measures have reduced the incidence of the disease and the advent of the sulphonamides and streptomycin has improved the patients' chances of recovery considerably.

5. Human cases of actinomycosis, hydatid cyst and malta fever occur only occasionally in the Union.

6. Only 3-4 human cases (all races) of rabies are notified each year.

7. Human trypanosomiasis does not occur in the Union, although tsetse flies exist in a defined area in Natal.

8. Tape-worm infestation is common in the Bantu Areas.

II. HEALTH SERVICES FOR THE BANTU AREAS

9. The Bantu Areas do not constitute a separate health entity for which special statutory arrangements exist. For health administrative purposes, each Bantu area is an integral part of the local authority district within the boundaries of which it is located. Health services are provided by the various agencies, as a rule irrespective of the ethnological origin of the community concerned. The agencies providing these services can be considered under the following headings:

A. Services Provided by Statutory Bodies

10. These bodies are the Central, Provincial and the Local Authority Governments. The primary responsibility for carrying

out the provisions of the Public Health Act rests with the local authority for the area concerned. Its health functions which are detailed in the Act, relate, *inter alia*, to the control of infectious disease and where necessary for this purpose, to the provision of isolation facilities and cleansing and disinfecting stations, while it is also its duty to ensure that sanitary conditions are satisfactory and that domestic water, milk and food are produced and sold under hygienic conditions.

11. The Bantu Areas are all rural areas and are, therefore, administered by the rural local authorities, i.e. by divisional councils or by magistrates acting as local authorities in terms of section 9 of the Act, when they act on the authority and instructions of the Ministry of Health. As the magistrate lacks the technical qualification and has no health staff, he depends on the assistance of the Union Health Department's district surgeons and other regional staff; the expenditure incurred on health work in these districts is recoverable from the Provincial Administration concerned except for that portion which would have been refunded by the Department to a statutory local authority.

12. The Union Health Department has, for administrative purposes, divided the Union into six health regions. Each regional office operates under the general direction of the Department's head office in Pretoria and administers or supervises the services in the region it controls. The Department provides the following services:—

13. A *curative* medical service, through its district surgeons, health centres and other clinics. This service is mainly for indigents to which category the bulk of the Bantu in the reserves belong. It includes the supply of free medical appliances (spectacles, artificial limbs, etc.) to indigents. The district surgeons also do the medico-legal work in their areas and provide a nation-wide free anti-venereal disease service.

Hospital services, for the following categories of patients—the mentally ill, the feeble minded, tuberculosis cases, lepers and a few small institutions for special cases of venereal disease.

A *laboratory service*, either through its own laboratories at Cape Town and Durban, or by arrangement with provincial hospital laboratories or the laboratories of the South African Institute for Medical Research.

A *preventive service*. In areas where the magistrate is the local authority, the regional staff undertakes the work necessary. This staff also supervises the preventive and general health services of the local authority areas, gives advice on technical difficulties, may coerce the local authority when necessary or may temporarily take over its functions, e.g. when an outbreak of infectious disease is not being dealth with satisfactorily. The regional office also administers the Foods, Drugs and Disinfectants Act, and the provisions of the Medical, Dental and Pharmacy Act relating to habit-forming drugs and poisons.

A *financing service*, arising out of the statutory refunds and grants-in-aid provided for in the Public Health Act in respect of health services and facilities provided by local authorities, provincial administrations and charitable bodies including missionary societies. The regional staff are responsible for the general supervision of these subsidised services.

14. The provincial administrations are responsible for the provision and maintenance of general hospitals which of course form a very large and important part of the medical and health services of the country. In addition to providing their own hospitals the provincial administrations contribute towards the capital cost of mission hospitals which are generally situated in the Bantu Areas. The operational costs of assisted hospitals are also subsidised by the provincial administrations, each province having its own basis on which this is calculated. Broadly, the provinces are responsible for general hospital services while the Union Health Department is responsible for special hospitals as indicated above, and for all extra-institutional services.

15. A measure of correlation and co-ordination of the general hospitals and other personal health services provided by the Provincial and the Central Governments respectively, is secured by the Central Health Services and Hospitals Co-ordinating Council.

16. In exercising their control of local authorities, the provinces have enacted ordinances which confer or impose powers and duties of a complementary nature to the Public Health Act, on local authorities and empower them to make 'health' by-laws which are usually based on standard regulations drawn up by the provinces with the technical advice of the Union Health Department.

B. Services provided by Non-statutory Health Bodies

17. *The South African National Tuberculosis Association*, (SANTA) deals with tuberculosis. It has raised funds from the public and establishes and maintains tuberculosis settlements with financial assistance from the Union Health Department in respect of capital and operational costs.

Missionary societies maintain mission hospitals and sometimes operate district nursing services with liberal financial assistance of the Union Health Department.

Certain large *employers* of labour, such as the gold mining companies, provide extensive medical services. They carry out medical examination of recruits for their respective industries and promote the health of their labourers by good feeding, housing and the provision of adequate medical and hospital facilities. A certain amount of health educational work is also undertaken.

Charitable organisations, in the form of voluntary committees provide district nursing services with the financial assistance of the Union Health Department. Financial assistance is also available from the Deferred Pay Interest Fund in those areas where Bantu are recruited for employment on the mines.

Other voluntary bodies, such as the S.A. Red Cross Society, the S.A. Council for the Blind, the Cripple Care Association, and the National Council for the Deaf provide services which in most cases are available to all races, including of course the Bantu.

C. Services provided by Private Practitioners

18. Most of the doctors in the Union, including specialists, provide their services by private practice at a fee payable by the patient. There is no racial bar between doctors and patients and most of the doctors in the Bantu Areas are Europeans.

19. A fair number of nurses practise their calling privately either through a nursing agency or as independent practitioners, either as general nurses or midwives or in both these capacities. If considered necessary and in the public interest, the Union Health Department supplements the earnings of a private nurse, European or non-European.

20. The great majority of dentists in the Union provide their services by private practice at a fee payable by the patient. There is no racial bar between dentists and patients. A measure of free dental services available to all races is provided by the provincial administrations, the Union Health Department, certain local authorities and voluntary organisations subsidised by the statutory bodies, and by the two universities with dental faculties.

IN PART III: DEVELOPMENT OF THE BANTU AREAS

CHAPTER 41: PROPOSALS FOR A HEALTH SERVICE

I. INTRODUCTION

1. In Chapter 15, the existing health services are reviewed and it is indicated that the district of a magistrate or a divisional council, in the Cape Province, constitutes the district of a rural health authority. For health administrative purposes, the Bantu Areas falling within the boundaries of such a district, form an integral part of that district. Certain difficulties arise out of this arrangement. Most of the rural local authorities have done little towards development of their health services, their activities in this regard often being limited to action in connection with outbreaks of infectious disease. The position is aggravated by the fact that the Bantu Areas within their boundaries, contribute little or nothing towards the expenditure incurred on health services by the local authority concerned. Confusion is created by the fact that, unlike magistrates in these districts, Native Commissioners do not provide health facilities, while the multiplicity of agencies providing health services described in Chapter 15, leads to overlapping and maldistribution of available services and facilities.

2. These difficulties could be alleviated by having a single health authority to provide all the facilities required for a complete service in the Bantu Areas. This health authority should employ Bantu wherever possible although in the initial period they should

work under the supervision of suitable Europeans to supervise the introduction of the service.

II. REQUIREMENTS FOR A FULL HEALTH SERVICE

3. The following facilities will be required for such a service:
(*i*) hospitals in the following categories:—
(*a*) general (including maternity, orthopaedic, chronic sick and convalescent);
(*b*) infectious diseases (general infectious disease, tuberculosis, venereal disease, and leprosy); and
(*c*) mental (including institutions for the feebleminded);
(ii) clinics (operated by specialists, medical officers of health or clinical medical officers, general practitioners, dentists and clinic nurses on outpatient lines) for—
(*a*) specialist attention;
(*b*) medical and dental attention including minor ailments, dressings, etc.;
(*c*) ante-natal and post-natal attention including birth control;
(*d*) paediatrics, including preventive immunization facilities; and
(*e*) venereal disease and tuberculosis diagnosis and treatment on out-patient lines;
(iii) laboratories;
(iv) ambulances;
(v) domiciliary medical services;
(vi) nursing services by district nurses (for minor ailments, general nursing assistance and midwifery), and health visitors (doing health educational work with special reference to tuberculosis, venereal disease and other infectious diseases);
(vii) non-personal health services—sanitation, environmental health, etc., by sanitary inspectors with field assistants; and
(viii) training facilities.

4. The personnel for such a service will comprise medical specialists, general practitioners, medical officers of health, clinical medical officers, dentists, clinic nurses, district nurses, health visitors, sanitary inspectors and field assistants.

A survey of the facilities available to the Bantu Areas revealed the following:—

A. Personnel

5. To date no Bantu has been registered as a *medical specialist* in any of the 21 recognised specialities. Although specialist practice is almost confined to the larger towns, facilities exist whereby Bantu indigents, like paying patients, may be sent to such places where specialist services are available.

6. The number of *doctors* registered in the Union in 1948, has been compared with the 1946 census figures, and it was found that there were then 2,381 persons of all races per doctor in the Union as a whole, while in the five Bantu Areas there were 4,640 Bantu per doctor. It is usually considered that there should be about one medical practitioner per 1,000 population.

7. There were 5,777 medical practitioners on the Medical Register in 1951, of whom 61 were Bantu; of the 55 practising in the Union, 29 or 53·5 per cent had settled in the Bantu Areas.

8. There are 444 district surgeons in the Union of whom 385 are part-time and 59 whole-time. Of the district surgeons 200 are stationed in districts with extensive Bantu Areas; 167, including three missionary doctors and one Bantu [private practitioner, are part-time district surgeons, the remaining 33 being whole-time district surgeons.

9. *Medical Officers of Health* are responsible for the health services which the employing local authority provides. The Union Health Department refunds one-third of the salary of a whole-time medical officer of health to the local authority. As far as is known, no Bantu practitioner in the Union has the diploma in public health which is necessary for appointment to a post of whole-time medical officer of health.

Clinical Medical Officers are engaged by local authorities in clinical work either in an isolation hospital or in an out-patient clinic. The Union Department refunds seven-eights of the salary of whole-time clinical officers, and the same proportion of the expenditure incurred by local authorities employing part-time officers on a 'per hour session' basis. It is not known what number of clinical medical officers are employed in the Bantu Areas.

There were 991 registered *dentists* in the Union in 1951. It is considered that there should be no more than 5,000 non-Europeans per dentist. There are no Bantu dentists practising in the Union, and no facilities exist for their training; it is not known what dental clinical facilities exist in the Native Areas.

Clinic and hospital nurses are the counterpart of the clinical medical officers working in clinics or isolation hospitals.

District nurses are expected to devote most of their time to domiciliary visits. They may have either the general or the midwifery qualification, or both, depending on the requirements of the employing body. In the Bantu Areas, Bantu nurses with provincial hospital certificates, mission hospital certificates or mines hospital certificates are also acceptable for refund purposes if no nurses with registerable qualifications are available. There are at present 204 district nurses employed in the Bantu Areas, with the assistance of the statutory refunds, and also 14 subsidised nurses.

Health visitors are normally employed on health educational and preventive work in respect of, for example, infectious diseases and child welfare. They may conduct ante-natal and post-natal clinics under the supervision of a doctor. The incumbents must have either the midwifery or the general certificate as well as a health visitor's certificate. A mothercraft certificate is always regarded as a strong recommendation for appointment. It appears that a number of Bantu nurses have qualified for this type of work, although the number working in the Bantu Areas is not known.

Health Inspectors attend to the non-personal health services for which local authorities are responsible. The Union Health Department refunds one-third of a health inspector's salary to the employing local authority. Bantu may qualify as health inspectors but few, if any, have done so.

Field Assistants are uncertified persons employed, mainly by the State, on field control work in connection with malaria, bilharzia, typhus, plague, small-pox and general sanitation work, such as D.D.T. deverminization duties, work as lay vaccinators and organising rural Bantu communities for immunization. The few Bantu employed as field assistants, are proving most useful.

B. Hospitals

10. The beds for Bantu patients in hospitals in the Bantu districts, are available to patients from both the 'Bantu' and 'European' Areas of these districts, and also from surrounding districts. The 'population per bed' ratio is, therefore, not related to the population of the Bantu Areas alone, but is based on the total Bantu population of the Bantu Area district.

11. In general hospitals, there is 1 bed per 644·3 Bantu population. A ratio of 1 bed per 500 Bantu population is considered to be a reasonable standard for Bantu rural areas. On this basis, there is a shortfall of 2,563 beds. Mission hospitals provide 43·8 per cent of the available general beds. There is no accommodation for the chronic sick.

12. There is a total of 2,217 beds for Bantu suffering from infectious diseases—excluding leprosy—in the Bantu Area districts, and 51·5 per cent of these are provided in mission hospitals. The bed position regarding infectious disease patients is not unsatisfactory except that there is a shortage of beds for patients suffering from pulmonary tuberculosis; the number of beds available for leprosy patients, exceeds the demand.

13. The hospital accommodation available for mentally disordered Bantu patients, falls far short of the demand while there are no institutions for feeble-minded Bantu patients.

C. Clinics

14. Out-patient clinics are attached to most general hospitals, both provincial and missionary. Some such clinics provide for dental sessions.

15. Detached general out-patient clinics are maintained in some urban areas located in the Bantu Areas districts. They are established and operated by local authorities on a seven-eights refund payable by the Union Health Department or, where they are run by a provincial administration, on a 100 per cent refund basis.

16. Tuberculosis and venereal disease clinics are provided and operated by local authorities on a seven-eights refund payable by the Union Health Department. There are seven tuberculosis and 22 venereal disease clinics in the Bantu Areas districts.

17. Grants are made annually by the Union Health Department to voluntary societies, in respect of medicines and dressings used at 47 dispensaries in the Bantu Areas.

18. Most of the 204 district nursing services in the Bantu Areas,

are operated from clinics which serve as headquarters. The type of service provided depends on the qualifications of the nurse employed. The buildings and equipment are provided by the employing body.

19. Doctors, usually district surgeons, authorised by the Union Health Department, visit areas lacking medical aid in various districts, in terms of Section *four* of Act No. 36 of 1927, to provide an out-patient service. The Union Health Department also authorises district surgeons to visit specific areas in order to treat venereal disease. At the same time other patients may be seen. In view of the modern treatment employed, these visits are for a limited period only, so that accommodation is usually not provided.

20. At the health centres, free medical, maternity and child welfare services—including immunization work and health education—are provided on an outpatient basis. A certain amount of domiciliary work within a radius of about three miles of a centre is also undertaken by the staff. The staff usually comprise medical officers, nurses, midwives and health assistants, the latter being employed as recorders, educators and sideroom workers. In the Bantu Areas districts, there are 12 health centres, some of which have sub-centres.

21. Ambulance services in the Bantu Areas are inadequate. The Union Health Department provides ambulances at its hospitals and at some of its health centres, and bears the cost of transportation of indigent patients as a measure of poor relief.

Local authorities in the larger centres operate ambulance services for both infectious and non-infectious patients, while some charitable organisations such as missions, the Red Cross Society and the St. John's Ambulance Brigade, also operate a few ambulances.

D. Training Facilities

22. There are facilities in most spheres for the training of Bantu men and women as doctors, nurses and medical auxiliaries. The courses of training and the examinations are identical for European and non-European candidates. Non-Europeans including Bantu, have trained as doctors at the Universities of Cape Town and Witwatersrand since 1937, and in 1952 a medical school, specially for the training of non-European doctors, was established at the Natal University. The normal course extends over six academic years (seven at Natal University), and this is followed by a year of compulsory internship. The Universities of Cape Town and the Witwatersrand also conduct post-graduate medical education.

23. There are two dental schools, at the Universities of Pretoria and the Witwatersrand, respectively. The course of training extends over five academic years.

24. Courses of training for certificates in general nursing and in midwifery, registrable with the S.A. Nursing Council, are provided for all races, at the provincial hospitals. Courses of training for the hospital certificate (which is not registrable with the S.A. Nursing Council), are provided for Bantu women at certain provincial, mission and mine hospitals. Post-registration training for senior nurses, is available at three of the medical schools but has not as yet been taken advantage of by Bantu nurses. Certain technical colleges give a course of training for the health visitors' and school nurses' certificates, which is available to all races. There are at present no facilities available in the Union for Bantu girls who wish to nurse mental or mentally defective patients, or who wish to qualify for the mothercraft certificate.

25. Courses of training for the general certificate for sanitary (health) inspectors, are available at various technical colleges and are open to matriculants of all races. Qualified health inspectors may also train for the further certificates in meat and other foodstuffs inspection, tropical diseases and fumigation. The necessary facilities for training for the latter certificates, are provided by certain large local authorities approved for this purpose by the Union Health Department.

26. Courses of training for pharmacists are normally provided at technical colleges, but a parallel system of university training is now being developed. In addition to their academic training, candidates must serve a period of apprenticeship either in a pharmacy or, by a recent decision, in a selected hospital. The fact that the practical training can now take place in a hospital, will overcome the difficulty previously existing for non-Europeans when the apprenticeship had to be served in an 'open' shop.

E. Conclusions

27. A survey of health facilities in the Bantu Areas, indicated that the number of available trained units is inadequate. This is also true of hospitals and related facilities with the exception of hospitals for leprosy, general infectious diseases and venereal diseases. Many of these facilities are, moreover, located outside the Bantu Areas, or are not sited with due regard to the needs of these Areas as a whole, largely due to the fact that these facilities are provided by several different agencies. This could be improved by transferring the health responsibilities of these agencies to a single authority which would be responsible for providing a comprehensive and co-ordinated service. This service should be staffed by Bantu as far as possible to attract trained Bantu to these Areas, but should be operated initially under the direction of Europeans until the Bantu can assume full responsibility.

28. Practical considerations indicate that the Union Health Department, and not an independent Bantu health authority, should develop and operate the service. A network of clinics should form the basis of the service, and the Bantu concerned should contribute to the cost of the service through a health tax. In addition, patients should normally make a small contribution towards the cost at the time the service is rendered. This service should be supplemented by private practice by Bantu.

III. RECOMMENDATIONS FOR A FULL HEALTH SERVICE

29. (i) The Native Commissioners should, for purposes of the Public Health Act, replace magistrates and divisional councils as the rural local authorities for these Bantu Areas. The latter should, if possible, be consolidated into compact blocks, and be divided into a suitable number of Native Commissioner districts.

(ii) In the Bantu Areas, the health responsibilities of all the statutory authorities and also ultimately, with their prior agreement, of the charitable organisations and missionary societies, should be transferred to the Native Affairs Department which should then delegate these responsibilities to the Union Health Department.

(iii) The Union Health Department, in consultation with the Department of Native Affairs, should then be responsible for providing the full range of medical, dental, nursing, laboratory and preventive services—including the necessary hospitals, clinics and ambulances—the basis of which would be formed by a network of clinics. Meantime, the Union Health Department should have powers to control extensions to existing services.

(iv) In order to ensure satisfactory liaison, the Chief Health Officer should appoint a senior medical officer of his staff to act as his adviser in connection with the Bantu Areas, and to co-operate with the Native Affairs Department.

(v) This Bantu health service should be developed on simple lines and financed from a special Bantu Health Services Trust Fund to be established by the Department of Native Affairs and maintained partly by a health tax imposed on all taxable Bantu in the Bantu Areas. Those patients able to pay a small amount should make a contribution at the time of the service, at least in respect of the medicines and dressings supplied. Preventive services and immunization against infectious diseases, should, however, be provided free of charge. The extent of the services provided will naturally depend upon the moneys available in the Fund.

(vi) The Bantu health service should be staffed as far as possible, by qualified Bantu personnel working initially under the general supervision of Europeans who should, however, gradually be replaced by suitable Bantu incumbents. Bantu private practitioners should be permitted to supplement this service. Non-Bantu private practitioners already in practice in these areas should not be disturbed, but the influx of additional prospective non-Bantu private practitioners should be controlled by a permit system.

IN PART V: RECOMMENDATIONS AND POSSIBLE IMPLICATIONS

IN CHAPTER 50: RECOMMENDATIONS

VII. SOCIAL SERVICES

D. Health

(i) The health conditions of the Bantu and the health services made available in the Bantu Areas, are analysed in Chapter 15. Recommendations in regard to the institution of a comprehensive

medical service for the Bantu Areas, are set out in detail in Chapter 41. It was found that, with the exception of hospitals for leprosy and general infectious diseases, the present hospital facilities in the Bantu Areas, are not capable of providing for the need that exists there.

(ii) The Commission is of opinion that the present problem in regard to medical services can be overcome by the establishment of a Bantu Health Service, supplemented by private medical doctors, dentists, nurses and other practioners.

(iii) In order to privide for the special requirements of the Bantu Areas, the Commission recommends that Native Commissioners should replace both Magistrates and Divisional Councils, as rural health authorities in the Bantu Areas.

(iv) Regarding the establishment of a Bantu Health Service, the Commission recommends that the Union Department of Health, the provincial administrations, local authorities as well as all private undertakings, eventually including the missionary societies, should transfer their health service and responsibilities in the Bantu Areas, to the Department of Native Affairs. This Department should then delegate these responsibilities to the Union Department of Health. Simultaneously, the Commission recommends the appointment of an officer of senior rank in the Department of Health, with the following principal duties:—

(*a*) to study the public health problems of the Bantu Areas for the purpose of keeping the Secretary for Health informed; and

(*b*) to act as liaison officer between the Secretary for Health and the Department of Native Affairs.

(v) With reference to the proposed Bantu Health Service, the Commission recommends further that—

(*a*) it assumes the health services and responsibilities of all the other bodies concerned, eventually including those of the mission societies;

(*b*) it assumes responsibility for hospital services (including the erection of new hospitals), and controls the expansion of private hospitals, clinics etc.;

(*c*) it should provide a full range of medical, dental, nursing, laboratory and preventive services, through the medium of a network of Bantu clinics;

(*d*) this service be financed from a special Bantu Health Services Trust Fund which will have to be established by the Department of Native Affairs, and partially maintained by a health tax imposed on all taxable Bantu in the Bantu Areas; and.

(*e*) the personnel of this health service should consist, as far as possible, of qualified Bantu, and that the European personnel be gradually replaced by suitable Bantu.

(vi) In order to encourage Bantu medical doctors to practise among their own people in the Bantu Areas, the Commission recommends that European and other non-Bantu practitioners should only be allowed to practise in the Bantu Areas under a permit system.