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My task to-night in dealing with Health and People in general, and, Health and the Non-Europeans in South Africa in particular, is to avoid the part of a private physician who studies the individual and describes the causative factor, the signs, symptoms, pathology, and treatment of his patient.

I must assume the role of the epidemiologist who studies a disease or diseases as they invade the crowd or spread in the community. Like the philosopher, he tries to synthesise our knowledge and tries to heope us see things together.

In order to get a broad basis for our discussion, we must gather our facts wherever they have been proved. We shall make use of parallel experiences that throw light on our discussion from other countries.

Speaking generally, it is the aim and hope of the Union Public Health Department to carry out a satisfactory preventive medicine department. However, they only direct the Public Health Department and not the purse strings of the country.

Since the subject has been narrowed down to Health of the Non-European, I am inclined to confine my discussion to Africans except, with reference to Tuberculosis on the part of the coloured people, and accomodation provided for Indians by employers in certain estates in Natal, respectively. My reason for this separation is based on differential wage-scales as between Africans and the other Non-Europeans, and, the difference , both in equipment and fitting, in the municipal housing schemes put for these sections.

In discussing this question of Health of the African, we must ask ourselves questions whose answers must become as we develop the discussion.

Let us consider what has wealth or lack of it to do with health? Is education a factor in public health? How far do occupation, income and housing contribute to their ill-health? How far does their income level permit them to supply for themselves the bare necessaries of life? Are they able to purchase and maintain their health and well-being by means of adequate food, suitable clothing, comfortable

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shelter? How far does their income-level affect their employability and health? What diseases, if any, would suggest that their income-levels and their education play an important part? Given good accomodation, are they able to maintain it? If not, why not? Once health is lost what means have they within their control to restore it? in other words, are they able to obtain regular and adequate medical care ? Is there any relation between nutrition and sickness among them? How does this affect their industrieal efficiency, and what is its effect on their National well-being?

I believe that the prevalance and duration of illness among individuals, families or communities are conditioned largely by the income-level of the different classes.

Someone has said that "when the family income falls below a certain level, the standard of living rapidly declines." It is generally true to say that Health determines the wealth, progress and happiness of a people. From the public health point of view or from the point of view of preventive medicine, wealth determines health.

Our emphasis, therefore, will not be on death rates or mortality rates, important though these are; but we wish to point out that certain factors such as morbidity, imparred health, disablement, loss of earning capacity, chronic illness and finally death, are directly or indirectly influenced by social conditions and economic status of a people or community.

PROBLEMS IN THE STUDY OF NATIVE HEALTH. As soon as one desires to approach this subject of health seriously and intelligently, one is, at once, up against the difficulty of the lack of vital statistics. As far back as 1934 in a lecture before the World Education Fellowship Conference in Johannesburg, the present speaker pointed out how handicapped serious students of public health are , because of the absence of vital statistics pertaining to the Non-Europeans in particular. This is largely due to the fact that the census in South African in 1921 was taken for the whole population but for the quinquennia 1926 and 1931 respectively it was taken for white people only. In 1936 the census of the whole population was again taken.

The vital statistics in South Africa have been prepared for Europeans only. Birth rates and death rates refer to Europeans only. Consequently our so called vital statistics in South Africa do not reflect the true picture or give a cross section of the state of health of the Union population. They are a sample selected with a bias and are likely to be misleading, valueless to one who wishes to know the whole truth abouth South Africa. There are no compulsory registrations of births and deaths among Africans

Income-levels determine the ability or not to purchase sufficient food, fuel and clothing. They have a direct bearing on housing conditions and the presence or absence of overcrowding. All things being equal, they also influence the social conditions, the level of intelligence or education of individual families or communities. When incomes fail or are absent people go with little or no food, they are scantily or poorly clothed, they cannot afford fuel, they cannot afford adequate accomodation, they 'double-up' to reduce expense and thereby lead to overcrowding and slum conditions. As a result they develop a bad state of nutrition. They suffer from exposure, they drift into dilapidated premises that are often unfit for human habitation and prejudicial to health. They are 'packed up like sardines' with little or no amenities. They are devitalised. They become suitable soil for any infection or contagion that may begin. Deficiency of food supply leads to a bad state of nutrition, loss of efficiency for physical or mental work, reduced resistance to disease and even illness itself.

The food deficiency may be primary, that is (a) inability to get food, (b) insufficiency of food, lack of balance or deficiency in food accessories or vitamins.

It may be secondary, that is, inability for the body to use the food due perhaps to physiological disturbances or personal idiosyncracies.

The Africans or aborigineas in South Africa are suffering from increasing primary food deficiency or starvation more particularly since 1913 when the Natives' Land Bill was passed leading to evictions and aimless migration of these people from European farms with no homes for themselves or land for the grazing of their livestock. This has left them in a bad state of nutrition and poor physique. That is why mine recruiting agents reject them in large numbers. Even those who appear fit from casual inspection reveal their subnormal physical state as soon as they are put under stress and strain of labour. They must therefore be gradually built up and fed adequately before they are fit for a full day's job.

Such a state of affairs is a challenge for the powers that be to seek the root causes and remove them for this is remedial waste of human material and an economic loss to the victims of the system and to the country as a whole.

Taken as a whole, the Africans are the poorest section of the community. There are causes that are both fundamental and contributory to this state of affairs. The Natives' Land Act (1913) which segregated Europeans from Africans in rural areas aggravated poverty among the African people. The Urban areas Act (1923) segregating Africans from Europeans in urban areas has had the same

effect upon the town dwellers. The Colour Bar in Industry, the White Labour Policy and the restriction or exclusion of the African Industrial Labourer from certain Industrial legislation awards has not only forced the African out of what seemed to be traditional employment but has tendedt to depress his wage scale. The result has been to doom the African as a worker to the lowest income-level possible in South Africa.

The Land Act (1913) made many Africans landless and homeless. Many lost their livestock - their wealth - while trekking from pillar to post in search of land and home. Thus they became poverty-stricken and destitute. The result was increasing overcrowding and poverty in the reserves. The limited land in the reserves became overcrowded and land became overworked and eroded through limited pastures.

Some Africans drifted towards towns where they took jobs at any rate of wages thereby reducing or keeping wages at a very low level.

Africans, therefore, in town and in the country cannot get a living wage sufficient wages. They can only get a limited food supply becuase of lack of means to buy food with. They can neither provide nor maintain suitable accomodation for themselves.

There have also been repeated droughts which lead to crop failure and often death of their live-stock.

All this tends to increase poverty and lead to depression therefore a poor state of health if not starvation.

Where is the proverbial good physique of which the African had been known?

It has disappeard with his loss of land and pastures. This has led to scarcity of milk and meat because of the loss of herds and flocks. Formerly, these people often balanced their food with milk. To-day, they feed largely on mealie (pap) porridge, bread and tea. Such a diet is dificient in food accessories or vitimans, and tends to lead to deficiency diseases later or morbidity and disablement.

The conditions must be serious because even the Native Affairs Commission reported that "the Commission has felt much concern at the signs of ill-health and general deterioration of the physique of the natives that are manifest in most reserves." In his Annual report for the year ended June 30th, 1934 (see U.G. no 40/34) the Secretary for Public Health, in referring to the

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excessive mortality among the Bantu, has stated this high mortality must be attributed in the first place to the low social and economic status of the people which is "directly responsible for much preventable morbidity and, mortality." "And," he adds "that most of the deaths among the Natives are due to starvation."

ENVIRONMENTAL FACTORS: Housing. In modern cities housing conditions are considered an important adjunct to any public health scheme. The house should be fit for human habitation meeting a certain standard of fitness with all the amenities that are essential and conducive to health. Above all, the house must be kept and maintained in this habitable state.

However, people of low income-levels and poor economic circumstances often of necessity find themselves leaving under slum conditions. They have no choice. Their present fate binds them there. Even when slum clearance is under consideration, the housing schemes for Africans are considered under the Urban Areas Act which is not a housing Act but a segregation scheme or a scheme for effective control of these people. The standards of area and cubic space are much lower for Africans than for other sections. Besides, in order to satisfy the segregation policy the Africans are often put miles away from towns and places of their work without improving their economic level. Transport and rent eat up their money for food. The long periods spent between home and work is energy that a poor labourer needs to conserve for his work. The locations are often built with white labour which receives many times higher wages than the tenants to whom the municipality is going to rent the houses. These houses are often a shell of brick and iron, no doors between these small rooms, no ceiling, nor flooring. These tenants on the basis of our local municipal wages receive between 12/6 to 21/- a week. With the advent of municipal beer halls, most men must take home much less for their wives and children, hence the family is deprived of money for food and thus starvation in the family follows. By the way, this municipal beer policy is a policy of "robbing Peter to pay Paul". It facilitates the daily expenditure on liquor of moneys that would otherwise go to wife and children. No Public authority that has the interest of the people at heart will ever embark upon a policy that will undermine the welfare and health of mothers and children who are the primary concern and charge of any progressive public authority.

Black labour should participate more freely in these buildings and other schemes. They should be paid adequate and higher wages. Rents should be economic and tenants should have opportunity to buy. Labourers should live near their places of work. They would thereby have more money with which to buy food and therefore better health.

The argument often is that we give our natives accomodation. However, many employers who pretend to give accomodation give poor accomodation as the Union Public Health found in Natal in what is known as Housing of the Industrially employed non-Europeans in Natal. There were 270 estats in which there were 1,400 Indians and 1,400 Native Africans.

In table O(ii) The Union Health Report 1936 shows under "Suitability of Buildings" these were made of wood and iron, brick and wattle and daub native huts, and concrete shacks. The total number was 7,420 dwellings. The report states "Thus a total number of 7,420 dwellings has been inspected and reported on in detail. Of the number 14% are regarded as satisfactory and fit for human habitation according to present standards; 50% as being defective but capable of satisfactory alteration to render them fit for human habitation; 36% more than one-third as being so defective as to be totally unfit for human habitation and structurally incapable of satisfactory alterations. This means in effect, that at the commencement of this campaign, on the estates under review, some 86% non-Europeans employees and their dependents (where present) were living under unhygienic and unsatisfactory conditions."(p. 9 U.G. 1936 ref. ii)

While there are no statistics to show the state of health of these people, some of us have seen many tragic results under such and similar conditions. Anyway, these people would work more efficiently and would be fitter under healthier and under better circumstances.

Overcrowding. The next and third factor is overcrowding which signifies the number of people inhabiting a unit room area. Overcrowding is measured by the number of persons living in an occupied room. Overcrowding as associated with high infant mortality was studied by Newsholme. He studied overcrowding and mortality in children under one year and between one and five years. The results were as shown in the following tables:-

		No.of rooms per tenement.			
		1	2	3	4
Death rate per)	Under 1 year	210	164	129	103
1000 living.)	Between 1 yr. and 5 yrs.	41	30	18	10

7. Death of Children From Various Causes. /.....

~~Causes Of death.~~
~~Pneumonia~~
~~Pneumonia~~
~~Omfo~~

~~Number of rooms.~~			
~~1~~	~~2~~	~~3~~	~~4~~
~~6~~	~~6~~	~~2~~	~~1~~

Death Of Children From Various Causes.

Causes Of Death.	Number Of Rooms.			
	1	2	3	4
Pneumonia	6	6	2	1
Infectious Diseases	16	12	17	3
Diarrhoae and Enteritis	32.8	25.8	14.9	16.8
Respiratory Diseases	39.8	35.5	26.7	20.0

Dr. Feldman says "the death rates from pneumonia and the chief infectious diseases of childhood are propotional to the degree of overcrowding.

"Chalmers, late M.O.H. of Glasgow, always stressed the relationship of housing to high mortality. In Glasgow the tenement houses is still common, and it has been shown that the expected years of life of males aged ten years in one-apartment houses are exceeded by 2.3, 5.56 and 6.13 years respectively in the case of males of the same age living in two, three, and four or more room apartments."

"Magregor of Glasgow (Annual Report, 1926) has pointed out that as the size of the houses increases the incidence of pulmonary tuberculosis diminishes - more noticeably in the case of females." (J.&P. A Synopsis of Hygiene, p. 442)

It is clear therefore that overcrowding increases mortality and morbidity and decreases the life-span.

We now come back to South African conditions on the question of Infantile Mortality. It is generally accepted that more die before they are one year than at any other period of life. According to the Union Health Report 1936 infantile mortality among Europeans was 62.81 per 1000 live births. Ofcourse among Africans it is estimated anywhere between 200-800 per 1000. Deaths are due largely to gastro-intestinal diseases and r espiratory conditions. This figure for infantile mortality is not a true reflection or a correct state of affairs. While we are certain that the mortality rate is in 3 figures per 1000 we, however, are aware that there is more complete report of deaths than births as no one may be buried in urban areas without a death certificate. Many births are not reported and the discovery of their having been born is made after their death.

Gastro-enteritis, the chief cause of infantile mortality among Africans, is commonest during summer months and is associated with filth and flies. It is commonest among hand fed babies as a result of dietetic errors which are due to some changes

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which have taken place either as a result of bad preparation or no proper facilities for protecting food from infection or chemical changes.

Here ignorance and lack of adequate means are twin factors to infantile mortality.

Children of these people with low incomes are usually malnourished (or semi-starved), badly cared for or neglected, live in squalid surroundings, nursed and nutured in ignorance and many end in premature deaths from preventable conditions. In the majority of cases the people cannot afford medical advice for the baby until too late or only when death seems inevitable merely to get a death certificate. If special baby food is advised, they are often unable to supply it regularly and if available they may not be able to prepare and keep it properly partly because of ignorance or lack of proper facilities. Sometimes, the child is left with children only a little larger than itself because the mother must go out to work to supplement the low family income.

As antenatal, marternity and child welfare clinics are uncommon among the African people, the mothers have not had the opportunity of receiving instruction in baby care and feeding, since woman has no natural instinct for the proper upbringing of the baby especially under crowded urban conditions. She must be taught.

Africans have no free milk supplies for children of necessitous parents or school going age as are given to European and coloured children

As you know everything is being done not only to provide facilities for improving the health of the European mother and child but to establish a living wage scale for the European worker. Soup kitchens and milk are provided for necessitous European school children but nothing for Africans. Is there a difference in the physiological make up of the African child that makes these things unnecessary for him? I do not believe so. Yet, it has been said, with truth, that the "child welfare work represents the safest and most fruitful investment which a nation can have!"

There are diseases that are indication that something is socially and economically wrong.

Let us take first Typhus Fever. During 1935, 6,826 cases were reported and 1,605 in 1936. The Secretary of Public Health in his report (1936) suggests that the decline was due to (a) Immunity of the last two years infection. "The second and probably

"very much more important reason is the return of some measure of prosperity (if such an expression could be justified) among the natives in the reserves." Typhus fever or gaol fever spells poverty which encourages overcrowding, filth, lousiness which favour transmission of infection. It used to be common in gaols, in armies, and during famine. The disease occurs during winter months. Poor people have fewer clothing, less change clothings, limited, if any, washing facilities. Poor people tend to huddle together and this encourages and facilitates the activities of the louse - the disease transmitter.

Most African boys or girls often share the same cover because of limited supply of blankets. In certain places a bar of soap being economically a luxury, lousiness is to be expected.

The prevelance of Typhoid Fever or Enteric is considered to be an indication of bad sanitary conditions of an area. During 1936 there were 4,384 cases - 2,949 non Europeans and 1,435 Europeans. It is rare where modern sanitary provisions are made such as water-borne sewerage, good pipe water supply, protection of food and milk from contamnation by human carriers and flies.

Scurvy is a disgrace in a wealthy community like South Africa. Ours is a country of abject poverty in the midst of plenty.

Tuberculosis. There were 8,896 cases reported in 1935 and 8775 in 1936 according to the Secretary of Public Health. He observes that "the difference in these figures is so small that it conveys no information of any practical value, though improved economic conditions among the poorest classes of the community have, no doubt, played part in producing fewer cases of the diseases."

Table K.(i) gives the reported number of Tuberculosis in different areas in the Union in 1936 as follows:- Cape Province Europeans 511, Non-Europeans 4279; Transkei Europeans 1, Non-Europeans 959; Natal Europeans 143, Non-Europeans 1,270; O.F.S. Europeans 28, Non-Europeans 186; Transvaal Europeans 109, Non-Europeans 1,273; T Total Europeans 792, Non Europeans 7963 per 100,000.

From the Annual Report of the Department of Public Health (1936) it is stated that "there are large Native areas from which widely differing reports have been received as to the incidence of the disease. Many of these reports are founded on Native hearsay. But, unfortunately, undoubted evidence is beginning to accumulate that the disease is making serious inroads on the health of the natives even amongst those who had not been exposed to urban or mining conditions. We, have the evidence of many medical men practising in these areas. More recently as a result of reports that the disease was attacking native children of a school-going ages the department arranged with Dr. Westlake Wood, District

surgeon of Bizana to examine the 2252 children."

The results were that 4.5% had Tuberculosis and 3.9% of the number examined had Pulmonary Tuberculosis.

In order for you with me to appreciate the significance of the medico-socio-economic aspect of disease and especially Tuberculosis, I only mention that in Great Britain during the war the incidence of Tuberculosis rose from about 1915 and gradually declined after 1921 to pre-war level. It is said that it assumed almost epidemic proportions in asylums and gaols and among the poor populations similar reports during the same period are available for Prussia and France. 1914-1918 was a period of limited food supply. Food was scarce and dear. In other words, war conditions which meant rationing and starvation for many classes of the belligerent countries favoured the increase of the incidence of Turberculosis.

It is gratifying to record that the State through the Union Department of Public Health is doing much to stem the tide by making beds available for tuberculosis cases where previously there none. The supply is far from enough judgying from long waiting lists for Rietfontein in the Johannesburg area alone.

However, little or nothing has been done for the dependents and the after-care of the victim. Little is done to improve the economic standards of these people by increasing the wages to meet the high or increasing cost of living.

Housing schemes and the nutritional surveys are steps in the right direction, if they are followed by serious attempts to improve social and economic conditions of the people.

When dealing with this problem it must always be realised that incidence of tubberculosis is highest where there are such factors (or combination of them) as poverty, overcrowding, bad housing, ignorance or poor knowledge of personal hygiene and malnutrition or semi-starvation. In South Africa, the African enjoys the effects of them all.

VENEREAL DISEASES.

The incidence varies between rural and urban areas. It is less in rural than in urban areas. However, our labour system of seperating the men from their wives tends to importation of more venereal diseases into rural areas. The incidence is on the increase but it is not as high as certain sentimentalists, politicians and racialists would have us believe. According to newspaper reports it is highest were the author of the statistics quoted knows the least about the actual conditions. Medical men though aware that

the problem is with us are not extravagant in their estimates. To them and for them this is a universal problem. Table M. Venereal Diseases (Union Health Department Report) gives the number of cases treated and attendances during the year ended June 1936 by District Surgeons. For syphilis there were 1,445 Europeans and 69,458 Non-Europeans and 940 and 3,4207 gonorrhoae among the Europeans and Non-Europeans respectively. Total attendances only are shown being 39,000 Europeans and 82,572 Non-Europeans.

In 1939 cases by District Surgeons were 2,482 Europeans and 83,607 Non-Europeans. Attendances at Institutions and Clinics were 60,3404 Europeans and 169,956 Non-Europeans.

It would be wrong to conclude that the large number of Non-Europeans treated by district surgeons or at public institutions indicate a propotionate incidence of the disease. What it does mean, without minimising the true incidence, is that most natives not only cannot afford private treatment and therefore resort to Institutional treatments but also because of their economic status and certain special statutory requirements, they frequently come into contact with district surgeons. Other people who can pay for private treatment choose the latter for social reasons. Likewise, it must not be inferred that the high percentage of attendance at treatments by Europeans means a high incidence of the disease. It only means that they recognising the seriousness of the condition are more likely to remain under treatment until cured.

There are frequently, newspaper suggestions about the control of these diseases. The pet one is "Medical examination of native servants, especially females." What a simple solution!

However, that brings a lot of questions into one's mind such as: How long does such procedure guarantee non-infectivity? What is involved in establishing whether one is "V.D." free or not? More important are the following questions:- Are Venereal diseases a privilege which the gods reserved for African Natives only? If not, is there any wisdom in looking out for certain sources only and leaving out others? Can we hope to stamp out these diseases by following this method? Has the African in South Africa infected the whole civilised world with venereal disease because venereal diseases are an acute problem in most civilised countries?

However that reminds me that in the 17th century Heberdes declared only hated persons were reported as having died from French pox as such.

During my recent extended visit abroad, I found both the British Isles and the United States of America Health authorities much concerned about this V.D. problem.

PLEASE TURN OVER

For years I have adovcated for treatment centres which should be private, conveniently situated and sympathetically administered. People should be encouraged to follow treatment until cured. Information should be given freely about the dangers of these diseases to patient, family and public, and facilities for treatment until cured should be available. This envisages a corps not merely of experts/.....

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venereal diseases experts but of people with the Public Health or preventive point of view.

In the ANNUAL REPORT of the year ended June 30th., 1936, the Secretary of Public Health makes this well considered statement "Public interest in these diseases continues. Unfortunately, though the attitude is not singular to South Africa, this interest only too often expresses itself in demands and resolutions of an impracticable and ignorant nature. Wholesale compulsory examination and treatment are the usual procedures put forward and further, the government is regularly urged to introduce such class and race discriminatory measures as compulsory medical examination of Non-European female servants. Such views reveal the distorted attitude to venereal diseases of large sections of the public." p.50.

In short, I suggest, if we are going to achieve anything to reduce the incidence of V.D., We must face the problem as a detached unsentimental and intelligent manner free from all racial bias.

I have thus endeavoured, breiefly, to point out to you what an important part the Socio-economic conditions play in the health of the African and how far the wealth of the African Native or lack of it conditions his marked state of ill-health.

I have tried to suggest to you, if not to convince you, that much of the unemployability, morbidity, illness and even mortality among the African people are largely influenced by or due to their low income-level which make them victims of conditions of bad housing, overcrowding, malnutrition or semi-starvation, ignorance and bad general sanitary environment.

The present low-level of wages paid the African ~~native~~ by government departments, local authorities, the mines and the industry, the farming community and the employing public in general are not sufficient to meet the ~~xinimum~~minimum nutritional requirements and other essential needs of the African family. The people have to ~~themsex~~ starve themselves on food. They double up to meet high rent charges. They live in slum areas but they are not of slum mentality as proved by the improvements they make in the incomplete fourwalled "shells" of municipal houses in the locations. These people often live in filth and squalor not from choice; but because they cannot and may not ~~xxxxide~~ provide anything better for themselves.

In a forward to a Race Relations Official quarterly of the South African Institute of Race Relations Vo. Vl no 1 "On the subject of 'Problems of Nutrition in South Africa," the Minister of Public Health , the Honourable Richard Stuttaford said "but even if we raise the wage of unskilled labour ten shillings a week, there is no likelihood that an additional ten shillings a week would be spent on protective food; such of it would doubtless go in cinemas/.....

"cinemas, drink, and finery."

This deduction was perhaps, based on the table that appeared on page 4 of the above-named publication. The table shows amounts spent on different types of food-stuffs by five income groups. We shall reproduce the table only in so far as it shows the total amounts spent on food by each income group and the food expenditure expressed as a percentage of the total income as follows:-

"AVERAGE MONTHLY FAMILY EXPENDITURE ON FOOD FOR NINE URBAN AREAS OF THE UNION AS A WHOLE BY FIVE INCOME GROUPS."
(From the Report on the Inquiry into the Expenditure of European Families in Certain Urban Areas, 1936.)

	Up to £125	Over £125 to £150	Over £150 to £175	Over £175 to £200	Over £200 to £225.
	Amount	Amount	Amount	Amount	Amount
Total Expenditure	£3.19.7d.	£4.8.11d.	£5.2.0d.	£5.15.3d.	£6.2.11d.
Food Expenditure expressed as a percentage of the total Income.	39.76	38.69	38.23	37.46	35.27

Taking this abridged table as quoted we find that when food expenditure is expressed as a percentage of the total income, the percentage is highest on the low-income side and lowest on the higher income-level. In other words, people with a minimum income spend a greater proportion of their income on food than people with higher incomes. On the other, hand, as shown by this table, people with higher income-levels spend more actual cash on food, but a lower percentage than people with smaller incomes This is common experience. This is natural. Man, especially twentieth century man, has many other wants and inclinations than food. As soon after food requirements, he tries to gratify these other tendencies which differ according to tastes and attitudes..

There is no factual justification, therefore, to condemn people to these low income-levels only because they will not spend every penny of their income on food.

So far as the Africans are concerned, much of the Union's differential and special Native legislation, and, the general public attitude of the country towards the African needs, have contributed to the present undesirable state. Most, if not all, of these factors are improvable, if not preventable.

"Intelligence is the most potent factor that can be directed

"against disease" says the California Health Bulletin.

In view of these circumstances, is there anything that may be suggested as a start in the right direction? I would say this is primarily a problem of education in its various bearings upon our life. We must educate white South Africans for a proper and intelligent attitude towards the Native Health Problem. We must educate the African himself to be enlightened enough to appreciate the full significance of individual and community health problems. Public school education for the African is essential and fundamental for health propaganda. The general public school should be a centre of health propaganda by a well organised medical school inspection for early detection of deformities of school children and for inculcation of public health sense, and development of a sound knowledge of personal hygiene. The establishment of well organised child and maternity welfare clinics, special clinics for venereal diseases and Tuberculosis are good educational health agencies in themselves. The African people themselves should be afforded ample opportunities to train for the highest qualifications in medicine, surgery, public health and other allied subjects so that they may play their full part in the campaign against ill health.

Clinics that I have referred to are important adjuncts to a health scheme. But more important than clinics is a serious effort to remove some of the root causes of this poor state of health of the African. Firt and foremost - the economic status of the African must be raised. The African must be paid an economic wage. He must not be artificially made a charge and burden on the State by the conspiracy of exploiting and underpaying his labour. If he is given his due reward for his labour he will lift himself out of the filth and squalor in which we now find him. If, the legislative, the land and the industrial restrictions against the African were removed, he would thereby be enabled to be better housed, better fed, better clothed and therefore, healthier.

In order to improve the general health of the Africans there must be a state policy that will do all in its power and spend all reasonable means to remove any preventable conditions that predispose to ill-health of any community irrespective of race or colour.

Disease is democratic and colour-blind. It is gratifying to note that our Medical officers of Health recognise this and act upon it. All would be well for every section if they held the purse-strings of the country.

In conclusion, I would urge with all the earnestness at my command that all welfare services that have proved their value and usefulness among other sections must be made available for every section of the community. And as far as it is humanly possible all racial

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groups should be enabled economically to establish and maintain for themselves a healthy environment.

Wealth is Health. Health is Happiness. We must do all in our power to bring about this wealth and happiness within the reach of all our multicoloured and mutliracial population.