HISTORICAL.—It was not until the end of the nineteenth century that the prevention of tuberculosis become a recognized aim of public policy. Philip's pioneer anti-tuberculosis dispensary at Edinburgh dated from 1887, the first in France was opened in 1902, and the first in England in 1909. Voluntary notification of tuberculosis by doctors had begun in England by 1892, and was made compulsory throughout the country in 1908. From 1899 onwards a rapid building of sanatoria took place, and by 1906 several English local authorities were contributing to them. At that time certain local authorities were making provision for tuberculous patients in their isolation hospitals, and this was followed by the building of sanatorium-hospitals by local authorities. The provision of sanatorium-benefit under the National Insurance Act of 1911 gave a great impetus to the national campaign against tuberculosis.

Dr. Anderson was the pioneer of preventive measures against tuberculosis in South Africa. The disease was made compulsorily notifiable in 1904, and cases reported in Cape Town were systematically visited by health inspectors. A few patients were admitted to the new infectious diseases hospital from 1905 onwards, and in 1909 temporary wards for ten patients were built there, soon afterwards increased to twenty. A nurse was appointed in 1911 for the home visitation of cases. Tuberculosis clinic sessions were in operation by 1912. Nelspoort Sanatorium, made possible by the gift of John Garlick, of Cape Town, was opened by the Union Health Department in 1924.

SOCIAL BACKGROUND.—In conclusion I wish to return to the point that, as a disease of the community, tuberculosis is preeminently associated with bad social conditions, being promoted by poverty, undernourishment, bad housing and overcrowding, ignorance and vice. These factors are in my opinion sufficient to account in the main for the prevalence of the disease in the non-European part of the Cape Town population. It is a remarkable fact that in England and Wales, for example, there was a steady improvement in the tuberculosis position during the second half of the nineteenth century before ever the *ad hoc* measures that are now in operation were instituted. The most probable reason for this is the general social and sanitary improvement which was taking place at that time. Another factor that has been suggested as an explanation is the great amount of hospitalization of advanced pulmonary cases that was practised in the poor-law hospitals, which was done as a measure of relief and not as a preventive measure. It is difficult to explain the check in the fall of the tuberculosis death rate in Cape Town during the last 15 years or so, because during that time the preventive work of the City Health Department was intensified ; and although the number of beds provided for cases of pulmonary tuberculosis is still insufficient it has been considerably increased.

THE FUTURE.—Bad as the statistics show the tuberculosis position amongst the non-Europeans to be, it is probably no worse than what obtained amongst the labouring classes in European countries at the middle of the nineteenth century. The improvement that has since been brought about there gives us reason for confidence that with active measures of social reform and adequate facilities for the discovery, treatment and isolation of cases results no less satisfactory can be obtained in the non-Europeans of this country.

VENEREAL DISEASES

The most important of the venereal diseases are syphilis and gonorrhoea.

SYPHILIS.—Syphilis is justly regarded as one of the most formidable of infectious diseases. It is the cause of an enormous volume of disability and mortality, not only in those who acquire it by infection but also in their offspring.

The disease starts with a sore at the site of infection, followed after a few weeks, but sometimes longer, by an illness marked by eruptions of the skin and mucous membranes. These stages do not necessarily cause much disability and they may even pass unrecognized. Years later they may be followed by syphilitic disease of almost any part of the body, including degenerative conditions of the heart, blood-vessels and central nervous system. About ten per cent. of first admission to mental hospitals (U.S.A., 1930) are cases of general paralysis of the insane (a result of syphilis) and cerebral syphilis.

The child of the syphilitic parent develops the disease *in utero*. Congenital syphilis is estimated to be responsible for more than ten per cent. of pre-natal mortality, and it is the cause of far more infant mortality than is assigned to it in the death returns. In the London County Council schools for the blind (1920) one-third of the cases of blindness were attributed to congenital syphilis.

GONORRHOEA.—The symptoms and complications of gonorrhoea may be very severe and disabling, but fatal cases are now rare. It is a frequent cause of sterility, both in men and women, and it is also the cause of ophthalmia neonatorum, a severe inflammation of the eyes of newborn children. This form of ophthalmia is stated to be one of the chief causes of blindness, but fortunately loss of sight can almost always be prevented by adequate treatment. Ophthalmia neonatorum is compulsorily notifiable, and attention is concentrated on reported cases in order to secure proper treatment.

PREVALENCE.—The Royal Commission on Veneral Diseases (1909-16) estimated that the number of persons who had been infected with syphilis, acquired or congenital, could not be less than ten per cent. of the whole population of the large cities, and that the number infected with gonorrhoea was still greater. It is

difficult to get reliable comparative figures for their incidence. The death returns are less useful than with most other diseases, because firstly there is a tendency to avoid the use of the name of venereal diseases in death certificates, and secondly the cases in which syphilis is recognized as being the original cause of the fatal disease represent only a fraction of the deaths which actually result from it.

Set out below are the deaths (per million population) classified annually under the heading of syphilis for England and Wales, the Union of South Africa, and the City of Cape Town, and for syphilis plus tabes dorsalis and general paralysis of the insane, which are amongst the sequelae of syphilis.

	Syphilis	Syphilis, tabes and G.P.I.
England and Wales (10 years ended 1938) ...	32	75
Union of South Africa (5 years ended 1937) :		
Europeans	60	76
City of Cape Town (10 years ended 1938) :		
Europeans	70	110
Non-Europeans	720	850

Although for the reasons stated these figures should only be accepted with reserve they may be taken as showing that there is far more mortality from syphilis in the Cape Town non-Europeans than in Europeans.

A figure that is sometimes quoted as indicating prevalence is the number of cases attending the public veneral disease clinics. This again is not a reliable figure in the absence of further information, because it obviously depends on what proportion of the total number of cases report at the clinics. The new cases of venereal disease attending at the Cape Town municipal clinics in the year 1939-40 were as follows :

	Primary and Secondary Syphilis (excluding Congenital)	All forms of Syphilis	Gonorrhoea	Other Venereal Diseases
European ...	149	222	340	29
Non-European	663	1,500	662	84

(These figures do not include 727 cases of syphilis, mostly tertiary or latent, found amongst expectant mothers at the pre-natal clinics and maternity hospitals.)

Mode of Spread.—Venereal diseases differ from all other infectious diseases in the mechanism of their spread. It is true that syphilis can be contracted through infection of any mucuous membrane or any part of the skin with discharges from an infected

case, but under present-day conditions of western civilization the proportion of syphilis cases that are due to extragenital infection is small. Published estimates of the proportion vary in different communities from under 1 per cent. up to 10 per cent. The experience of the Cape Town clinics is more in accordance with the former figure. Almost every case of acquired syphilis is contracted by extra-marital intercourse or from a spouse who has caught it in that way.

Extragenital cases of gonorrhoea also appear. Cases of vulvovaginitis in little girls occur from time to time, and multiple cases have been reported from school hostels and other places where children live in crowded and unhygienic conditions. Infection is usually attributed to the use of common towels or other articles, but it is not certain to what extent it may be due to actual personal contact with individuals infected with gonorrhoea.

PREVENTION.—Chastity then is the sovereign preventive of venereal disease, but it seems that this knowledge is no more likely to result in preventing the continuance of the disease than considerations of morality have been.

The next line of defence is protection from possible infection without abstention. The failure of attempts to secure this by the control of prostitution I will do no more than mention. In the coloured people actual prostitution is not a large factor in the promiscuousness that leads to the spread of venereal disease.

There are methods, such as ablution stations and preventive packets, which have been found substantially to lower the frequency of infection amongst soldiers and sailors. It is generally agreed that information about these methods of prevention should be included in the knowledge about venereal disease which everyone should have, especially young persons. There is, however, difference of opinion whether it is desirable to include a public service on these lines as part of official schemes for the control of venereal disease.

The last resource is the medical treatment of the actual case, and this is the policy on which present-day schemes for the combating of venereal disease are based. It has been made possible in syphilis by the revolution in treatment inaugurated by the introduction of the famous 606 remedy in 1910. After the first injection or two the patient ceases to be infective, and during the early stages of the course of treatment the symptoms rapidly clear up. But to remove all possibility of a recurrence of infectiveness, to make marital life safe, and to avoid the threat of dangerous sequelae, it is essential that the complete course of treatment, which will extend over many months, should be taken.

The recent discovery of the value of sulphonamides in gonorrhoea has greatly increased the speed and efficiency of the treatment of this disease, and should lead to an increase in the value of treatment centres from the point of view of the prevention of spread.

In the majority of cases the treatment of venereal disease can

be adequately carried out on out-patient lines, but in some cases in-patient treatment is desirable for medical or social reasons. There are wide differences of opinion about the proportion of cases that ought to be admitted to hospital.

It is recognized that the campaign against venereal disease if it is to be effective must include educational and propaganda work designed to lessen if possible the amount of exposure to infection, and also to induce those who have been exposed to the risk of infection to take the precautions that are available and to make prompt and effective use of the facilities provided by the local authority. The social reform in the depressed classes, both white and coloured, which are necessary to secure proper health conditions, would have as one of its results the fostering of the sense of responsibility that would go far to remedy the present unsatisfactory position regarding venereal disease.

SCHEMES FOR COMBATING VENEREAL DISEASE.—Local authorities' schemes are based on the preventive value of efficient treatment. Treatment centres (clinics) are provided, where free and confidential treatment is available for all. The first object is the prevention of spread and the second object the prevention of the ill effects of the disease in the patients and their unborn children. A subsidy of two-thirds of the approved capital and maintenance costs of the schemes is payable to local authorities by the Union Health Department. The policy of the limitation of subsidies, already referred to, operates so as to reduce the proportional refund to the larger local authorities.

Municipal venereal-disease clinics were started in Cape Town in 1920, and a year later a full-time medical officer was appointed to take charge of the work. There are now, in addition to clinics for natives held at the Langa location, three treatment centres in the City, at which 28 medical sessions are held per week. The centres are also open daily for the irrigation treatment of gonorrhoea. Last year 3,339 new cases attended and the total attendances at medical sessions amounted to 49,355, besides 10,515 attendances for the irrigation treatment of gonorrhoea. The staff of the clinic service includes two full-time specialist medical officers, a number of part-time medical officers, four nurse-visitors and two orderlies. At the City Hospital 24 beds are reserved for venereal-disease cases, and in the year 1939-40 260 patients were admitted. The provision of additional beds is now under consideration.

In the evaluation of the success of municipal schemes the difficulties are again encountered that stand in the way of an estimation of the prevalence of venereal diseases. In England and Wales, where it is believed that 85 per cent. of all new cases attend the public clinics, the death rate from syphilis, tabes, general paralysis, and aneurysm, had been reduced by 1937 to one-half the rate prevailing from 1911 to 1920. The Cape Town figures do not show a corresponding reduction, but a tendency to decline is seen in the syphilis mortality rate of the last few years.

The campaign against venereal disease in South Africa, as in Britain, is not based on compulsion, but on co-operation. The diseases are not compulsorily notifiable by medical practitioners. Compulsory notification, such as is in force in certain countries, is strongly advocated in some quarters, but the Union Health Department share the view of those that hold that such a measure would tend to deter patients from consulting a doctor. There is a section in the Public Health Act of the Union which requires doctors to report cases of "venereal disease in a communicable form" who fail to continue to attend for treatment, but it is practically inoperative. There are other compulsory provisions, including one making it obligatory on patients to obtain medical treatment. Use is made of this power in the follow-up work carried out at the Cape Town venereal disease clinics. Every patient who prematurely defaults in attending is communicated with if he or she can be traced, and if the default continues is reported to the Magistrate in order that the compulsion prescribed by the Act may be applied.

Opsomming

Kindersterfte, Tering, Geslagsiektes

Die drie onderwerpe is nou verbonde aan volkswelsyn.

Die kinderwelsyn-beweging wat vanaf die einde van die negentiende eeu dateer, het gepaard gegaan met 'n afname van kindersterfte en 'n verbetering van die gesondheid van die oorblywendes. Kindersterfte word sterk deur maatskaplike toestande beïnvloed ; maar die afname in die kleurling-kindersterfte in Kaapstad is nie aan maatskaplike verligting toe te skrywe nie. Die kinderwelsyn-beweging het die kindersterfte onder ryk en arm verminder maar in 'n gemeenskap deur maatskaplike euwels geteister kan dit nie die syfer so laag as in 'n welgestelde gemeenskap verminder nie. Die probleem van kinderwelsyn sal nooit vir die nie-blankes opgelos word alvorens hulle maatskaplike peil nie grotendeels verhoog is nie.

In Kaapstad veroorsaak tering meer sterfgevalle as enige ander siekte. Slegte maatskaplike toestande bevorder sowel aansteeklikheid as die vernietiging van weerstandsvermoë. Die ondervinding van Europa laat dink dat daadwerklike maatreëls van maatskaplike verbetering en toereikende fasiliteite vir die ontdekking, behandeling en afsondering van gevalle 'n groot vermindering van tering in Suid-Afrika te weeg kan bring.

Statistieke van sifilis en gonorrhee is onbetroubaar, maar dit blyk dat hierdie siektes algemener is onder die nie-blankes as onder blankes in Kaapstad. Kuisheid is die hoogste beveiliging. Waar kuisheid nie bewaar word nie is die doeltreffendheid van voorkomingsmiddels en die welslae van mediese behandeling gedeeltelik afhanklik van maatskaplike verbetering onder die onderdrukte klasse.

UNDER-NOURISHMENT AND MALNUTRITION

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Read at the Third Session of the Social Survey Conference, Cape Town, 19th February, 1942

In all social surveys, the question of nutrition and malnutrition has featured largely. This is to be expected, since malnutrition might act as criterion of lowered socio-economic status. Furthermore, malnutrition is of very serious import, since its stigmata, especially if acquired in early life, remain in the body permanently, lowering the physical standard of that and subsequent generations and causing the race to deteriorate.

In dealing with the question of under-nourishment and malnutrition, it should be emphasized that while actual under-consumption of essential foods is of course the prime factor, overcrowding, ignorance, lack of sleep, unhappiness, and so on, may contribute just as effectively to cause mal-nourishment. Surveys which the National Nutrition Council are now considering stress the importance of these factors, and I would like also to emphasize them to members of this Conference.

FINDINGS OF THE SURVEY.—The effects of malnutrition do not show themselves equally upon all members of a community. The first to be affected are those whose need is greatest, growing children and pregnant and lactating women. In the reports on malnutrition, issued by the Social Survey, a group of coloured school children have been investigated, clinically and economically. In the Cape Nutrition Survey, carried out on more clinical lines, Coloured, European and Native children were examined. The results from the Coloured children have been incorporated into the Social Survey Reports, but the European and Native children have not been examined from the socio-economic standpoint.

The two reports[1] issued by the Social Survey comprise an assessment of the nutritional status of the Coloured children and the results of an enquiry into their socio-economic status. The children were selected, as far as possible at random, from 13 schools. 55.8 per cent. resided in the Eastern Survey area, and 43.3 per cent. in the Southern area. The first report deals with the Eastern Survey area, and the second report with the Southern area.

769 children, between the ages of 6 and 17, were examined by methods which included the assessment of stature, subcutaneous fat, muscular development, state of the skin, etc. The examination was carried out by a doctor and by a physiologist, acting independently. 62 diseased children were discarded. The remaining children were then classed on the Dunfermline scale, the two upper groups being combined as normally nourished, and the two lower groups as malnourished. Incidentally, it is of interest to note that no test or examination was found which would specifically select a malnourished subject. Many such tests have been described, but none were found to give reliable results.

The conclusions of chief interest arising from this survey are as follows : In the sample analysed, there was an excess of malnourished over normal children, 50 per cent. being malnourished, 42 per cent. normal, and 8 per cent. diseased. It is probable, in the last group, that in many cases, the disease was contributed to by malnourishment. The computers of the survey produce good evidence for supposing that this represents the state of affairs in the population from which the sample was drawn. Certain geographical conclusions were also drawn. The incidence of malnutrition was higher in the Eastern area compared to the Southern area. I will refer to this again later. A curious finding was that mothers born in Cape Town appeared to feed their children less well than those born outside Cape Town. This must be due to the inheritance of bad food habits.

The investigation of the relationship between poverty, malnutrition and age has revealed some interesting points. The first report, on the findings in the Eastern area, showed only a low degree of association between poverty and malnutrition in the population from which the sample was taken, but the second report, which analyses the Southern area, shows a high degree of association between poverty and malnutrition which makes it virtually certain that this relationship exists in the parent population. In arriving at this conclusion, the surveyors have gone into the relationship between malnutrition and age, and poverty and age, in some detail. A negative association was found between malnutrition and age. Physiologically, this is of interest. It may be due to the relatively greater energy requirements of the younger child. The age of 12 was found to be particularly significant in this respect. This may be due to the onset of puberty, as it has been shown by many workers that the basal calorie requirements rise at that age to a higher figure than at any time after the age of two.

The second report on the children in the Southern area showed that there was a lower incidence of malnutrition in this area (48 per cent.) than in the Eastern area where it was 52 per cent. This difference is solely due to the higher incidence of younger children in the sample analysed from the Eastern area. When this is allowed for, there is no significant difference in the incidence of malnutrition in the two areas.

The fact of a positive association between overcrowding and malnutrition, and largeness of family and malnutrition, point essentially to the same causes, among which must figure largely discomfort and unhappiness.

No relationship was found between malnutrition and sex, or malnutrition and lack of sleep.

The report of the Cape Nutrition Survey[2] deals with the more clinical findings. Apart from Coloured children, the findings of which have been incorporated into the reports I have referred to, this team investigated 328 European children and 176 Native children. The incidence of malnutrition was 49 per cent. in the European children, though no claim was made in this case that this represents the state of affairs in the parent population. It does show, however, that in this section of the population widespread malnutrition *can* exist on the same scale as in the Coloured children, where it was 50 per cent.

In the small group of Native children only 32 per cent. were found to be suffering from malnutrition. The clinical examiners state that this low figure may be due to flaws in the assessing technique when applied to Natives, or else to the fact that European standards do not apply to Natives. I will refer to this second point in a moment.

Future Enquiry and Research.—In all surveys conducted so far in this country, it has been assumed that the conditions and standards obtaining overseas can be applied here. Are we justified in applying them indiscriminately? We have as yet no direct evidence that we are not so justified, but much indirect evidence exists to hint, at least, that the standards overseas do not always apply, at any rate, to Natives. Prof. Brock points out in the Report of the Cape Nutrition Survey, that this may be one reason for the low incidence of malnutrition in Natives—namely that though their diets are known to be poor according to the established standards, actually they may not be for Natives, owing to a more efficient utilisation of foodstuffs. Work with which I have been associated supports this view[3], and it is hoped that very soon research work will be undertaken to go into this. This must not be construed into the supposition that I favour poorer diets for Natives. It is merely a statement of possible scientific fact.

Another factor which we have in South Africa and which is much less evident overseas, is the abundant sunshine. It is well known that sunshine will replace vitamin D, the antirachitic vitamin, in the diet, and we may therefore expect that the sunshine in South Africa will reduce the amount of vitamin D that needs to be taken to prevent rickets, though this disease is not unknown here. But we do not know to what extent this holds. Nor do we know the other effects, good or bad, of such continuous sunshine.

Many other purely nutritional questions need to be investi-

gated. With respect to the Social Survey, one investigation that should be done is an enquiry into the food habits of these families that have been investigated—what they eat in detail, the kind of foodstuffs they mostly consume and the amount of protective food they do or do not get. Also what they pay for their food. The kind of investigation I have in mind is that carried out by Sir John Orr and described by him in his book *Food, Health and Income*[4]. Prof. Batson has already issued a report[5] on the amount spent on different foods, but it is also important to know the actual amount of each foodstuff consumed. There is no doubt that protective foods are not consumed in sufficient, or in some cases, in any amount. We need concrete evidence on these points so as to have something really strong behind our arguments. In the report on the Poverty Datum Line[6] several specimen minimum rations, which could be purchased at this economic level, have been listed. It is essential to know how closely the real state of affairs approximates to this.

As I stated earlier, children and pregnant and nursing women first bear the brunt of dietary deficiencies. An investigation of the nutritional and socio-economic status of women, especially of the childbearing age, should be undertaken. Enough evidence exists to show that gross malnutrition exists among children. How many of these stigmata are due to unhealthy mothers and poor lactation must be determined. In surveys carried out overseas[7], anaemia in poorer women has been found to be common, but little is known about conditions here.

FUTURE POLICY.—It seems to me that the following are the chief causes for malnutrition in this country* :

1. Ignorance.
2. Overcrowding.
3. Poverty.
4. Not enough food is produced to supply the population.
5. The Agricultural policy practised is devised primarily to help the producer not the consumer.

1. With regard to ignorance, nutritional education is badly needed throughout the whole country. It is possible that lack of knowledge makes the Cape Town mother a poor caterer for her family. Nutritional education should begin in the schools, children being taught what to eat and why to eat it. Parallel with this, housewives should be taught, by posters and pamphlets and by other means, what food to buy and how to prepare it least wastefully. In this, traditions will have to be broken down and ways of thought changed, especially in the platteland. Professor Cathcart of Glasgow considers ignorance to be as important a factor in

* These are in order of convenience for discussion, not necessarily in order of importance.

malnutrition as poverty. I do not subscribe to this view, but do consider that ignorance is a big factor to contend with.

2. Overcrowding is on paper simpler to alleviate. Many towns overseas have built garden cities and evacuated the inhabitants of slums into them. Here however many pitfalls exist. McGonigle describes in detail in his book[8] how at Stockton-on-Tees a move of this kind led to greater malnutrition owing to increased rents and more spent on travel to work. Any project of this kind will have to be very carefully planned beforehand.

If such moves are contemplated, the question of communal feeding should be considered. In the first place, this method of feeding greatly reduces the price of the flats to be built, as no kitchens are needed in them. It also reduces the expenses of the tenant both as regards provision of cooking and eating utensils, and also usage of water. It also ensures that the tenants do get good food, since if the feeding is properly supervised, good and well balanced rations should be obtainable at a relatively low cost. Dr. Williams, in an informative paper[9], has described methods that could be used for communal feeding, based on the practice of feeding Natives on the Rand, where a good well-balanced meal can be obtained for 3*d*. per day.

3. Poverty. Although treated third for convenience, this is first in order of importance. The remedies for destitution have already been discussed by speakers more competent to deal with it than I am. Nutritionally speaking, poverty is bound up with the questions of inadequate production of foodstuffs and agricultural policy. However, an immediate alleviation can be applied and that is the use of subsidies. A start has been made in the provision of free meals by local authorities at clinics and welfare centres. Cape Town is, I am glad to say, well in advance in this respect, though not nearly enough is yet being done. The provision of an Oslo breakfast, or some similar meal, has proved most successful in Norway and in parts of London[10], and could be easily adopted here. Similarly, the provision of cheap or free food to destitute families, such as state-aided milk and butter schemes, is urgently called for on a larger and more widespread scale.

However, these measures do no more than scratch at the surface of the real sources of the trouble. The first of these is the level of food production.

4. Dr. Haylett[11] has clearly shown that the food production of the Union is inadequate to feed all the inhabitants properly. In 1936, too little meat, cheese, poultry, fish, butter, milk, and potatoes were produced for all members of the population, and too little milk and butter for even the European section alone. On the other hand, the production of cereals and sugar was considerably in excess of the needs of the total population, maize meal being produced in highest amount. Mr. Rees Davies has confirmed and extended these conclusions in a recent number of *Trek*[12].

The only cure for this is a farsighted constructive agricultural policy. This includes a better use of the soil available, the checking of soil erosion, the making of fertilizers more available, irrigation, and particularly education and encouragement of the farmer to grow, not what he likes to grow, but what the country needs, especially in the way of protective foods. The dairy industry in particular should be greatly encouraged.

5. This brings me to my final point, namely the agricultural policy in general now being applied. At present the prices of essential and protective foodstuffs, such as bread, butter and cheese, are higher in this country than overseas. The effects of duties in raising the prices of the constituents of the minimum dietary known as the BMA ("Bare Ration") Diet No. 1, has been worked out by Prof. Batson[13]. The results show that the amount of these essential commodities which can be bought by families with low incomes is considerably cut down by these duties. Looking at it from the purely nutritional point-of-view, it appears that the agricultural policy aims solely to benefit the producer, and takes no note of the consumer. This explains why the farmer concentrates on easily sold commodities, especially for the export market and neglects articles more urgently needed. To overcome this, the whole production of the country should be under the direction of a Ministry of Nutrition, which would be in touch with the needs of the country as a whole, and which would direct the production of such foodstuffs as would satisfy these needs. Nothing should be exported till these needs are satisfied. This Ministry would also control the prices so that the essential foodstuffs would fall within the reach of all. Here it is true subsidies would be needed. But such subsidies would benefit everyone. The provision of an Oslo breakfast is impossible at present. Not enough milk is produced in the country. But by establishing this meal, the dairy industry would be directly benefited and would have to expand to meet the demand.

The cure of the whole problem is met by the happily coined phrase "The Marriage of Health with Agriculture". What I have said in this short space of time shows how the two are absolutely interdependant. We must learn to think of agricultural products in terms of Health, as weapons to use in the fight for social reconstruction.

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Opsomming.

Ondervoeding en Wanvoeding

Die Maatskaplike Opname het in die skoolgaande kleurlingbevolking van Kaapstad 'n positiewe verband tussen wanvoeding en armoede vasgestel en 'n negatiewe verband tussen wanvoeding en ouderdom. Die Voedingsopname van die Kaap het 'n wydvertakte wanvoeding onder blanke, kleurling- en naturelle-kinders in Kaapstad vasgestel.

By die toekomstige studie van wanvoeding sou dit wenslik wees om ondersoek in te stel na : Voedingstandaarde, die uitwerking van sonskyn, die voedsel-gewoontes van die bevolking, die voedings- en sosio-ekonomiese status van vroue.

Die hoofoorsake van wanvoeding in Suid-Afrika is onkunde, oorbevolking, armoede, ontoereikende voedsel-produksie, landboubeleid. Middels word aan die hand gegee.

A HEALTH POLICY FOR THE STATE

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Read at the Third Session of the Social Survey Conference, Cape Town, 19th February, 1942

For some years now I have been an advocate of a State Medical Service for South Africa. Some of my colleagues have put to me the quite pertinent question "Why pick on the doctors for socialisation and not also the lawyers, the farmers, the butchers and the bakers?"

My answer is that quite independently of what might or might not be advisable for such other groups of the population the "socialisation" of Medicine seems to me to be the only efficient means of meeting the health needs of the community as a whole and if that view can be justified then I think the case for a State Medical Service is unanswerable.

We are already to some extent a "socialised" State (I use this term as a convenient one to include the taking over of any utility service from individual or private initiative by statutory authorities such as the Central Government, Provincial Governments, Municipalities or other Local Authorities). If precedents for the socialisation of Health are wanted one need only point to the fact that it has been found desirable in the interests of the community to socialise completely or almost completely such services as the military forces, the police, railways, postal services, education and veterinary services.

Further, in the domain of Health itself a very considerable degree of socialisation has taken place. It has long been realised that the provision of such elementary requisites for health as good water supplies and sanitation could not be left to private enterprise. The control of infectious and contagious diseases and of mental diseases is accepted without question as largely an affair of the central government. Provincial authorities are in the main responsible for our hospitals and our school medical services.

As our Society has become more complex other health needs have become evident, and some of them have been met by *ad hoc* legislation, under the control of one or another department of state or some other authority. I need not attempt to list all these here, but merely cite a few examples such as Workmen's Compensation for Accidents or Industrial Diseases, Pre- and Post-Natal Clinics, Nursery Schools, Chronic Sick Homes, District Nursing services, Rehabilitation Centres, Medical services for Native workers on mines, etc.

Then, one must just refer to the provision of medical services for the indigent by the Government District Surgeons, most of them private practitioners on a part-time basis, a few of them in full-time salaried posts. Also, the large service provided by the Government for its railway employees through the S.A.R. & H. Sick Fund. This work is largely done by private practitioners on a part-time basis. Mention may also be made of the start made to set up Benefit Societies in connection with particular industries under the Industrial Conciliation Act of 1937.

It will be gathered from this very brief survey that the provision of health and medical services for the community is a patchwork of private practice, mixed private practice and contract work and of salaried service under a multitude of different authorities. As things stand, some needs are reasonably adequately met, many very poorly so, or hardly at all..

In actual experience, it is found that the inco-ordination of the multiple agencies concerned with Health or Disease leads to a good deal of overlapping of effort on the one hand and, on the other, to many heart-breaking difficulties in getting things done. Many problems arise in which more than one department or agency is concerned and those with any experience of such cases can tell you in language which will probably be more eloquent than parliamentary of how each one tries (in Army parlance) to "pass the buck" and shift the responsibility (usually financial) on to some other party. In the end nothing may be done, or perhaps the patient dies and the argument changes into the new one of "Who is responsible for the funeral expenses?"

As an example of how chaotic things can be at present, may I just illustrate by citing what may happen if one wishes to have an "alcoholic" treated. He may be treated in a general hospital under a Provincial Administration; here he will probably receive adequate "first-aid" treatment but is, as soon as possible, turned out into the cold, cold world, or, with luck, he may be transferred to one of three other authorities, *viz.*, the Department of Social Welfare, in a private retreat; the Department of Prisons, in an Inebriates Reformatory; or the Department of Interior, in a Mental Hospital. Treatment in these varies from what may be termed punitive and repressive to what is humane and tolerably scientific, regarding the patient as a sick human being, not as a social outcast or criminal. Much depends on the exigencies of the moment what will happen and, in any case, attempts at rehabilitation are usually woefully deficient and of too short duration to be effective.

It may be argued that all these difficulties would be solved if the present organised medical activities were brought under one control and, where necessary, expanded. My answer is that although such integration is very desirable and, indeed, essential, it is not in itself enough. There are two other large factors which must be taken into consideration in thinking of the health needs of

the community and in planning a service to meet these needs. These are :

(1) The fact that the ordinary everyday medical services for the treatment of ill-health and disease have largely broken down, or are, at any rate quite inadequately meeting the legitimate demands for them. Medical practitioners as a body, and all ancillary services, must be brought into any complete Health scheme.

(2) The fact, now fairly widely recognized but not yet adequately translated into action, that much ill-health could be prevented and positive health promoted by improving environment. Social security, good conditions of work, housing, food and recreation are as essential for good health as the conditions which may be regarded as the more strictly medical requisites. Social welfare work must therefore occupy a prominent place in any comprehensive Health policy. Let us consider these two factors in some more detail.

Firstly, Medicine of to-day is rapidly becoming an exact science. You could easily, of course, taunt me with a number of conditions against which medical science is still comparatively powerless, nevertheless I affirm, and I do so with some professional pride, that with the knowledge we do possess we could prevent, cure or alleviate a great deal more of ill-health and suffering than we do, if only that knowledge could be applied.

Why is it not applied? Simply because medical science of to-day has become too expensive a commodity for most people to buy. This is not the doctors' fault ; it is the inevitable result of the increasing complexity of diagnostic and therapeutic measures and there is no going back on this state of affairs. As things are to-day, the rich can purchase the best and we needn't worry about them ; a iew, but only a very few of the very poor, can also get of the best at the expense of the State ; the lot of the "in-betweens," many of whom would like to pay for good service but just cannot afford to, is hard.

The extent to which some sections of our population are unable to pay anything for medical attention—to say nothing of many other of the amenities of life—is well brought out for the Coloured community in Cape Town in Report SS4 of the Social Survey of Cape Town. Here it is shewn that 85 per cent. of this section of the population had inadequate incomes for the provision of the bare requisites of health and decency, and that 53 per cent. had means so scanty that even if devoted entirely to the purchase of the barest necessities of physical health and decency, a minimum standard could still not be obtained. "Race Relations", Vol. 9, No. 1, brings out that similar conditions prevail amongst the Coloureds throughout the Union.

I do not know of equally detailed studies for other sections of the population in South Africa but most doctors can confirm the statement that for a large proportion of their patients any big

operation, lengthy or serious illness means—if his fees are paid—a financial crippling of that family for quite a period.

Attempts to cope with this situation have been numerous and varied, taking the form of private medical clinics, benefit societies, more Government provision for the treatment of indigents and, finally, the Government's proposed scheme of National Health Insurance. Something may be said, of course, in favour of all such schemes ; they do aim at providing better attention for the sick. At best, however, (and, in actual working out some of them are far from being "best") they are only sickness insurance schemes and get nowhere with the other aims of a real health policy.

The thought of the so-called National Health Insurance scheme being made law scares me more than anything else. It no doubt appeals to a Government because it would act like a baby's rubber dummy and keep a lot of voters quiet for a while as they would feel that something was being done for them. Admittedly, no country that has introduced such a scheme would like to go back on it, but equally certainly all of them want to go forward to something better. It has been stated that it is the logical first step to take in socialising medicine, but why waste time with it as a mere stopgap? When drawing up the Bill, the Government itself obviously regarded it as merely a temporary provision as they stated that "the time was not yet ripe for a state medical service". Since then, there has been time for consideration, conditions are altering rapidly and our conception of what should be done in the way of promoting health for the whole community has broadened. I am of opinion that the time is now ripe for a state medical service and that, if it be considered even only from the aspect of providing treatment for the sick, such a service is the only way in which satisfactory attention can be given.

Secondly, Man's environment. The time is past when it can be considered sufficient for the promotion of health to keep streets and backyards clean and to eliminate the major filth diseases, but it is quite unnecessary for me, in a gathering such as this, to stress how intimately poverty and social insecurity, malnutrition, and bad conditions of housing or work are tied up with ill-health.

Take malnutrition alone ; your Survey and Professor Brock have demonstrated a figure of approximately 50 per cent. of the Coloured children in Cape Town as so affected ; other investigators have shewn it to be prevalent throughout the whole of the Union, in both urban and rural districts. Some of it may be due merely to ignorance, but much, I fancy, comes from sheer poverty.

Much ill-health could be prevented if these socio-economic conditions were put right, and then there is the tragedy of some of the doctor's work when a patient physically or mentally "cured" has to go back into the maelstrom of economic or social maladjustment and all the work is undone through lack of suitable provisions for rehabilitation.

The problem of a Health Policy for the future is a complex one and it is a Social problem as much as a Medical one. In whatever

way the problem is solved, there should be a close collaboration between Medicine and Social Welfare, but I must confine myself to the more strictly medical aspect of it.

There seems to me to be only one body big enough to bring about a solution, *viz.*, the central government or State. No group of individuals or lesser authority could cope with it. The State is the only body interested enough in the whole community and at the same time dis-interested enough to get round or over the numerous personal, corporate or local vested interests which may have to be disturbed in the setting up of a State Medical Service.

I would hesitate to advocate such a large change in policy if I did not think that the needs of the community absolutely demanded it. The ordinary quiet evolution of building on the past and adding a bit here and there is not enough ; a mutation (which is still evolution and not revolution) is necessary. Use the present as a stepping stone where possible, of course, but do not be afraid of a jump.

Through a lesser loyalty (*viz.*, to my profession), I might still hesitate to advocate this change, if I did not believe that it would also be in the truest interest of the medical profession. Trained as scientists, the exigencies of life to-day are forcing us to become hucksters ; if Health and Medicine are made an affair of the State it is the surest way of our getting back to the old Greek ideal of "service"—our work will be done for the good of humanity and not for the sake of gain.

If you accept the thesis that a case is made out for a State Medicinal Service, or, as I would prefer to call it, a State Health Service, what is the structure of this service to be ? You may say "Oh, leave that to the Government and the doctors to work out". Well, that is perhaps all right as regards details, but I think you should take some interest at least in the principles on which such a service might be started, as these principles will very vitally affect success or otherwise of a State scheme.

To many of the public, I fancy a State Medical Service means merely free doctoring when they are ill but I think you will agree that Health for the community must be built on a much wider basis than that. The health pyramid will require strong and intelligent technical guidance from the top but the success or failure will largely depend on co-operation from the base as health measures cannot and never will be carried out unless the population as a whole responds to them. Therefore, in addition to centralised guidance there must be decentralised activity and this latter will have to include much propaganda among the less enlightened sections of the community.

My conception of a Health Policy for the State is that in the first place there should be a joint Ministry of Health and Social Welfare. (Some of my friends think it should be one of Social Welfare and Health but I won't argue about the relative importance of the two divisions so long as they are combined.)

This Ministry should take over all the present inco-ordinated social welfare, health and medical services. These might be run on the same lines as other Civil Service departments, but I must admit that many, probably most, members of my profession have very strongly rooted objections to this. Some of their objection may be unjustifiable and merely an expression of the individualism which is perhaps rather characteristic of most medical practitioners. They have some justification, however, in view of the many unfortunate experiences they have had in contract practice under lay control.

There is also the fear that under the peculiar conditions of South Africa the service, if under purely State control, might be captured by the political machine and I can imagine nothing more calculated to wreck any scheme than having appointments, promotions, etc., dependent on political views rather than on professional ability.

To avoid this danger, a Planning Committee set up by the Medical Association of South Africa has suggested that the health and medical services should not be run directly by a state department but that the Minister should delegate the technical control to a Health Commission and Health Advisory Council to be set up on lines similar to those by which electric power is controlled under the Electricity Supply Act.

The details of course would have to be worked out but the plan in general envisages a full-time small "Health Supply Commission" of medical men, in the appointment of whom the profession would have at least a considerable say ; also a larger "Health Control or Advisory Board", meeting, say, quarterly. This Board would have on it representatives not only of the medical and ancillary professions but also of social welfare, finance, agriculture, labour, etc These two bodies would be the central authority ; peripherally there would also have to be District Sub-Commissions.

It is felt that under such democratically appointed bodies, with technical experts in charge of the technical working of the health scheme the possible drawbacks of purely State control would be avoided. Financial control would necessarily remain a State affair.

And that brings me to what usually has the last word—finance. Any such policy as I have outlined is undoubtedly going to cost money, a lot of money, although I cannot give even a rough estimate of just how much. I regret that I cannot give even an approximate figure because, of course, this will have to be figured out before any scheme can become practical politics. It would not all be new expenditure, of course ; some of it would merely be paying in taxes what is at present spent in doctors' fees. I feel pretty certain, however, that the cost of any such scheme would not nearly approach the colossal amount we cheerfully spend on defence for the destruction of life. Could we not equally cheerfully spend something rather less colossal for the saving of life and look upon it

as an investment which will give a large dividend in health and happiness?

Cost, although it may have the last word, should not have the first say. I conceive it to be the duty of medical and social welfare experts to state as clearly and as fully as possible what they think is necessary to be done. If the people are convinced of this necessity then it is the duty of the Government to work out the cost and to see how near the ideal they can get. If we have, for a time, to be content with something short of it, it will still be our duty to co-operate in helping towards the next best possible.

I would, therefore, end with an appeal to the financial pundits that, when the time comes, as it must, for them to get busy on a health policy for South Africa, they should start with the aim "Here is the ideal, how near can we get to it" and not on either such tacks as "Here is so much for you, get on with it" or "How can we prune this down, so as to cost less?"

Opsomming

'n Gesondheidsbeleid vir die Staat

Die sosialisering van geneeskunde blyk die enigste doeltreffende middel te wees om aan die gesondheidsbehoeftes van die gemeenskap as geheel te voldoen. Tans bestaan die geneeskundige en gesondsheidsdienste uit lapwerk van private praktyk, kontrakwerk en ongekoördineerde gesalarieerde werk. Daar is behoefte aan (i) die samestelling van bestaande dienste, (ii) die uitbreiding van fasiliteite na alle sosio-ekonomiese klasse, (iii) die bevordering van positiewe gesondheid deur verbetering van omgewing. Die Staat is die enigste liggaam wat sowel geïnteresseerd as ongeïnteresseerd is om hierdie oogmerke te bereik. Aan 'n gesamentlike Ministerie van Gesondheid en Volkswelsyn behoort die administrasie van die gesondheidsdiens van die Staat toevertrou te word. Die koste sal heelwat laer wees as diè van die vernietiging van lewes in oorlogstyd.

THE SOCIAL SURVEY AND THE HEALTH OF THE URBAN POPULATION

DISCUSSION AT THE THIRD AND SUBSEQUENT SESSIONS OF THE SOCIAL SURVEY CONFERENCE, CAPE TOWN, THURSDAY, FEBRUARY 19TH AND FRIDAY, FEBRUARY, 20TH, 1942.

PROF. J. F. BROCK, Director of the Cape Nutrition Survey, opened the discussion :

The Cape Nutrition Survey was sponsored by the Public Health Department in association with the National Nutrition Council as part of a nation-wide attempt to get more information about malnutrition in South Africa. In Cape Town we have been very fortunate in certain circumstances which have made it possible for us to get a body of information for one racially homogeneous group which in its entirety must, I think, be unique in the world. I refer to the Cape Coloured people of Cape Town. The reason why we have been so fortunate is that the main purpose which was given to my Survey was to attempt to define the criteria by which malnutrition could be assessed. That meant that we must work on comparatively small numbers of children, and it would have been impossible to draw any conclusions from these small numbers had it not been for the fortunate circumstance that I was able to enlist the co-operation of Professor Batson, who had already included the Cape Coloured people in his Social Survey. The result is that it is possible to tell how far the children examined by us are representative of the Cape Coloured community ; and I think we can say that to-day we have information about the incidence of malnutrition among the Cape Coloured people which is probably not equalled for any other racial group in the world. I do not purpose to-day to go into the figures ; these will very shortly be published. I do propose to say that the incidence of malnutrition in the Cape Coloured people is very considerable, and that we are in a position to say that malnutrition is largely correctable.

Professor Batson has definitely been able to correlate the incidence of malnutrition among our children with the incidence of poverty as determined by his Poverty Datum Line. The result is that we can say that poverty plays a very considerable part in the malnutrition of the Cape Coloured people. The remedy lies in a short-term policy and a long-term policy.

For a short-term policy, Prof. Brock recommended the provision of a meal for school children "based on what is known as the Oslo breakfast."

I can say that it is possible to correct every nutritional deficiency in this way without altering the home circumstances, if the funds can be provided.

For a long-term policy, Prof. Brock referred the Conference to "those social and economic realities that Dr. Shadick Higgins has brought out."

We have found in Cape Town that the nutrition of Europeans living in the same economic conditions as the Cape Coloured people is just as bad as that of the Cape Coloured people.

MAJOR REES DAVIES congratulated Prof. Irving on his "very lucid exposition of malnutrition."

He brought up one important fact : from the physiological standpoint the natives might be able to utilize foodstuffs more efficiently than the European. To what extent we cannot anticipate at present. Professor Irving made reference to the nutrition of the natives on the mines. Analysis of the rationing scale as applied to the mine labourers would indicate that it is not one which is recognized as adequate for Europeans. It has been reported that all the natives on the mines are in a sub-scurvy stage.

MR. STAKESBY LEWIS thanked Dr. Shadick Higgins for his valuable paper, which however contained no reference to the influence of intoxicating drink on tuberculosis and venereal disease.

Tuberculosis is spreading throughout South Africa like a veld fire. Not only does the man who indulges in alcohol lay himself open to chances of tubercular infection, but his children are born with a diminished power of resisting the disease. Syphilis also is spreading throughout the Union at a rapid rate. It has become a national menace. As General Smuts said a few months ago, "Africa is a diseased continent." Moral control and continence is very soon annulled by relatively small doses of alcohol, and thus the individual becomes infected. The resistance of the body to the contagion of syphilis is distinctly lowered by alcohol. We have to consider not only the tragic consequences of this disease to the sufferers and their offspring, but also the poverty caused by it and the needless expense to the State in dealing with it.

MRS. N. HANEKOM also thanked Dr. Higgins for his paper :

Na hierdie lesing het ons 'n dieper besef dat die hele maatskaplike struktuur van die lewe en arbeid van 'n volk onafskeidbaar verbonde is aan goeie of slegte gesondheid.

Dwarsdeur die geskiedenis van Volksgesondheid en Volkswelsyn word ook erken dat armoede en siekte hand aan hand gaan as oorsake van mekaar. Dog in die meeste gevalle is die grondoorsaak van siekte en verarming onkunde. Uit onkunde spruit ondervoeding, verkeerde voeding, verkeerde lewenswyse, ens.

Hoër lone word verwelkom maar hoër lone sal nie die probleem oplos nie. Die mag van onkunde moet eers gebreek word. Dit is van die allergrootste belang dat ons meer voorbehoedende en opbouende werk onder die minder-bevoorregtes sal verrig en hulle met die nodige kennis sal voorsien. Die allertreurigste onkunde word onder behoeftiges aangetref, en daarom pleit ek met al die erns van my siel vir meer opgëleide werkkragte. Die vernaamste redmiddel om die vraagstuk op te los is meer verpleegsters, meer maatskaplike werksters, meer klinieke, genoegsame hospitaal, akkomodasie vir gewone moederskapgevalle.

Daar sal 'n nuwe dag vir Suid-Afrika aanbreek wanneer daarin geslaag word om die onkunde te verwyder en die nodige fasiliteite te skep.

Voorkomende dienste en voorligting is nodig om die wortel van armoede en onkunde te verwyder.

MRS. F. H. HOLLAND remarked that the tuberculosis figure for the Coloured people rose in 1931, and asked if this rise co-incided with economic depression.

DR. T. SHADICK HIGGINS :

I think the most likely explanation of the increase is the socio-economic. There are fewer skilled tradesmen among the Cape Coloured to-day than there were some years ago, and if we could have had an investigation of

the social conditions for an earlier period similar to that which Professor Batson has now carried through, I believe the comparison would have shown an economic decline and an increase in the amount of overcrowding.

THE REV. A. F. LOUW :

Hoe nou hang al die toestande saam ! Hoe kan ons op aarde verwag dat daar 'n groot verandering sal kom solank as die kleurlinge in die swak toestand bly waarin hulle is, solank as hulle op alle moontlike maniere in staat is om alkohol te kry ? Dit is 'n klad op die Europese beskawing in Suid Afrika dat 'n 800,000 kleurlinge in die Kaap Provinsie in die toestand van onkunde en ellende verkeer waarin hulle vandag is—vir 'n baie grootgedeelte van hulle altans. Ons wat ons voogde van die mense noem behoort toe te sien dat daar verbetering sal kom. Een saak waarin met krag moet opgetree word is die misbruik van sterke drank.

DR. T. SHADICK HIGGINS expressed regret that time had now allowed him to deal with the points raised by Mr. Stakesby Lewis and the Rev. Mr. Louw.

I am quite sure that drunkenness among a section of the Coloured people is an important cause, not only in the prevalence of tuberculosis and venereal disease, but also in mortality from other conditions. Not only does drunkenness have a deleterious effect on the body, but it is a direct cause of social and economic degradation, not to mention the fact that those who indulge in drunkenness are spending the already insufficient means available for their wives and children. Drink is a terrible menace to the non-Europeans of Cape Town

MRS. H. S. EXLEY, moving the following resolution on behalf of the Parents' Association of Port Elizabeth and District :

> That the Government be requested to provide adequate dental care for indigent children,

said that health depends upon many factors, including a healthy mouth. A recent examination of 5,000 indigent children had revealed that 97 per cent. had dental caries, and of 12,500 children in Government primary schools in one town, 65 per cent. were estimated to need urgent dental treatment for which they were unable to pay.

In many cases there is no dental treatment owing to the difficulty of getting dental surgeons to visit outlying districts. As a result of many extractions, far too many adolescents are without their own teeth and without much hope of obtaining false teeth. Preventive work, education in dental health, and sufficient full-time dentists and mobile surgeries, could do much.

Resolution moved.

COUNCILLOR H. S. WALKER suggested the addition of the words "of all races."

MRS. H. S. EXLEY accepted the proposed addition.

Revised resolution put, and adopted. [*See* Resolution 18, p. 207.]

MRS. H. HORWOOD, moving the following resolution on behalf of the South African Trained Nurses' Association :

> That education of the child in personal health, hygiene, and nutrition, should begin at entry into school, and be progressive and well illustrated throughout school life.

said that the thing that impressed her most profoundly when she visited the United States was the change in the dietary habits of the nation brought about in a decade by the education of the child.

> It is no use counting only on the education of the mother. The real foundation of the health of the population lies in the education of the child. Children are perhaps educated for passing examinations; they may even be trained for the earning of a livelihood; but they are not being sufficiently trained in the art of living.

Resolution moved.

DR. G. D. LAING objected to the words "begin at entry into school."

> Personally, I feel that the inculcation of health habits in children must begin long before school age.

Dr. Laing proposed the following amendment :

> *Delete* "begin at entry into" *and substitute* "be given from entry into".

Amendment moved.

MISS V. MAGNIAC proposed the following amendment :

> *Delete* "education of the child" *and substitute* "education of children of all races".

Amendment moved.

Miss Magniac's amendment put, and carried.

Dr. Laing's amendment put, and carried.

Amended resolution put, and adopted. [*See* Resolution 16, p. 207.]

MRS. H. HORWOOD, moving the following resolution on behalf of the South African Trained Nurses' Association :

> That this Conference calls on the City Council and the Government of South Africa to increase the number of beds available for cases of pulmonary tuberculosis to not less than the total annual deaths from tuberculosis; and that this resolution apply to all other areas where similar conditions exist,

said that Dr. Higgins had shown segregation of cases of pulmonary tuberculosis to be the most important factor in the fight against infection.

In reply to a question, Mrs. Horwood substituted the words "all Local Authorities" for "the City Council."

Resolution moved.

MRS. H. HORWOOD, moving the following resolution on behalf of the South African Trained Nurses' Assocation :

In view of the fact that war almost invariably brings a recrudescence of venereal disease, this Conference urges that immediate steps be taken to increase hospital accommodation and treatment centres in suitable localities, and every step to educate people as to its incidence and curability,

referred the Conference to the plain statement of the facts in the Annual Report of the Secretary for Public Health.

Resolution moved.

THE CHAIRMAN (DR. P. ALLAN) :

These two resolutions meet with universal approval. They fit in with my own opinion. You may think the Government moves slowly, but in times like this it speeds up. I am glad that the public conscience is waking and giving us support.

Mrs. Horwood's two resolutions put, and adopted. [*See* Resolutions 14 and 15, p. 206 f.]

DR. J. H. RAUCH asked permission to draw the attention of the Conference to the state of affairs regarding tuberculosis on the mines of the Witwatersrand.

Yesterday I heard the economists here refer to poverty-creating legislation. But I want to say that there is also tuberculosis-creating legislation. I am putting this matter before you to test the sincerity of this New Deal in Public Health that we are to get.

Dr. Rauch then asked permission to move a resolution which, he stated, referred to the repatriation of mine Natives who had contracted tuberculosis.

DR. I. FRACK urged that the "tuberculosis menace on the Rand is continually on the increase."

One hundred and sixty-five cases were notified in Krugersdorp last year, and eighty per cent. of those were from the mines.

THE CHAIRMAN (DR. P. ALLAN) ruled that the statements of Dr. Rauch and Dr. Frack were welcome as a contribution to the discussion, but that the proposed resolution could not be held to arise out of the Social Survey of Cape Town.

Tuberculosis in the Transkei is an endemic disease. We are doing something about it. Last year we opened a hundred-bedded hospital in the Ciskei. We are making use of the mission stations. We are experimenting with two types of clinic. We have a health centre—one at Bulwer in Natal. I can assure Dr. Rauch and Dr. Frack that we are in sympathy with their statements and that we are getting on with the job.

PROF. W. H. HUTT, moving the following resolution :

That, in view of the malnutrition disclosed by the Survey, the Government be urged to investigate the methods of removing, without injustice to home producers of foodstuffs,

(1) all tariffs and prohibitions on the importation of health-giving foodstuffs,

(2) all systems of internal control which involve the raising of food prices internally and the destruction or dumping abroad of home-produced foods,

said :

Dr. Pirie tells us that medical men to-day are in the position of hucksters. But he says it is not their fault, that they are without blame for any inadequacy of medical services. He tells us that we should not worry about the past, but should collectively spend more than we do to-day on medical services. To-day thousands of young men and women are striving to get into the medical profession. Why ? Is it that they are striving for entrance to a lucrative and remunerative profession ?

MR. W. BALLINGER :

This is not the first time that Professor Hutt has got in ahead.

PROF. W. H. HUTT :

I am speaking directly to my resolution. Before any steps are taken towards State Medicine, income-tax statistics should be analyzed to discover whether aggregate medical earnings have increased, and, if so, by how much. Will you find a sharply rising curve ? The poor people certainly need more medical attendance, but they do not necessarily need more doctors. They need more vitamins and calories.

THE CHAIRMAN (DR. P. ALLAN) ruled that Prof. Hutt's remarks were not relevant to his motion.

PROF. W. H. HUTT :

I simply ask you to support this resolution which, you will note, merely asks for investigation.

Resolution moved.

MRS. J. E. CONRADIE claimed that the time had arrived for the Government to assume the right to prescribe the foods that the people should eat.

What has become of the wonderful physique of the native race ? It is deteriorating simply because the staple food of the natives has been refined to such a degree that it is practically of no value. Instead of asking for removal of tariffs, I would like this Conference to support a motion asking the Government to make it possible to bring protective foods within the purchasing power of all classes of people. We have an example in State-provided butter. This may sound a little revolutionary ; but I think it will need nothing short of a revolution in our mental approach to these things if we are to get anywhere.

THE REV. F. X. ROOME urged the Conference not to forget the need for the protection of home production.

SENATOR S. J. SMITH suggested that the procedure proposed in the resolution would be a waste of time, since the cause of the trouble, as everybody knew, lay merely in the lack of purchasing power.

I submit, therefore, that the very precious time that is left to this Conference shall not end until we have a definite mandate from the people who have done this selfless work, that poverty shall no longer prevail in our land.

MR. S. PAUW objected that the resolution was one-sided and an attack on the producer, inasmuch as it implied that the high prices of foodstuffs were due to the prices obtained by producers.

Die hoë pryse is nie in die eerste instansie te wyte aan hoë invoertariewe of aan die stelsel van beheerrade nie, maar aan die gebreke van ons huidige distribusiestelsel. Ons distribusie word nou somar aan die geluk oorgelaat en aan daardie verkwistende vrye kompetisie waarvoor hier soveel propaganda gemaak word. Distribusie kos in die meeste gevalle meer as produksie.

Mr. Pauw proposed the following amendment to Prof. Hutt's resolution :

> *Between* "investigate" *and* "the methods" *insert* "(*a*)" ; *and after* "home-produced foods" *add* "(*b*) the possibility of improving the present wasteful methods in the distribution of essential foodstuffs."

PROF. W. H. HUTT accepted the proposed amendment.

MAJOR REES DAVIES said that he thought Prof. Hutt was an optimist.

I should like to know from him where he anticipates finding foodstuffs for importation into the Union if every country is to feed its own population. The question of food supply concerns every nation in the world to-day.

The farm value of foodstuffs required to feed the whole of the urban population of the Union can fairly easily be assessed. It would amount to approximately £23,000,000. On the existing basis the consumer will have to pay approximately £61,000,000 for identically the same food. There undoubtedly lies a big possibility, not only of reducing the cost to the consumer but, if necessary, of increasing the return to the producer.

Prof. Hutt's revised resolution put, and adopted. [*See* Resolution 19, p. 207.]

DR. J. HARVEY PIRIE, moving the following resolution :

> The Social Survey Conference 1942, sitting in Cape Town at present, has observed with satisfaction the action of the Government in appointing a Commission to investigate and recommend the best measures for ensuring adequate health services for all sections of the population of the country,

stated that the resolution referred to the acceptance of Dr. Gluckman's proposal in the House of Assembly a few days earlier.

Resolution moved.

MR. W. BALLINGER objected that the matter had not been passed in the House.

Discussion postponed and resumed at a later session.

ADV. D. BUCHANAN urged that there would be no harm in thanking the Minister for the remarks he had made on the subject. It would be of assistance to the Government if the Conference were to express an opinion.

MR. F. H. HOLLAND proposed the following amendment :

Delete the present words of the resolution and substitute: "That this meeting cordially approves of the proposals put forward by Dr. H. Gluckman for a comprehensive medical service and expresses its appreciation of the sympathetic attention of the Minister of the Interior and Public Health."

Dr. J. Harvey Pirie's resolution withdrawn.

Mr. Holland's motion put as substantive resolution, and adopted. [*See* Resolution 17, p. 207.]

Die Maatskaplike Opname en die Gesondheid van die Stedelike Bevolking

Hoofpunte in die Bespreking op die Derde en Daaropvolgende Sittings van die Konferensie insake Maatskaplike Opname, Kaapstad.

Donderdag, 19 Februarie en Vrydag, 20 Februarie 1942.

PROFESSOR J. F. BROCK het die bespreking ingelei met 'n beskrywing van die werk van die Kaapse Voedingsopname wat aan die lig gebring het dat daar onder die Kaapse kleurlinge 'n groot mate van wanvoeding was wat verhelp kon word. Daar is bewys dat armoede 'n baie belangrike faktor by hierdie wanvoeding is. MAJOOR REES DAVIES het na die wanvoeding onder mynnaturelle verwys. MNR. STAKESBY LEWIS het enige opmerkings by die verhandeling van Dr. Shadick Higgins gevoeg oor die verband tussen alkohol, tering en geslagsiektes. MEV. N. HANEKOM het gepraat oor die verband tussen armoede en siekte en onkunde. In antwoord op 'n vraag van MEV. F. H. HOLLAND, het DR. SHADICK HIGGINS verklaar dat sosio-ekonomiese faktore die waarskynlikste verduideliking bevat van die toename van tering by die kleurlinge in 1931. En in antwoord aan Mnr. Stakesby Lewis, en na aanleiding van sommige opmerkings van Ds. A. F. LOUW oor die verband tussen armoede en misbruik van alkohol, het DR. SHADICK HIGGINS die mediese en maatskaplike gevolge van dronkenskap beskryf as ,,'n verskriklike bedreiging vir die nie-blankes van Kaapstad".

MEV. H. S. EXLEY het voorgestel ,,dat die Regering versoek word om toereikende tandheelkundige sorg vir behoeftige kinders te verskaf" en het RAADSLID H. S. WALKER se wenk aanvaar dat die woorde ,,van alle rasse" bygevoeg behoort te word. Die besluit is aangeneem (*Sien Besluit.* 18, *bl.* 212).

MEV. H. HORWOOD het 'n besluit voorgestel waarin gevra is om die invoering van gesondheidsonderrig in skole. DR. G. D. LAING het by die voorstel van 'n wysiging verklaar dat gesondheidsonderrig voor skoolgaande ouderdom behoort te begin en MEJ. V. MAGNIAC het voorgestel dat die besluit herbewoord word om kinders van alle rasse te omvat. Die wysigings is goedgekeur en die besluit is aangeneem (*Sien Besluit.* 16, *bl.* 212).

MEV. H. HORWOOD het Besluite No. 14 en 15 (*Sien bl.* 212) voorgestel wat aangeneem is.

DIE VOORSITTER (DR. P. ALLAN) het verklaar dat die Regering inderdaad nie die sake wat in die besluite vermeld word verwaarloos nie.

DR. J. H. RAUCH en DR. I. FRACK het verlof gevra om 'n besluit handelende oor tering onder mynnaturelle voor te stel. Hulle opmerkings is verwelkom as 'n bydrae tot die bespreking maar daar is beslis dat die voorgestelde besluit buite die orde sou wees. DIE VOORSITTER (DR. P. ALLAN) het verklaar dat die Regering maatreëls tref om tering te bestry.

PROFESSOR W. H. HUTT het 'n besluit voorgestel waarin gevra word om 'n ondersoek na die metodes van verwydering van tariewe en ander beperkings op die verbruik van voedsel. Daar was meer behoefte aan vitamines en kalories dan aan meer dokters. MEV. J. E. CONRADIE het verklaar dat 'n uitbreiding van die beginsel van die verskaffing van botter deur die Staat beter sou wees as die verwydering van tariewe. SENATOR S. J. SMITH het aangevoer dat die besluit nie die wortel van die saak raak nie wat te vind is in die gebrek aan koopkrag. DS. F. X. ROOME het die aandag gevestig op die behoefte aan beskerming van binnelandse produksie en MNR. S. PAUW het 'n wysiging voorgestel met betrekking tot verkwisting by distribusie en het beswaar gemaak teen die voorgestelde besluit omrede daarvan dat dit onbillik en eensydig was. MAJOOR REES DAVIES het verwys na die gaping tussen die plaaswaarde van voedingsware en die koste vir die verbruiker. PROFESSOR HUTT het Mnr. S. Pauw se wysiging aanvaar en die besluit is aangeneem (*Sien Besluit* 19, *bl.* 212).

DR. J. HARVEY PIRIE het 'n besluit voorgestel om genoeë uit te spreek oor die aanstelling van 'n Regeringskommissie om die daarstelling van 'n nasionale gesondheidsdiens te oorweeg. Toe MNR. W. BALLINGER beswaar gemaak het, is die bespreking uitgestel. By hervatting op 'n volgende sitting het ADVOKAAT D. BUCHANAN by die Konferensie aangedring om 'n mening oor hierdie saak uit te spreek en MNR. F. H. HOLLAND het Besluit 17 voorgestel wat, nadat Dr. Pirie se voorstel teruggetrek is, aangeneem is (*Sien* bl. 212).

DIE MAATSKAPLIKE DIENSTE IN DIE STAD
'N BESKRYWENDE OPNAME

deur Ds. P. du Toit, B.A.
Vise-Voorsitter Algemene Armesorgkommissie, N. G. Kerk

Gelees voor die Vierde Sitting van die Maatskaplike Opname Konferensie, Kaapstad, 19 Februarie, 1942

Dit is nodig om een of ander metode van klassifikasie te volg as ons 'n oordeelkundige beskrywing van die maatskaplike dienste in die stad wil gee. Daar is verskeie metodes wat gevolg kan word Die verdeling kan bv. as volg wees : Dienste wat uitgaan (i) van die Staat, (ii) van die Kerke, (iii) van private organisasies of persone. Ook moet daar op gewys word dat daar 'n groot verskeidenheid van dienste is, baie waarvan nie juis in een bepaalde rigting werk nie, sodat dit moeilik is om te besluit juis in watter kategorie sommige geplaas moet word. Eie deskresie moet dus gebruik word en ruimte gelaat word vir verskil van opinie. Ons opname maak ook nie aanspraak op 100 persent volledigheid nie, aangesien daar dikwels kleinere en minderbekende instellings of komitees is wat vir korter of langer tyd bestaan, en een of ander vorm van maatskaplike werk in 'n beperkte omgewing verrig.

Daar is 'n ondersoek van Prof. O. J. M. Wagner van Stellenbosch : Social Work in Cape Town, uitgegee in 1938 en wat 'n nuttige opsomming van maatskaplike dienste bevat en waaraan ons (met verskuldigde erkentlikheid) heelwat inligting kon ontleen, en wat ons sover moontlik gewysig of aangevul het deur ondersoek na veranderde omstandighede. Ook moet daarop gewys word dat ons nie die abnormale oorlogsomstandighede in ag geneem het nie, waardeur daar soms maatskaplike dienste van tydelike aard in die lewe geroep word. Ons bepaal ons so na moontlik by die normale toestande.

Ons maak die volgende vyf hoof-verdelings :

A. Noodleniging.
B. Behuising.
C. Kindersorg.
D. Gesondheidsdienste.
E. Opvoedkundige-en Voorligtingsdienste.

By die volgende onder-verdelings kan al die maatskaplike dienste ingegrepe word, waardeur ons dan 'n algemene oorsig kry.

A. Noodleniging, gerangskik volgens

(*a*) Voorwerpe wat hulp ontvang :

(i) Instellings vir spesiale tipes van behoeftiges.

(ii) Organisasies van algemene aard (dws. sonder enige beperkings wat die voorwerpe van hulp betref)
(iii) Organisasies van beperkte aard (dws. wat hulp verleen spesifiek aan sekere volks- en kerklike groepe)

(*b*) Vorm van hulp :
(i) Organisasies wat *alle* vorms van materiële hulp verleen ;
(ii) Die wat net bepaalde soorte van hulp gee.

B. BEHUISING, onderverdeel as volg :

(i) Vir gesinne met baie min inkomste,
(ii) Vir alleenlopende mans en vroue,
(iii) Vir bejaardes,
(iv) Vir diegene in tydelike nood,
(v) Vir laagbesoldigde jeugdiges,
(vi) Vir diegene wat sedelike beskerming nodig het.

C. KINDERSORG, as volg verdeel :

(i) Inrigtings vir behoeftiges en verwaarloosdes,
(ii) Bewaarskole,
(iii) Inrigtings vir kinders wat sedelike proteksie nodig het,
(iv) Beskerming en versorging van jeugdige misdadigers,
(v) Voorligtingswerk,
(vi) Staatsorg onder kinderbeskermingswette.

D. Gesondheidsdienste, ingedeel as volg :

(i) Vry klinieke,
(ii) Vry hospitaalbehandeling (Algemeen en spesiaal),
(iii) Verplegingsdienste,
(iv) Behandeling van verstandelik-afwykende kinders.

E. OPVOEDKUNDIGE- EN VOORLIGTINGSDIENSTE, as volg :

(i) Klubs,
(ii) Instellings tot geldelike hulpverlening,
(iii) Aan liggaamlike gebreklikes,
(iv) Opleiding en indiensname van maatskaplike werkers (sters).

Nadere toeligting.

A. NOODLENIGING.

Onder hierdie hoof bestaan daar ongeveer 30 organisasies in die stad, behalwe die verskillende kerkgenootskappe wat in engere kring aan hulle eie lidmate tydelike materiële hulp verleen waar die nood druk. Die organisasies (en in sommige gevalle slegs komitees) wat hierdie soort van werk doen, verdeel ons in twee groepe, te wete, volgens (I) Die voorwerp aan wie hulp verleen word, en (II) Die vorm wat die hulpverlening aanneem.

Onder (I) val :

(*a*) Vereniginge en instellings (van nie-institusionêre aard) wat *spesiale* tipes van behoeftiges dien, nl. die volgende klasse :
(i) Die liggaamlik gebreklikes. Vyf organisasies waaronder Cape Town Civilian Blind Society ; Care Committee for Tubercular Patients ens., behalwe die twee staatskemas van pensioene vir Blindes en liggaamlik ongeskiktes.

(ii) Die lede van gesiene families wat in armoede verval het (The Genteel Poor). Vir hierdie klas bestaan daar drie fondse wat deur trustees bestier word, soos o.a. die Frederick Fish Fund.

(iii) Die oues van dae (buitemuurse versorging). Behalwe die hulp wat kerkgenootskappe aan hulle eie behoeftiges verskaf, kom hier alleen in berekening die staatskema van Ouderdomspensioene.

(iv) Manne uit die militêre diens getree of ontslaan (Ex-servicemen). Hiervoor bestaan daar die plaaslike organisasie van die Goewerneur-Generaal Fonds, en daarby nog twee organisasies, nl. Die B.E.S.L. en die Fairhaven Work Party. Laasgenoemde verskaf veral vry huisvesting in besondere gevalle.

(v) Die Werklose tipe. Die plaaslike buro van die Departement van Arbeid is hier die vernaamste organisasie, wat egter nie direkte noodleniging doen nie, maar werkverskaffing as funksie het. Dan is daar die Citizen's Unemployment Relief Fund en die Stabilis-agentskap. Laasgenoemde bepaal hom veral by die werksoekende intrekker na die stad uit die platteland.

(*b*) Organisasies wat in die algemeen hulp verleen afgesien van die tipe van liggaamlik behoeftige, of wat die oorsaak van behoeftigheid ookal mag wees. Hiervoor bestaan daar 12 instellings waarvan die A.C.V.V., die Board of Aid, Salvation Army Metropole en die Society of St. Vincent de Paul die vernaamste is.

(*c*) Vereniginge wat hulp verleen in beperkte kring, aan bepaalde volks- of kerklike groepe. Uit die ongeveer 10 instellings noem ons die volgende voorbeelde : Sons of England Patriotic and Benevolent Society. (Alleen vir Engels-sprekendes wat lede is), Hebrew Helping Hand Association, League of Friends of the Blind (vir Kleurlinge), Society of St. Vincent de Paul (Rooms Kat. Blankes), ens.

Onder (II) val :

(i) Vereniginge wat alle vorms van hulp verleen, soos voedsel klere, geldelike lenings, betaling van huur, medisyne ens.

(ii) Vereniginge wat hulle toelê om spesifiek sekere vorms van hulp te verskaf. Bv., Salvation Army Metropole—maaltye en slaapplek ; Eaton Trust—geldelike toelaes ; Hebrew Helping Hand—finansiele lenings, ens.

B. BEHUISING.

(i) Vir gesinne met lae inkomste.

(*a*) Die Stedelike Behuisingsbond Utiliteits-maatskappy het oor die 1,600 huise reeds gebou en meer is in aanbou. Vir Blankes.

(*b*) Die Kaapstadse Munisipaliteit Behuisingskemas vir kleurling-families.

(ii) Vir behoeftige alleenlopende mans en vroue. 6 Tehuise en hostels, waar gratis of baie goedkoop akkommodasie verkry kan word.

(iii) Tehuise vir behoeftige bejaardes. 8 Tehuise.

(iv) Tehuise vir laagbesoldigde jeugdiges. Vier Tehuise, twee vir werkende seuns en twee vir werkende meisies : Prof. de Vos Hostel en die Louis Botha Hostel ; en die A.C.V.V. meisies Tehuis en die pasvoltooide Tehuis vir 120 meisies deur die Hostels Utiliteits-maatskappy.

(v) Inrigtings vir diegene wat sedelike bewaking nodig het. Vier inrigtings, een vir kleurlinge.

C. KINDERSORG.

(i) Inrigtingsorg ; tehuise vir verwaarloosdes en weeshuise. 18 tehuise, meestal kerklike, en die meeste het maar beperkte ruimte.

(ii) Bewaarskole, waarvan daar vier is en die twee mees-bekende die A.C.V.V. bewaarskool en die Board of Aid Day Nursery.

(iii) Inrigtings vir kinders wat sedelike beskerming nodig het. Sien onder B (v) hierbo.

(iv) Jeugdige misdadigers. Drie inrigtings, een vir kleurlinge ; en die Proefbeamptediens van die Departement van Volkswelsyn.

(v) Voorligtingswerk. Sien onder E.

(vi) Staatsorg onder kinderbeskermingswette. Die Kommissaris vir Kindersorg, Die Kinderhof, Die Proefbeamptediens. Ook kan ons hier noem die Vereniging tot Kinderbeskerming (Society for the Protection of Child Life).

D. GESONDHEIDSDIENSTE.

(i) *Vry Klinieke*, vir behandeling van siektes en raadgewing. Verreweg die meeste sorteer onder die Gesondheids-departement van die Stadsraad.

3 Klinieke vir die behandeling van veneriese siekte ;
1 Kliniek vir die behandeling van tande ;
12 Klinieke vir Verwagtende moeders en kindersorg ;
2 Sentra vir Teringlyers,
Die Vry Apteek onder kontrole van die Hospitaalraad ;
Die Buite-pasiente afdelings van die verskillende hospitale.

Hierdeur word vry behandeling verskaf binne die stadsgebied aan 'n groot getal behoeftige siekes, beide blank en gekleurd.

(ii) *Algemene Hospitale*, waar behoeftige siekes vry behandeling ontvang. Vier Hospitale.
Spesiale Hospitale, waar aan armes gratis behandeling op bewys van behoeftigheid gegee word
Vir Bevallinge 3,
Vir lyers aan geestesverstoringe 2,

Vir Orthopediese Behandeling 4 ; twee vir blankes en gekleurdes en een vir blankes alleen en een vir kleurlinge alleen.

Vir Aansteeklike siektes 2, nl. City Hospital en Rentskies Plaas onder kontrole van die Munisipaliteit se Gesondheids-dept.

Vir Kroniese siekes—die Conradie Tehuis.

Vir klein-kinder behandeling (dieet)—Lady Buxton Tehuis.

'n Totaal van 13 *inrigtings*.

(iii) *Verplegings- en versorgingsdienste*

(*a*) Verplegingsdienste—nege Organisasies, waarvan die belangrikste die is van die Gesondheidsdepartement van die Stadsraad deur middel van sy Gesondheids-besoeksters. Voedsel aan verwagtende moeders en melk aan babas, teen baie goedkoop tarief of gratis as nie betaal kan word nie. Behandeling tuis indien omstandighede dit vereis.

(*b*) Sorg vir herstellende behoeftiges onder toesig. Sewe Inrigtings, soos die Duinendal tehuis vir teringlyers, en die Sunshine Home vir kinders.

(iv) *Behandeling van verstandelik-afwykendes :*

(*a*) Inrigtings : Adams Farm for Young Women, onder kontrole van die Kaapstadse Ver. vir "Mental Defectives"; Alexandra Instituut vir kinders ; en Valkenberg Hospitaal.

(*b*) Voorligting : Kinderleiding Kliniek (onder beheer van die Universiteit van Kaapstad) : die Kaaplandse Ver. vir Geestes-higiëne.

(*c*) Spesiale klasse by 17 skole onder die Provinsiale Administrasie.

E. OPVOEDKUNDIGE EN VOORLIGTINGSDIENSTE

(i) Deur middel van Klubs, waarvan daar 15 is insluitende drie vir kleurlingkinders. Die vernaamste is die Voortrekkers, Boy Scouts en Girl Guides en Gordon's Instituut en die Seuns Afdeling van die Y.M.C.A.

(ii) Die Gemeenskapsentrum van die A.C.V.V. te Soutrivier.

(iii) Instellings wat geldelike hulp verleen aan behoeftige leerlinge —5 in getal :

Die A.C.V.V. i.v.b. met boeke,
Die Hofmeyrfonds (Kerklik, N. G. Kerk),
Helpmekaar Vereniging,
Moslem Education Trust,
Salesian Instituut.

(iv) Opvoeding en sorg vir liggaamlik gebreklikes. Soos bv. die Kriel Tehuis vir Epileptici, die Lady Michaelis Home, Spesiale klasse vir hardhorende kinders, Princess Alice Home of Recovery en ongeveer agt ander, waaronder vir kleurling kinders, te wete ; Athlone Blind School, St. Joseph's Home (vir kreupeles).

(v) Opleiding en indiensname van maatskaplike werkers (sters).
   (*a*) Universiteit van Kaapstad Departement van Sosiale Wetenskappe.
   (*b*) Inrigting van die Vroue Sendingbond (N.G. Kerk) vir opleiding van kleurling vroue.
   (*c*) Subsidie skema vir sosiale werksters van die Departement van Volkswelsyn.
(vi) Die Christelik-maatskaplike Raad v.d. Skiereiland.

Hiermee het ons probeer om 'n beknopte oorsig te gee of 'n beskrywende opname van die maatskaplike dienste in die stad. Elkeen sal tot die konklusie kan kom dat daar ruim voorsiening gemaak word en dat die hart van die gemeenskap vir weldadigheid oop is. En tog sal dit by 'n kritiese beskouing duidelik word dat daar hier en daar groot leemtes bestaan, en dat die nood en lyding in ons onmiddelike omgewing hartverskeurend is. Daar is grondoorsake van verwaarlosing en verarming wat nie aan geraak word nie, die aanwysing waarvan nie binne die bestek van hierdie referaat val nie.

Summary

The Social Services in the City—A Descriptive Survey

Before attempting an analysis of urban social work, it is essential that some classification or other be adopted. The following outline has been decided upon, and covers the field of social services operating under peace-time conditions :

Poor Relief: Arranged according to recipient and type of aid.

Housing; Subdivided according to beneficiaries—aged poor, destitute, households with small incomes, etc.

Child Welfare; Institutions for the needy and neglected, Places of Safety, protection of juvenile offenders, etc.

Health Services; Free clinics, free hospital treatment, treatment of mentally defective children, etc.

Educational and Vocational Services; Clubs, education and care of the handicapped, training of social workers, etc.

A more detailed enumeration is then given of the social services existing in Cape Town, which are still considered inadequate.