(c) Transport

(i) In Native areas the clinics are placed at distances of from twelve up to thirty-five miles from the hospitals, usually over very bad roads. The cost of travelling is thus a considerable item in the doctor's budget. Where the doctor is a district surgeon he is able to recover this item from the Union Government at the rate of 1/- per mile.

It is strongly urged that where a Mission Hospital has organised a system of clinics the doctor should be appointed assistant district surgeon and his travelling expenses recovered in the same way as those who have been appointed district surgeons; and that where this is not done the Provincial Administration should pay the travelling expenses at the same rate, i.e. 1/- per mile.

(ii) In respect of the transport of patients to hospital it is suggested that the extra payment of 6d. per mile now made to district surgeons for the transport of pauper patients under a magistrate's order he made applicable even where the hospital doctor is not a district surgeon.

FINANCE

At present Mission hospitals are financed from the following sources:-

(a) Grants from Mission Boards
(b) Patients Fees
(c) Provincial Grants - arbitrarily fixed without relation to any criterion
(d) Grants from the Native Affairs Department for the training of nurses conditional on certain medical and nursing staffing requirements
(e) Grants from the Union Health Department in respect of infectious cases at the rate of 2/6 per patient per day
(f) Donations from such bodies as the Board of Control for Deferred Pay, Native Recruiting Corporation, and European sympathisers in South Africa and oversea.

With regard to (a) Mission Boards are finding it very difficult to maintain, let alone to increase, the grants they make. The starving of Native Education by the State has, in recent years, compelled the Missions to carry a great proportion of the burden of meeting the demand for education among the Bantu; the necessity for entering the field of social welfare, particularly in urban areas has imposed new financial burdens on them; and the remarkable response of the Bantu to medical missions has challenged the Boards to strain their resources to the utmost. But, while the calls on Missions have increased enormously, their financial resources have not proved as elastic. It is time that, despite the ravages of the Great War, the religious public in Europe and America even increased their support of missions; but the financial depressions of the post war period have made inroads on the revenues of Missions. How the present War will affect Missions we cannot foretell; but already all Missions have had to face the necessity for drastic cuts in expenditure. Hitherto the Bantu have not benefited from the general prosperity through increased wages, although they have, it is true, benefited through a reduction in their unemployment. Since

as has been stated the vast bulk are too poor to pay the fees as laid down by hospitals, it is not likely that they will be able to bear any greater share of the cost of medical services through increased hospital and other fees. On the other hand, State revenue in South Africa has been mounting in an astonishing way in recent years, and there are signs that South Africa as a whole will experience, for a period at any rate, financial prosperity. The Missions cannot be expected to increase their contributions even if they manage to maintain them: any advance in Native health organisatioh must be financed by or through the State.

We understand that the Union Government has informed the Provinces that it has accepted, in principle, greater responsibility for the financing of Native hospitalisation. If this means that the Union Government has recognised that the great increase in Native hospitalisation in recent years justifies an increase in the grant which the Union Treasury makes annually to the Provinces, we welcome the decision since it will enable the Provinces more easily to meet the increased cost and to do more justice to Medical Missions.

But if this should mean that the Native Trust Fund is to be raided for Native hospitatlisation as well as for the various social services which have recently been cast upon the Fund, then we must protest in all earnestness. Apart from the utter inadequacy of the resources of the Fund to bear these burdens it is utterly wrong to ignore the fact that over 80% of all our unskilled labour engaged in all forms of activity which gives us our national income is Native. Practically the whole of our taxation depends upon their labour and they are, therefore, partners in our national economic system. To provide medical services for the Bantu is not only to safeguard the health of the Europeans, it is to recognise the right of the Bantu to a fair share of the fruits of their labour in the form of Social Services.

The separation of Native health can only lead to the isolation of the Bantu from the national health organisation and the removal from the national consciousness of the urgency of the necessity for arresting the steep decline in the health and physical efficiency of that three-fourths of the population upon whose labour our national economy depends.

MM.

Misc.41/39

MEDICAL SERVICES IN THE SIBASA AREA

The purpose of this memorandum is to submit suggestions for the extension and improvement of medical services in the Sibasa area, a district with an area of 3,500 square miles and a population of 153,000. As these suggestions are based upon the experience gained in the area during the last six years, it is necessary first to outline briefly the existing services.

Up to 1930 the area was virtually without medical services of any kind. The nearest hospital was at Elim, 50 miles away, and the nearest district surgeon was at Louis Trichardt, 60 miles away. In 1930 the Church of Scotland appointed Dr. Lamont as a medical missionary at Gooldville, and on his resignation, the present writer, Dr. R.D. Aitken, was appointed.

In 1934 a small hospital was opened at Gooldville in the centre of the area, and a start was made with the training of Native nursing assistants. The doctor in charge of this was appointed Additional District Surgeon for a part of the area, west of the Levubu River. By 1937 three Native girls had completed their training and it was possible to make a start with the establishment of outlying clinics, and with a system of periodical tours by the Additional District Surgeon in the course of which these clinics were visited.

These clinics were established first of all on other mission stations, belonging to the Berlin Mission and the Gereformeerde Kerk, for the following reasons:-

1. Some of these stations were on large farms with a population in the case of Tshakoma for instance of four or five thousand people, who were already accustomed to go to the missionaries in charge for help in times of sickness.

2. The missionaries were prepared to provide quarters for the nurses and to take an interest in their welfare, as well as to supervise their work. This was a consideration of very great importance in ensuring the successful starting of the scheme.

The position at present is therefore that we have in the Sibasa area:-

1. A central hospital, the Donald Fraser Hospital with 40 beds under the care of a medical superintendent and a qualified matron. There is a staff of 8 probationers who are being trained as "Native Nursing Assistants". We hope to increase this number to 10 or 12 by the end of the year.

2. Associated with the hospital are four clinics with Native Nursing Assistants in charge. These are at Sibasa itself, Tshakoma, Georgenholtz, and Siloam. At Siloam a small hospital has recently been built with accommodation for 12 patients. The Additional District Surgeon visits the clinic at Sibasa once a week and the others once a fortnight.

3. In addition there are four centres, Thengwe, Tshaula, Ramputa and Makuya, which are visited once a month, but where there is no nurse in charge.

- At -

At the clinics the nurse sees patients every day, and carries out such simple treatments as dressing wounds and ulcers, irrigating eyes, and applying poultices, and also gives out such remedies as quinine, aspirin and a few simple mixtures. She visits patients who are unable to come to the clinic, and advises those who need medical attention to come for examination at the doctor's next visit. In the case of those who evidently need hospital treatment, but are afraid to submit to this, she is often successful in overcoming their fear and the opposition of their relatives, and in persuading them to agree to go to hospital. In this way she is doing work of considerable educative value. The extent of the work done by these nurses is shown by the fact that in 1938 the total number of attendances at these clinics was 12,521.

The doctor visits the clinics in a light delivery truck, in which he carries a stock of medicines and dressings. On each tour he sees a number of patients, and those who require hospital treatment are taken back with him in the truck. On some of these tours he frequently sees as many as 50 or 60 patients. During this year he has seen to date 1,888 patients at the clinics and centres, and of these 103 were brought into hospital.

The experience gained in this way has shown that the major health problems in this area are Malaria, Bilharzia, Septic conditions due to infected wounds, Blindness due to cataract and neglected infections of the eye, Syphilis and to a less extent Leprosy. During the last two years there has also been a widespread epidemic of Tropical Ulcer. The success of the clinics and tours in dealing with these and many other conditions seems to us to justify an extension of these services, and the following suggestions are therefore submitted:-

1. The <u>establishment of more clinics</u> with nursing assistants or orderlies in charge. It is suggested that in addition to the existing clinics at Sibasa, Tshakoma, Georgenholtz and Siloam, the following centres are suitable for the establishment of new clinics:- Tshaula, Thengwe, Ramputa, Tshifudi, Mukula, Beuster, Lomondo, Phiphidi and Makuya. A map is attached with this memorandum showing the position of these in relation to the hospital. It would of course be impossible to establish all of these immediately, but if this programme was accepted it should be possible to aim at starting three new clinics each year, and so completing the scheme within three or four years. With a view to this I propose to apply to the Native Affairs Department for dispensary sites at each of these centres with the exception of Beuster. This is a station of the Berlin Mission, and I am already assured that the missionaries there will welcome the establishment of a clinic there.

The chief difficulty in starting these clinics will be to obtain Native Nursing Assistants to staff them. For some years we had considerable difficulty in getting girls from this district to take up nursing, and we had to take girls from other districts, who were not always willing to remain in the area after they had completed their training. We now have 6 Venda girls in training out of a total of 8 probationers, so that this difficulty should soon be overcome. If the scheme I am advocating is approved and there is a reasonable prospect of the nurses

being able to obtain posts here when they complete their training, we could ask them to give an undertaking to serve for at least three years in the area after they qualify and we could in future make this a condition of accepting them for training. As it is I hope to have three nurses ready for posts by the end of next year and another three the following year.

It will be noted that I have not included any sites in the Knobnose, Mawambe, Tshikundu and Mhinga locations, as these are outside the area of my district surgeoncy. These locations are at present without any adequate medical service, but I believe it would be possible for me to visit clinics there, if they were established. I would be prepared to do this if it were desired, and provided that I did not have to undertake any other district surgeon's duties, such as medico-legal work, in these locations. Such duties would be carried on as at present by the District Surgeon, Louis Trichardt.

2. <u>More frequent periodical tours by the doctor</u>. Ideally each clinic should be visited once a week, but it is quite impossible for one doctor to do this. At present one clinic is visited weekly, three fortnightly, and four centres are visited monthly, the programme of tours being as follows:-

Fortnightly:
1. Vondwe, Makula & Georgenholtz
2. Sibasa, Lomondo and Tshakoma
3. Sibasa, Phiphidi, Khalavha & Siloam

Monthly:
1. Tshaula
2. Thengwe
3. Ramputa
4. Makuya

All the centres for new clinics which I have suggested lie on the route of the present periodical tours, and could therefore be visited without any great increase in the travelling necessary. I suggest that an immediate improvement could be affected by rearranging the tours as follows: -

Fortnightly:
1. Vondwe, Georgenholtz, Thengwe
2. Makula, Tshifudi, Tshaula
3. Sibasa, Lomondo, Tshakoma
4. Sibasa, Beuster, Phiphidi Khalavha, Siloam
5. Matangari, Tshiombo, Ramputa.

If it is desired and can be arranged it would also be possible to include

6. Mawambe, Tshikundu, Mhinga.

This programme would involve being away from headquarters three times a week and I do not think that more frequent absences would be justified. I propose to make application to the Public Health Department for approval of the first five of these tours at an early date.

3. Training of orderlies for public health work. At present a number of "malaria spotters" are employed in the district to arrange for the distribution of spray pumps and insecticide. I have seen very little of their work, but they appear to me to be men of rather poor education who carry out their duties somewhat perfunctorily and mechanically.

I suggest that it would be preferable to secure three or four men of better education, (if possible with some training as Teachers), and give them six months or a year intensive training dealing particularly with malaria, bilharzia, sepsis and infection, causes of blindness, syphilis, and leprosy. These men would then form a mobile corps of Health Assistants to move about the district giving instruction on these subjects, combatting popular superstitions, spotting cases of infectious disease, particularly syphilis, and arranging for suitable treatment. They would make the work of the hospital and its clinics better known and arrange for patients to see the doctor when he is out on tour. They could also work in conjunction with the agricultural demonstrators to encourage the growth and use of vegetables and fruit.

4. Measures for dealing with Bilharzia. Bilharzia is widespread in the district. In some schools 70% to 90% of the children have been found to be infected. At present sporadic cases come to hospital for treatment but the great majority go untreated. I believe that it would be possible to arrange for a specified area to be taken and for all the children in that area to be examined. The headmen in that area would then be made responsible for seeing that all those found to be infested attend regularly for treatment at a convenient centre. Treatment would be carried out by an orderly specially trained for the work. It should be possible to deal with 6 or 8 such areas each year.

Estimated Cost of the Above Scheme

If the scheme which I have outlined were approved and put into effect over a period of three or four years it would result in a greatly improved health service for this area at a comparatively small cost. I estimate the cost of the service as follows:-

Salary of Additional District Surgeon as at present	£200
Cost of travelling on proposed tours (This does not include the tour to Mhinga)	£300
Salaries of 12 Native nursing assistants, commencing at £48 p.a. and increasing to £72 after 5 years	£864
Salaries of 3 orderlies, commencing at £72 p.a. and increasing to £96 after 5 years	£288
TOTAL	£1,652

In addition there would be the actual cost of drugs and dressings used at the clinics, which would amount to approximately £350. A total expenditure of £2,000 per annum would therefore result in a greatly improved service, and it should be remembered that this means an increase of only £1,400 on present expenditure.

The capital cost of providing buildings for the clinics would also have to be considered. At two of the existing clinics there are already suitable buildings, so that another 10 would eventually be needed. I believe that these could be provided at a cost of about £200 each, which would mean a total capital expenditure of £2,000

spread over three years. Probably the question of how this money should be provided would have to be a matter of negotiation between the various Departments concerned.

Increase of Qualified Staff

One difficulty in giving effect to these proposals must be considered. At present there is only one doctor in the Sibasa area, and even now it is difficult for him to do justice to the needs of the area. It might be possible to make a start with the programme outlined and to carry out at least a part of it for a year or two, but the need for another doctor will soon become urgent. If the Provincial Council can be persuaded to give the Donald Fraser Hospital more adequate support than it does at present, it would be possible to provide the salary of another doctor almost at once, and I could arrange to give him more of the hospital work to do, while I gave more time to the organisationand administration of the health service throughout the district. Alternatively if the Public Health Department will increase my salary as Additional District Surgeon in view of the increased work that I shall be undertaking, I could then employ an assistant to relieve me of some of the work. Without such assistance I do not see that we could undertake the training of the Health Assistants at present.

Co-ordination of Preventive and Curative Services

The scheme which I have outlined above is one in which both preventive and curative work will be closely co-ordinated. It is highly desirable that this should be so. In this area we are dealing with very primitive people, who are still very suspicious of the white man's medicines and his methods of dealing with disease, particularly when these involve treatment in hospital. The result is that they frequently do not seek medical help until they are driven to do so by the failure of other means to give them relief. One of the first tasksof preventive medicine in this area is to undermine this suspicion and fear, and replace it by confidence in modern medical and surgical methods. This cannot be done unless there exists within the district adequate clinical facilities for the treatment of disease.

In illustration of this I should like to refer to the experience gained in our hospital. In 1938 we treated 381 patients in the hospital, of whom 74 or approximately 20% were suffering from septic conditions such as septic fingers and hands and osteomyelitis. We frequently see cases where quite trivial wounds are neglected and lead to the loss of a finger or hand, which could have been saved by earlier treatment. Clearly it is of no use telling people this and urging them to seek early treatment, unless you bring the means of treatment within their reach.

Practicability of the Scheme

I believe that the scheme which I am submitting has the further advantage that it can be carried out under the existing laws and regulations. The Additional District Surgeon has already been appointed, and authority given for him to carry out periodical tours. The re-arrangements of these tours involves very little increased expenditure, and even if they were eventually to be made weekly instead of fortnightly, the additional

cost would only be another £300 p.a. The greater part of the increased expenditure is for the salaries of Native Nursing Assistants, and represents simply an expansion of an existing service. Provision already exists under the Public Health Amendment Act for such appointments. The only new features of the scheme are
1. The proposal to train and use a staff of Health Assistants for constructive health work in the district.
2. The necessity for a grant for the expenditure on drugs and dressings used at the clinics in addition to the nurses' salaries. The responsibility for this grant would probably have to be settled by the various bodies concerned.

Summary

The main points of the scheme are therefore:-

1. The recognition of the Donald Fraser Hospital as the medical headquarters of the district with associated clinics and Health Assistants attached to it.

2. The provision of a further 9 or 10 clinics with Native Nursing Assistants in charge.

3. The revision of the periodical tours so that the clinics can be visited at least once a fortnight, and later once a week.

4. The training and supervising of a staff of Health Assistants to work throughout the area.

5. Provision either by the Provincial Council or by the Health Department of funds so that the qualified medical staff can be increased.

As a first step towards carrying out the scheme I propose to apply:-

1. To the Native Affairs Department for dispensary sites at suitable centres.

2. To the Public Health Department for approval for a revised scheme of periodical tours in the district.

Method of Financing the Scheme

At several points in the above memorandum I have indicated the need for allocating the responsibility for financing the various sections of the proposed scheme. It appears to me that there is provision under the existing legislation for the scheme to be financed as follows:-

1. The Native Affairs Department to continue to subsidise the training of the Native Nursing Assistants who are needed to staff the clinics.

2. The Provincial Council to subsidise the actual cost of treatment at the hospital and the clinics on the basis suggested by the Medical Work Committee of the Christian Council:-

a. A subsidy of 2/6 per patient per day for the hospital
b. A grant of £200 for each clinic built, to cover cost of building and equipment
c. A subsidy of 6d. per attendance at clinicsup to 10,000 attendances and thereafter 4d. per attendance.

3. The Union Department of Public Health to support the scheme by :-

a. Continuing to pay the salary of the Additional District Surgeon
b. Continuing to pay the salaries of the Native Nursing Assistants and employing more of these, as well as Health Assistants
c. Continuing to pay the travelling allowance of the Additional District Surgeon for his periodical tours.

While the details of the above scheme apply to the Sibasa area, I believe that the general principles on which it is based are applicable to practically all areas in which there is a mission hospital.

MM.